CMS Survey Readiness 101

South Dakota Association of Healthcare Organizations
April 2022
Nancy M. Ruzicka B.S., RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting
Speaker
Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC

Over 30 years experience teaching and assisting hospitals and other healthcare facilities in understanding applicable Federal and State laws, rules, regulations and interpretative guidelines.

Previous experiences include:
- Director of Integrity & Compliance, Privacy Official at Mercy Medical Center, Des Moines
- Director of Regulatory Compliance, UnityPoint Health, West Des Moines
- Twenty years with Iowa Department of Inspections and Appeals
Learning Objections

• Describe what the provider should do upon notification of surveyors at the door
• Discuss how to prepare front line staff for surveyor questions and observations
• Review examples of how the provider can keep current on changes in regulations
• Discuss methods of how to be your own watch dog
What Does Survey Readiness Mean?

• Creating a culture of compliance
  • Education of staff on requirements and hold accountable
• Provider is able to prevent, spot and correct potential deficiencies prior to surveyor arrival
• Objective is to avoid adverse findings completely
• Look at patterns and trends of deficiencies
• Survey is basically an open book test—follow the regulations and follow own policies and procedures
Why is Readiness for CMS Surveys Important to Accredited Providers?

• Validation Surveys—Conducted on ~5% of all accredited hospitals, CAH, HHA and Hospice in each state annually
  • Used to validate the accreditation process

• Complaint Investigations-
  • Complaints are reviewed by the CMS Regional Office to determine if there is a possibility that a Condition of Participation is Out of Compliance
  • CMS Regional Office will then authorize the State Survey Agency to investigate one or more Conditions of Participation
  • State Survey Agency will use the regulations, survey procedures and interpretative guidelines to determine compliance
  • One warning sign of possible CMS complaint survey
    • Grievance filed with organization and whoever complained is unhappy with the internal investigation and response
Resources/Reference Material
Need to Know the Regulations--How does a Provider keep current on regulations?

• Know where to find the most current regulations and surveyor interpretative guidelines
  • General Acute Hospital and Psych Hospital—Appendix A
  
  • Home Health Agencies—Appendix B
  
  • Hospice—Appendix M
  
  • Long Term Care Facilities—Appendix PP
  
  • Critical Access Hospital—Appendix W
  
  • Emergency Preparedness(applicable to all providers)—Appendix Z
Additional Surveyor Guidance

- CMS updates surveyor guidance periodically (no set schedule) through the usage of Policy & Memos to the States
# Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Showing 1-10 of 589 entries

<table>
<thead>
<tr>
<th>Title</th>
<th>Memo #</th>
<th>Posting Date</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2020 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program</td>
<td>QSO-22-06-AO-CLIA</td>
<td>2021-12-15</td>
<td>2022</td>
</tr>
<tr>
<td>Evidence-based best practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities</td>
<td>QSO-22-05-Hospitals (ADVISORY)</td>
<td>2021-12-07</td>
<td>2022</td>
</tr>
<tr>
<td>Vaccination Regulation: Enforcement of Rule Imposing Vaccine Requirement for Health Care Staff in Medicare- and Medicaid-certified Providers and Suppliers is Suspended so Long as Court Ordered Injunctions Remain in Effect</td>
<td>QSO-22-04-ALL</td>
<td>2021-12-01</td>
<td></td>
</tr>
<tr>
<td>Ending the Streamlined Process for Ambulatory Surgical Centers and Independent Freestanding Emergency Departments to Temporarily Enroll as Hospitals during the COVID-19 Public Health Emergency</td>
<td>QSO-22-03-ASC &amp; Hospital</td>
<td>2021-12-01</td>
<td></td>
</tr>
</tbody>
</table>
Other Resources

• Last accreditation or state survey survey

• State trends in deficiencies - 12 states post Statements of Deficiencies

• CMS posted “substantial” deficiencies
  https://qcor.cms.gov/hosp_cop/State_Level.html
Percentage of Hospitals with a Substantial Deficiency Cited by CMS in the Last Six Months by State

Select a state to see a list of hospitals cited

Last updated on 10/01/2021 with all surveys since 04/01/2021

Go To: Hospitals with Substantial Deficiencies
List of CMS-Certified Hospitals with Recent Substantial Deficient Practice

Hospitals participating in Medicare and Medicaid receive onsite surveys by State Survey Agencies and private Accrediting Organizations to ensure compliance with Federal Regulations. When the survey agency or Accrediting Organization finds a hospital not to be in compliance, it cites a deficiency and issues a survey report that summarizes the findings.

This website lists all hospitals who were found to be substantially out of compliance during a State Survey Agency survey in the last six months and provides the survey report for public review.

To locate a hospital, begin by selecting to see a list of hospitals by state or by Accrediting Organization to the left.

Medicare Oversight of Accrediting Organizations

To ensure private Accrediting Organization provide a sufficient level of oversight, Medicare conducts Validation Surveys by conducting a survey of a hospital shortly after an Accrediting Organization completes a survey. In addition Medicare submits an annual Report to Congress on the effectiveness of Accrediting Organizations.

The below table gives a brief overview of how many Validation Surveys were conducted for the last few Federal Fiscal Years and the disparity between the Medicare conducted surveys, and the private Accrediting Organization Surveys.

You can find the latest Report to Congress [here](#).

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-Day Validation Sample Surveys</td>
<td>98</td>
<td>95</td>
<td>107</td>
</tr>
<tr>
<td>SA Surveys with Condition-Level Deficiencies</td>
<td>50</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>AO Surveys with Missed Comparable Deficiencies</td>
<td>45</td>
<td>43</td>
<td>50</td>
</tr>
<tr>
<td>Disparity Rate</td>
<td>46%</td>
<td>45%</td>
<td>47%</td>
</tr>
<tr>
<td>Sampling Fraction</td>
<td>0.07</td>
<td>0.07</td>
<td>0.08</td>
</tr>
<tr>
<td><strong>Psychiatric Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-Day Validation Sample Surveys</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>SA Surveys with Condition-Level Deficiencies</td>
<td>12</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>AO Surveys with Missed Comparable Deficiencies</td>
<td>12</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Disparity Rate</td>
<td>57%</td>
<td>57%</td>
<td>38%</td>
</tr>
<tr>
<td>Sampling Fraction</td>
<td>0.11</td>
<td>0.11</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Critical Access Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-Day Validation Sample Surveys</td>
<td>34</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td>SA Surveys with Condition-Level Deficiencies</td>
<td>16</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>AO Surveys with Missed Comparable Deficiencies</td>
<td>15</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Disparity Rate</td>
<td>44%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Sampling Fraction</td>
<td>0.24</td>
<td>0.19</td>
<td>0.08</td>
</tr>
</tbody>
</table>
Use of State Specific “Substantial” Deficiencies

• Can identify patterns and trends of Condition Level deficiencies in your state

• Assists in identification of situations causing immediate jeopardy

• If your state has low number of “substantial” deficiencies, look at what other states in your CMS region are being cited for

• When conducting mock surveys/tracers, can identify if similar situations exist
Another Resource for Cited Deficiencies

- Can sort by individual state
- Can sort by provider type
- See each tag and the frequency cited by year
**Citation Frequency Report**

**Selection Criteria**

**Hospitals**

**Display Options**

- [ ] Display top 25 tags
- [x] Display all results

**Time Interval**

Please select the year or years for which you would like data.

- **Year Type:** Fiscal Year
- **Begin Year:** 2022
- **End Year:** 2022

**Geographic Region(s)**

You may run a national report or you may limit the report to one or more CMS regions or states. To select more than one, hold down the Ctrl key while you click on the desired region or state names.

- National
- All (National)
- I Boston
- II New York
- III Philadelphia
- Alabama
- Alaska
- American Samoa
- Arizona

**Provider Characteristics**

Use these filters if you want to limit the report to providers that have certain characteristics.

- Providers with Deemed Status:
  - [ ] Non-Accredited:

**Select One or More Accreditation Organizations (AOs):**

- JOINT COMMISSION
- ACCREDITATION COMMISSION FOR HEALTH CARE
- COMMUNITY HEALTH ACCREDITATION PROGRAM
- ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE
- THE COMPLIANCE TEAM
- AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES
- DNV HEALTHCARE USA INC
- CENTER FOR IMPROVEMENT IN HEALTHCARE QUALITY
- INSTITUTE FOR MEDICAL QUALITY

**Subtype:**

- [ ] All

**Certification:**

- [ ] Medicare Only
- [ ] Medicaid Only
- [ ] Medicare & Medicaid

**PPS-excluded Units:**

- [ ] Rehabilitation Unit
- [ ] Psychiatric Unit

**Bed Size:**

- [ ] All
- [ ] 0 to 25 beds
- [ ] 26 to 99 beds
- [ ] 100 to 299 beds

**Swing Bed?**

- [ ] Has Swing Beds
- [ ] Does Not Have

**Ownership:**

- [ ] All
- [ ] For Profit
- [ ] Non-Profit
- [ ] Government
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Tag Description</th>
<th># Citations</th>
<th>% Providers Cited</th>
<th>% Surveys Cited</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0914</td>
<td>MAINTENANCE</td>
<td>27</td>
<td>18.3%</td>
<td>38.6%</td>
</tr>
<tr>
<td>C1016</td>
<td>PATIENT CARE POLICIES</td>
<td>20</td>
<td>13.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>C1120</td>
<td>PROTECTION OF RECORD INFORMATION</td>
<td>18</td>
<td>11.0%</td>
<td>25.7%</td>
</tr>
<tr>
<td>C1008</td>
<td>PATIENT CARE POLICIES</td>
<td>17</td>
<td>11.0%</td>
<td>24.3%</td>
</tr>
<tr>
<td>C1056</td>
<td>PATIENT VISITATION RIGHTS</td>
<td>13</td>
<td>8.5%</td>
<td>18.6%</td>
</tr>
<tr>
<td>C0962</td>
<td>GOVERNING BODY OR RESPONSIBLE INDIVIDUAL</td>
<td>12</td>
<td>7.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>C1206</td>
<td>INFECTION PREVENT &amp; CONTROL POLICIES</td>
<td>12</td>
<td>7.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>C1028</td>
<td>LABORATORY SERVICES</td>
<td>12</td>
<td>7.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>C1018</td>
<td>PATIENT CARE POLICIES</td>
<td>11</td>
<td>7.3%</td>
<td>15.7%</td>
</tr>
<tr>
<td>C0999</td>
<td>PERIODIC REVIEW OF CLINICAL PRIVILEGES</td>
<td>11</td>
<td>7.3%</td>
<td>15.7%</td>
</tr>
<tr>
<td>C1306</td>
<td>QAPI</td>
<td>11</td>
<td>7.3%</td>
<td>15.7%</td>
</tr>
<tr>
<td>C1612</td>
<td>FREEDOM FROM ABUSE, NEGLECT &amp; EXPLOITATION</td>
<td>9</td>
<td>6.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td>C0340</td>
<td>QUALITY ASSURANCE</td>
<td>9</td>
<td>6.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td>C1102</td>
<td>RECORDS SYSTEM</td>
<td>9</td>
<td>6.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td>C1144</td>
<td>ANESTHETIC RISK AND EVALUATION</td>
<td>8</td>
<td>4.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>C1142</td>
<td>DESIGNATION OF QUALIFIED PRACTITIONERS</td>
<td>8</td>
<td>4.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>C0922</td>
<td>DRUGS AND BIOLOGICALS ARE APPROPRIATELY STORE</td>
<td>8</td>
<td>4.9%</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

Totals represent the # of providers and surveys that meet the selection criteria specified above. Iowa Active Providers=82 Total Number of Surveys=70
Survey Preparedness Process
Survey Preparedness-Five Phases

• Assessment
• Planning
• Execution
• Demonstrated Competency and validation checks
• Taking Action

• Ideal Time frame-12 months
  • Keep in mind survey cycle
  • States are surveying non-accredited hospitals/CAH every 3-5 years
  • States surveying long-term care annually (every 9-15 months)
  • Surveying home health and hospice every 3 years
  • Accrediting bodies on similar survey cycle

• Continuous year-round effort
Assessment Process

• Initial step in readiness
• Time frame for completion – Two months
• Facility wide assessment based upon comprehensive review of the regulations

• Assessment should be based upon:
  • Review of regulations and interpretative guidelines
  • Review of changes that have occurred in regulations since last review
  • Mock surveys
  • Chart reviews
  • Patient Observations
  • Executive rounding
  • Patient or family complaints/grievances
Key Tools Used During Assessment Phase

• Federal and State databases
• Federal regulations and interpretative guidelines
• State licensing regulations
• State trends in deficiencies - 12 states post Statements of Deficiencies
• Facility’s last accreditation or state survey survey
• Any complaint investigations
Assessment Workgroups

• Workgroups should be developed for each Condition or Standard

• Name lead with subject matter expertise

• Responsible for determining current state of compliance for each Condition

• Example-Team with social work director or lead is responsible for reviewing understanding and ensuring facility’s compliance with patient rights standard.
Assessment Deliverable

• Each assessment team develops a “binder” for their assigned Condition or standard
  • May be electronic or paper
  • Collection of policies, procedures and pertinent documents
• Each team develops mock survey tools to assess actual practice against policies and procedures and regulations
• Interview staff using survey probes from interpretative guidelines
• Determining current state of readiness
• Identify gaps and opportunities for improvement
Planning Phase

• Based upon assessment, leadership strategize survey readiness efforts
• Development of survey readiness-- both long term and high priority goals that need immediate action
• Develop survey readiness tracking tool to help organize and monitor any identified concerns and related corrective action action
• Appoint leads for each area who are accountable for ensuring completion of corrective action
• Establish a survey readiness committee at leadership level that includes area leaders to ensure overall organization oversight of corrective action and compliance
• Time period for completion between 1 and 2 months
Implementation or Execution Phase

- Use existing Structures within Organization
- Performance Improvement (Quality Improvement) Committee
- Leadership Council
- Environment of Care / Safety Committee
- Disaster Preparedness
- Infection Control Committee
- Compliance Committee

HOWEVER -- It is important to have one committee that oversees Continuous Survey Readiness
Implementation Phase

• Review the survey readiness tracker on a monthly basis
  • Tool should identify issues, responsible individual, what corrective action is, corrective action proposed date and actual completion date.
  • May also want to identify priority

• CEO or other senior leadership member should be chair

• Quality and compliance staff should be directly involved
  • Assist in meeting coordination
  • Facilitate discussion
  • Assist team in achieving project milestones

• Phase should be completed in approximately 4 months
Another meeting? – or Not........
Implementation Phase--Survey Readiness Workgroups

- Work groups for each standard/Condition should meet on bi-weekly basis—could use same group as did assessment
- Communication is key
- Hands-On
  - Identifies missing, outdated, inaccurate and duplicative policies
  - Helps draft and revise policies for leadership approval
  - Provides appropriate staff education and training after policy revisions
  - Brings concerns identified to Survey Readiness Committee
- Committee helps guide incorporation of corrective action plans into everyday work
Accountability is Key to Success

First base: Who
Second base: What
Third base: I Don't Know
Left field: Why
Center field: Because
Pitcher: Tomorrow
Catcher: Today
Shortstop: I Don't Give a Darn
Demonstrated Competency and Validation of Corrective Action Plan

• Staff expected to demonstrate competency and knowledge
  • Make sure staff are comfortable with observations
• Quality and Compliance conduct mini-mock surveys, audits and checks on staff competencies to validate actions are completed
• Quality staff need to analyze audit data for trends and to identify other improvement opportunities
• Data should inform leadership about progress and achievements AND lack of progress
• Validation by Survey Readiness Leader of completeness of binders, accurate policies
• Phase takes minimum of 3 months
Taking Action

- Based upon audits, mock surveys and checks, corrective action plans should be discussed at next survey readiness meeting
- Further actions need to be implemented and monitored
- May need to implement different actions if original actions did not correct
- Performance improvement projects may be initiated for more complex corrective action plans
- Continue to utilize the survey readiness tool on ongoing basis
- Binders updated as changes made throughout the year
- Minimum time involved – 2 months
Education-Mock Survey Process Preparation

• Provide leadership adequate lead time to schedule education
• Hold education session
  • Address staff concerns
  • Have staff explain organizational structure for their area and how it operates
  • How to handle surveyor observations of care
  • Make sure information tailored to group
  • Present in at least three ways to reach all staff at all learning levels
  • Stress patient care not just compliance with regulations
• Make sure to include all sites including all off-campus provider based locations
• Identify patients with specific care needs on each unit to follow during mock inspection
  • Help evaluate individual nurse work and adherence to organizational structure
• Meet with individual nurses and other involved staff to discuss identified issues such as infection control, medication management
• During mock survey talk to individual patients and families regarding the care
Communication is Key to Success

- Staff must understand the “what” and “why”
- Explain clearly what changes in policies have occurred and why
- Do the changes reflect new regulations?
- Do the changes reflect clarification of existing practices?
- How do the changes impact safety, patient care or work environment?
- What is at risk if requirement not observed?
- Understanding the why can help motivate staff to comply with changes.
Are your Staff Engaged?

- Has your organization set a culture of survey readiness?
- Does the facility share information about how you’re doing?
- Does the facility encourage staff to tell their own stories about what is working and what didn’t work?
- Does the facility encourage innovation—better way of doing things (not work arounds or short cuts)?
- Does the facility encourage a strong team environment-working together?
- Does feedback focus on “positive” or just the “negative”?
- Do you provide “immediate feedback” or monthly or quarterly?
- Do you celebrate improvements and achievements?

Adapted from: https://www.torbenrick.eu/blog/category/performance management, June 14, 2011
Medical Staff Engagement

• Have key members of the medical staff been prepared for survey?
• Has medical staff been made aware of previous deficiencies involving medical staff?
• If changes made in medical staff policies, how are each medical staff member notified?
• If house wide policies changed, how are medical staff notified and educated?
• How is medical staff notified when surveyors arrive?
Have Medical Staff Been Prepared?

- Surveyors now directed to interview Chief Medical Officer or Chief of Medical Staff
  - Credentialing Process
  - Adherence to Medical Staff regulations
  - How is medical staff accountable for quality of patient care
  - Frequency of communication between medical staff and governing body

- Ask Medical Staff leadership how best to train rest of medical staff (and residents) on survey preparation
Governing Board Engagement

• How is governing body prepared for survey?

• How is governing board apprised of survey results?

• Does the board receive reports on new CMS, Accrediting Organization standards and what they mean to the organization?

• How is the board made aware of new standards that may directly effect how the board is surveyed?
Governing Body Preparation

• May interview Governing Body President or other Officers
• Survey Concentration
  • How is Board apprised of medical staff quality issues
  • How do periodic consultations between governing body and medical staff occur and how frequently
  • How does medical staff enforcement of policies regarding physician availability
  • How is budget developed
  • How is Board involved with overall QAPI plan and implementation
Taking Action--Summary

• Be realistic in survey preparation plan and time commitment needed
• Use your data wisely-take action based upon data to improve performance and consistency
• Learn from mistakes and successes-make sure information flows up and down the organization chart
• Don’t accept mediocrity when it comes to patient care
• Remember practice makes perfect
What does Survey Readiness Look Like?

• Facility data is aggregated and analyzed
• Results of data analysis have been communicated and acted upon
• Committee Structure is conducive from leaders to line staff and back up
• Staff members can address patient safety and quality goals and how they contribute
• Staff are aware of the organization as a whole
• Staff members are familiar with the regulations and standards
• A culture of compliance and reliability
You Know the Organization is Not Ready If......

• Data has not been analyzed or staff isn’t knowledgeable of results
• Team is not familiar with the quality and safety goals or organizational efforts
• Employees only see their own department’s functions and not aware of organization as whole
• Employees don’t know the CMS, accrediting body regulations or language
• Staff is not aware of changes in regulations and why procedures changed
Survey Response Team

• Team should be defined during Planning Phase
  • Staff should be knowledgeable of facility’s operations
  • Familiar with regulations and organization policies
  • Able to access EHR

• Responsibilities include:
  • Organize and respond to requests
  • Escort surveyors
  • Take notes
  • Schedule meetings as surveyors request with specific staff
  • Prepare advance documentation
  • Assist in location of documents and policies
  • Make copies as requested
Advance Document Preparation
Common Documents Requested

• Can prepare in advance
• Maintain in survey readiness binder and update annually
• Map of your facility
• List of off-site locations and services provided – helpful to have address and directions from main organization
• Senior/Department leader contact information – phone numbers
• A copy of the facility’s organizational chart;
• A copy of the facility’s floor plan, indicating the location of patient care and treatment areas;
Other Documents Requested upon Entrance

- Survey Response Team should know where these documents are:
  - Quality Assessment and Program Improvement Plan
  - Infection control plan;
  - A list of all employees;
  - Governing body bylaws
  - The medical staff bylaws and rules and regulations;
  - Minutes from governing body and medical staff for past year
  - Committee meeting minutes, as requested, for past year
  - A list of contracted services
Standardized Email Notification

• Prepare a survey checklist to send in email for department leaders
• This will serve as a reminder to department leaders to make a quick walk through of their areas
• This will allow time for leaders to alert their staff and give last minute reminders
• Prepare an announcement to go out to all staff
• Email should let staff know nature of surveyor visit
  • Is it routine recertification survey?
  • Is it a validation survey?
  • Is it a complaint investigation and if so, what general areas?
What to Do When Surveyors Arrive
“Regulatory audit today?”
Surveyor Arrival Steps

• Activate the Survey Readiness Team
• Hold the entrance conference in accordance with their direction with appropriate staff of Senior Team
• Do not attempt to delay entrance conference due to staff being in meetings, on vacation or otherwise occupied
• NEVER tell the surveyors that they can not conduct an investigation, validation survey or other type of survey. This action can result in recommendation of termination.
• Send out notice (usually email) to Department Directors and other appropriate staff letting them know surveyors onsite
• Pay attention to time frames the surveyors request documents in
• Treat as guests—a little hospitality goes a long way
• Expect the unexpected...
Survey Characteristics

• CMS/ State survey team size varies depending:
  • Upon size of facility
  • Type of facility
  • Type of survey
  • Reason surveyors are on-site
  • Number of off-campus locations

• May not arrive at the same time
• Length of survey will also vary
• Complaint may involve 1 or 2 nurses for a few days
• Validation of large organization with multiple sites may involve 5 or more surveyors including nurses, dietitians, social workers, fire marshals for one to two weeks
• Accrediting organizations usually include physician surveyors (for hospitals)
Surveyor Information Requests

• Provide material timely

• One major request upon entrance will be:
  • A list of current inpatients, providing each patient’s name, room number, diagnosis(es), admission date, age, attending physician, and other significant information as it applies to that patient. (Hospitals and CAH)
  • Long Term Care Facility—Surveyors will provide list of targeted residents (70% and 30% surveyor selected after arrival)
  • Home Health and Hospice—Surveyors provide list of targeted patients plus request current patient list including: start of care date, list of services, primary diagnosis and if hospice where receiving services (home, hospital, long term care)

• This material is normally requested to be done within 3 hours of entrance

• Can your EHR provide this information?
Survey Information Organization

• Previously established survey binders for each Condition will keep the facility organized—reduce time to collect documents

• Track all documents surveyors reviewed—may want to double copy or maintain a master listing
  • If surveyors take copies of policies or records, make sure to maintain list

• Survey Schedule—reflect all meetings, facility tours and units observed. Helps Survey response team track location of subject matter experts and key staff
Conclusion

• Survey Readiness takes practice, training and overall commitment by leadership
• Staff must work together and in organized fashion
• Survey Readiness Prevents:
Post Survey Activities
Daily Debriefings and Final Exit Debrief

• Daily internal debrief after surveyor exit

• Focus on high priority items needing immediate attention

• Survey readiness team members who functioned as escorts and scribes provide daily recap
  • Note areas of weaknesses, opportunities for improvements and other concerns

• Survey readiness leader summarizes any surveyor requests and notes issues with documents and data

• Discuss exit conference and possible next steps
Corrective Actions

• Begin to develop corrective action plan—especially for patient care issues
• DO NOT wait for Statement of Deficiencies to arrive
  • Normally CMS or State will arrive in 10 business days (Some states leave copy onsite)
• Organization has 10 calendar days to respond
• Corrective Action needs to include:
  • How specific issue corrected
  • How systematic issue causing problem has been corrected
  • When will issue be corrected
  • What will be the monitoring plan—frequency of audits
  • Who is responsible for corrective action and monitoring (by title—not name)
Additional Tips For Survey Success
Employee Tips for Dealing with Surveyors

• Look and behave professionally—first impression is everything
• Ensure workspace is clean and organized
• Be enthusiastic and friendly
• When surveyors ask question:
  • Relax and take deep breath
  • Make sure you understand the question
  • After giving it some thought, answer the question
    • Choose words carefully
  • If you don’t know the answer, tell the surveyor where you could find the answer or who can help provide
  • Stop talking once you answer the question. Surveyors not looking for long answer
  • Don’t use words such as attempt, try, sometimes, or usually
  • Never guess if you don’t know the answer
Additional Employee Tips

• Create competition
  • Offer rewards for departments with greatest education participation

• Offer small rewards
  • Who can find the most out of date drug or supply?
  • Who finds the greatest number of expired items?
Additional Employee Tips

• Maintain appropriate security/privacy protocols

• If unclear about “why” something is out of compliance-ask them where in the regulations is the requirement—Politely
  • Favorite question is—“I am confused, would you please show me where that regulation/standard is”
QUESTIONS?
Contact Information

Nancy M Ruzicka B.S. RPh., MBA, MJ, CHC
Ruzicka Healthcare Consulting LLC
nancy@ruzickaconsulting.com
515/360-2086