

CASCA Conference 2020

Erica Brudjar RN, Acute Care Section Manager

Margaret Mohan RN, Branch Chief, Acute Care
and Nursing Facilities

June 4, 2020

References - Federal

CMS State Operations Manual, Chapter 2 -
The Certification Process - sections 2825 - 2826H

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf>

CMS State Operations Manual, Chapter 5 -
Complaint Procedures

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf>

CMS State Operations Manual, Appendix L Ambulatory
Surgery Centers

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf

CMS State Operations Manual, Appendix Z Emergency
Preparedness

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SOM-Appendix-Z.pdf>

References - State

6 CCR 1011-1 Chapter 2: Standards for Hospitals and Health Facilities - General Licensure Standards

<https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8662&fileName=6%20CCR%201011-1%20Chapter%2002>

6 CCR 1011-1 Chapter 20: Standards for Hospitals and Health Facilities - Ambulatory Surgical Centers and Ambulatory Surgical Centers with a Convalescent Center

<https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8504&fileName=6%20CCR%201011-1%20Chapter%2020>

CMS Participation

Social Security Act -

Section 1864 -

- Delegates the authority for certification recommendations to the State Agency

Section 1865 -

- Allows certain providers to demonstrate compliance through accreditation of CMS recognized Accreditation Organizations.
- AO requirements must meet or exceed the Medicare requirements.

Mission and Priorities Document (MPD)

- Issued yearly based on federal fiscal year
- Identifies workload priorities for the State Agencies on a tiered basis
- Four tier options for most providers, only 2 tiers for deemed hospitals
- **Tier 1** - EMTALA complaints, Validation Surveys, Immediate Jeopardy complaint investigations and full surveys pursuant to complaints

MPD (cont.)

Tier 2 - Non- IJ Complaint investigations. SA must initiate the survey within 45 days of authorization by the Regional Office.

Tiers 3 - Non-deemed facility recertification surveys. Average survey interval is 3 years and no facility survey interval can exceed 6 years.

Tier 4 - Initial ASC surveys

COVID-19

Certification:

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group:
Prioritization of Survey Activities - Ref: QSO-20-20-All

Licensure:

Public health & executive orders resource: <https://covid19.colorado.gov/covid-19-in-colorado/public-health-executive-orders-resource>

Survey Process

- All surveys and/or complaint investigations are unannounced
- Entrance conference will take place upon entry: org chart, scope of services provided, staff roster, etc.
- Additional documents will be requested throughout the survey.
- The facility will need to identify a lead staff member to work with the survey team. This needs to be someone knowledgeable of clinical functions as well as administrative operations
- A tour of the facility will occur
- The survey will include observations, interviews and document review

Survey Process cont.

Observations may include - care and education being provided, procedures performed and inspection of the physical environment.

Interviews may include direct care staff, providers, administrative and executive staff, contract staff and patients and family members

Record review may include medical records, policies, procedures, contracts, protocols, monitoring and registration logs, credential and HR files, manufacturer's instructions, etc.

The survey is focused on the system processes regarding compliance to the Conditions of Participation and state licensure requirements.

Survey Findings

An exit conference concludes the investigation and preliminary findings are identified to the facility.

Survey findings are reviewed by the department and CMS to make final deficiency determinations. The survey findings result in either-

- **Compliance** - no deficient practice findings; or
- **Noncompliance** - deficient practice findings identified resulting in Standard, Condition or Immediate Jeopardy* deficiencies
- **A Plan of Correction (POC)** - developed by the facility and submitted to the State Agency for approval is required for Standard and Condition level findings. After the POC has been accepted and the facility has instituted the identified actions addressed in the POC, a revisit is conducted to assess compliance.

Plan of Correction

The report issued by CMS contains instructions regarding a Plan of Correction. The facility is required to draft a plan of correction to address each of the deficiencies identified in the report.

The plan of correction must be submitted to CDPHE within 10 calendar of receipt of the report from CMS.

For each deficiency identified the facility drafts a specific plan to correct the issue (i.e. educational training, policy revisions, on-going monitoring, purchase of equipment, etc.)

The facility also identifies a specific date when the deficiency practice will be back into compliance.

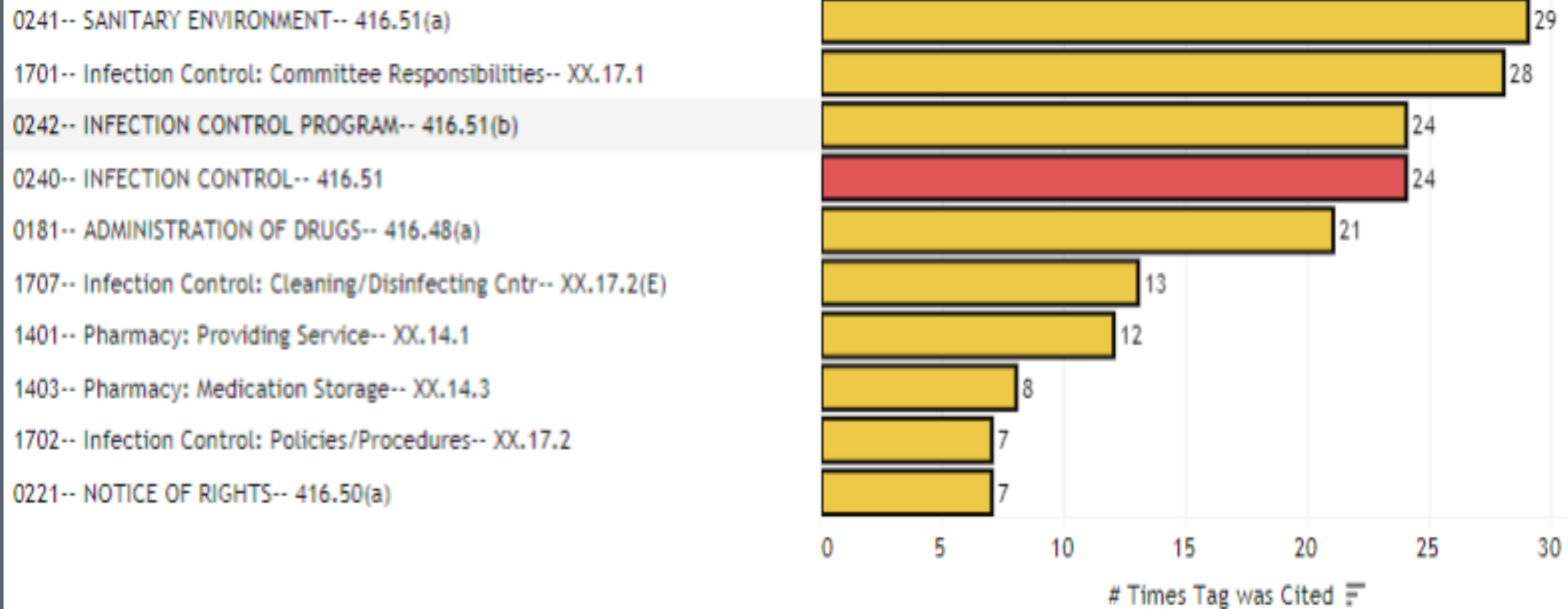
CDPHE conducts either a desk or onsite revisit after the date of compliance.

01/01/2017 to Present

Top 10 Tags cited in ASC's:

Condition Tag Standard Tag

Tag -- Tag Title -- CFR



IJ Deficiencies for 2019-2020

Immediate Jeopardy has been called a few times -

- Wrong site surgery/procedure performed - QAPI/Governing Body
- Intravenous injection of sterile water - Care in safe setting
- Procedure room being used for 2 patients only divided by a curtain - Infection Control

This & That

- CMS Final Payment Rule 2019 - addition of cardiac procedures
- Missions and Priorities Document requires the states to continue to use the Infection Control Worksheet when conducting full recertification surveys
- Tier 2 workload requires recertification surveys at 25% of non deemed ASCs. Anticipate this may be adjusted due to COVID 19.
- QSEP - able to do the same training as the surveyors
- <https://qsep.cms.gov/welcome.aspx>

Questions?

Erica Brudjar 303-692-6211

Erica.brudjar@state.co.us

Margaret Mohan 303-692-6486

Margaret.mohan@state.co.us



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Health Facilities & Emergency
Medical Services Division

Department of Public Health & Environment

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