American Health Care Association
CMS Survey Process for Nursing Centers
Summary of Member Responses
*From 703 responses to a survey distributed to AHCA members*

1) What would improve the Entrance Conference?

- **QIS**
  - QIS entrance is an improvement over traditional survey entrance.  
  Recommendations:
    - An introduction of all surveyors on the survey team to nursing center staff would be helpful. Introduction could include their professional discipline and experience, limited time for discussion of the process, and introduction of staff to the survey team. It is prudent that the administrative staff actually meets and can identify those working in the residents’ home. This introduction should occur before survey team members proceed directly to care and service areas in the center.
    - It is helpful for nursing center staff to have the business cards of each survey team member.
    - If the survey is a complaint survey, this should be shared at the time of the entrance conference.
    - CMS should review the time frames for providing required documents and adjust if some documents are not required immediately.

- **Traditional**
  Recommendations:
    - Allow the entire survey team and nursing center management team to participate in the initial entrance conference. This will set the stage for a more collaborative and professional process and set a more positive tone. This will also facilitate ongoing communication among surveyors and center staff.
    - It is helpful for nursing center staff to have the business cards of each survey team member.
    - Allow additional time to complete some of the required documents.
    - Improve the "conflict of interest" standards. Presently, former staff outside certain time frames can show up as surveyors. Or, there may be personal relationships between former employees and surveyors that create problems for fair surveys. There needs to be a confidential, secure way for facilities who believe surveyors are not being objective to report this and secure appropriate oversight or changes on revisits.
• Include a discussion of the type of survey (standard, follow-up, complaint or combination) and expected length of survey. If a complaint survey, this discussion would include if it is related to a self-reported incident.
• Survey team members often ask for policy/procedure, clinical and other information and staff often feel extreme anxiety trying to provide the information timely without interrupting resident care. It would be helpful if CMS were to specify reasonable timeline guidance for surveyors when such information is needed from nursing staff providing direct care/services to residents.
• The nursing center should make the decision about which staff will accompany surveyors on the initial tour. It is helpful if staff who accompany the survey team are individuals who are well known by residents.

2) What would improve the surveyors’ investigative process?
   • QIS
     • QIS improves the investigative process.
       Recommendations:
       • When Stage II begins, it is helpful if surveyors tell the center staff. This will improve communication and will allow the center to assist in locating information needed by the surveyors.
       • Survey team members should be respectful of center staff and residents. This includes not taking residents’ personal effects or center records without asking.
       • Team leadership is critical to having an organized survey, including only asking center staff for a document one time.
       • Improve training of surveyors in the area of electronic records and health information technology.
       • Improve consistency among survey teams and states.
   • Traditional
       Recommendations:
       • Team leadership is critical to having an organized survey, including only asking center staff for a document one time.
       • Complaint surveys are often not completed in a timely fashion – for example, the investigation can take many weeks to complete or it can take many weeks for the nursing center to be advised of the findings.
       • Current standards of practice must be used to conduct the investigation.
• Daily “mini exits” would allow a fair opportunity for the center to provide appropriate information about concerns identified by the survey team.
• The investigative process should be outcome-focused and identify actual impact on residents which will then drive the identification of deficient practice and the decision making for the scope and severity level.
• When investigating and requesting information, it is helpful when the survey team is as specific as possible about the information they are seeking and the relationship of the information to the regulation they are investigating. (One commenter said: be more precise.) The specificity will reduce the length of time required to obtain documentation.
• The survey team acting in a professional manner is very important. This includes how they talk and act toward nursing center staff as well as keeping any discord among the survey team “behind closed doors.”
• When conducting interviews with residents, it is essential that surveyors ask questions carefully and without the use of acronyms or abbreviations (e.g. “H.S. snacks” should be stated using full words).
• Provide surveyors with thorough training in the investigative process (e.g., how to ask questions that are not leading) would be helpful for both surveyors and nursing center staff.
• Investigations should use a systems approach to determine compliance NOT perfection.

3) What changes to you recommend for the exit conference process?

• QIS
  Recommendations:
  • Allow enough time and amend the process to include a more thorough discussion of the findings.
  • Provide a written list of findings with the disclaimer that office review could change the actual F-Tag cited. This would allow centers to begin corrective action and clearly understand what the survey team identified on-site.
  • Encourage the survey team to share positive feedback with the facility at exit.

• Traditional
  • Comments indicate a large variation by state regarding exit conference process.
  Recommendations:
  • Clear expectations of the survey exit process must be established by CMS.
• Survey teams should maintain professionalism and when there is disagreement among the survey team members regarding citations, the conflict should remain within the survey team.

• Exit conferences with the center team and the medical director should be based on fact. Tag number and scope and severity should be discussed at the time of exit.

• Honest feedback – both positive aspects and opportunities for improvement – is appreciated by the centers and help to enhance performance and quality of care.

4) What should be changed about the 2567 and its delivery to the facility (e.g. information included; time lines, etc.)? (QIS & Traditional)

Recommendations:

• Improve surveyors’ skills related to objective writing of deficiencies and accurate description of events.

• CMS should include a legend on the survey form stating "The findings on this report solely represent a review for regulatory compliance. They are not intended to establish standard of care for any other purpose."

• Complaint investigations that coincide with the annual survey should be reported separately.

• When errors appear in the 2567 (e.g., wrong resident numbers; citations not related to regulations; statement taken out of context; statements attributed to center staff incorrectly or inaccurately) create a process for correction before the 2567 becomes public.

• Provide facilities more time to complete the 2567, allowing for a root cause analysis and not just a Band-Aid plan.

• State agencies must be held to the SOM time frames for delivering the 2567. It should be made clear that, when the delivery of the 2567 is provided after 10 calendar days, all other deadlines are adjusted, i.e. the date certain, the time for a PoC, allegation of compliance, and mandatory penalties such as DPNA should all be adjusted when the survey report is not provided in 10 calendar days.

• Survey citations should be based on professional standards of practice (evidence-based standards) used in the delivery of care. For example, citations to Wikepedia should be prohibited. If there is a standard not met, the basis should be identified.
• Deliver the 2567 to facilities in an electronic format that also allows the facility to enter the plan of correction electronically and submit to the state electronically.
• Guidelines for writing the 2567 more objectively should be developed and implemented.
• If changes are identified by the survey team after exit, that information should be given to the center administrator by phone and not just appear on the 2567. This allows the center to begin addressing this new concern.

5) What changes should be made to complaint surveys to improve the process? (QIS & Traditional)

Recommendations:
• Provide the center with clear information about the complaint in the entrance conference to facilitate better investigation.
• Differentiate self-reported incidents/issues from complaints in a very clear way for the public’s review. In other words, call the “self-reports” something other than a “complaint.” One suggestion – Facility Generated Report.
• Develop a surveyor guide for the complaint process to improve consistency.
• Complaint surveys should be initiated soon after the complaint/incident report is received and completed timely with no gaps in the investigation.
• Communication must be open and clear. Surveyors should clearly describe the complaint and continue to interact with center staff members about the progress of the investigation and issues that have been identified.
• If the center shows the survey team that they have identified the complaint concern and has corrected or has implemented an acceptable process to achieve correction, the survey team should reconsider any deficiency finding.
• Complaint surveys should be conducted by more than one surveyor.

6) What changes would you recommend to the life safety survey process (e.g. training of surveyors; experience of surveyors; use of contractors; when it is conducted; etc.)?

Recommendations:
• The practice of facilities passing LSC surveys but then having LSC deficiencies cited by nurse surveyors during health inspections should stop.
• Presently, there seems to be no reference to K Tags in any CMS regulation or manual. These should be discussed and the standards (i.e. interpretive guidelines) made clear.
• There do not seem to be consistent interpretations or expectations. For example, something in the center has been the same (as it relates to LSC) for years and with no changes to regulations, codes or standards, a citation is issued regarding this “something”.
• Provide culture change training for life safety surveyors.

7) What do you think about the interaction between the State Survey Agency and the Regional Office as it relates to the life safety survey and the facility? Please make any recommendations for improvements.
• Three CMS Regional Offices were specifically identified as having troubled relationships with state agencies: Regions IV, V and IX.
• Written life safety code interpretations need to be shared across all affected parties: Central Office, Regional Offices, State Survey Agencies, and nursing centers.
• Education and training regarding code interpretations need to be shared across all affected parties (as identified above) so that everyone hears the same message and expectations.
• By implementing the recommendations in the two bullets immediately preceding, contradictory code interpretations between and among the Regional Offices and State Survey Agencies will be minimized or eliminated.

8) What is the most difficult/challenging issue providers face as it relates to the life safety survey? Please provide recommendations for changes that could be made to alleviate this challenge.
• Number one challenge: Inconsistency of interpretations between surveyors, State Survey Agencies, and Regional Offices.
Recommendations:
• Develop and implement interpretative guidelines that everyone can access and understand.
• Joint training for surveyors and providers on single set of requirements.
• Any change in interpretations must be implemented through CMS Central Office guidance and accompanying information.
9) Are plans of correction the most effective means for having a facility achieve and maintain compliance for life safety deficiencies? If not, what would be the most effective means?

- Most respondents believe that plans of correction are effective for maintaining compliance with the life safety requirements.

Recommendations:
- Follow-up visits are more effective than writing a plan of correction.
- Desk reviews for life safety revisits should be utilized (picture of building changes; submission of credible evidence such as purchase orders, work orders, etc.)
- Time lines for building-related plans of correction are unrealistic – they are too short for implementing physical plant changes.
- Plans of correction in an electronic format.
- There should be an ability to negotiate a longer term corrective action plan that takes into account corrections and available funds, as well as potential danger (or not) to residents.

10) What do you think about the interaction between the State Survey Agency and the Regional Office as it relates to the health survey and the facility? Please make any recommendations for improvement.

Comments:
- There seems to be a negative relationship and a lack of trust between the state agencies and the Regional Offices which often results in punishment of the nursing centers.
- Regional Offices IV and V were mentioned several times by respondents. These offices seem to “follow their own rules, be unprofessional and inappropriate. Centers/companies are fearful or retaliation.” In some instances centers are being mandated by Region IV to write plans of correction that will never enable the center to achieve and sustain compliance.

Recommendations:
- A confidential feedback process related to performance of surveyors and Regional Office staff must be developed and implemented.
- Require training of state agency and Regional Office staff to ensure they are knowledgeable of current clinical practice skills and standards.
- Increase communication between Central Office and the Regional Offices and the State Survey Agencies to encourage and achieve a consistent and
fair process that was intended to positively impact quality of care versus punishment and penalties.

- Presently, when there is a federal oversight survey, the federal team not only evaluates the state team, but also treats this as a new facility survey and citing completely new areas. The purpose and use of federal survey teams should change, so that federal teams do not directly cite deficiencies unless at the immediate jeopardy level, but rather report their findings to the state agency for training purposes. The doubling up of state and federal surveys is problematic.

11) What changes do you recommend to improve the State Survey Agency’s survey process (e.g., number of surveyors; processes followed when in the facility; interaction with staff and residents)?

Recommendations:

- Size of survey team: correlate the number of surveyors with the size of the center, generally no more than 3 - 4 surveyors to avoid disruptions to daily operations. Limit trainees per facility to avoid 8 – 9 surveyors in a center. Have the survey team be consistent through the survey to avoid the recently common practice of surveyors coming and going throughout the survey (which causes delays in the survey).
- Improve interactions between survey team and nursing center staff and residents. Provide surveyor training about the importance of professionalism (which means surveyors should not focus on a punitive, negative, demeaning attitude).
- Increase communication with the center administration during the survey to allow the facility to assist with identifying evidence regarding deficient practices. Remove the secretive nature of the process.
- Lengthen the time between surveys for high-performing centers that have not had administrative changes.
- Allow center staff to show surveyors their centers and operations and showcase what they really do well rather than having the entire survey be a deficiency-finding mission.

12) Are plans of correction an effective means for having a facility make changes to their operations and improve the quality of care they provide? If not, what would be the most effective means?

Recommendations:

- If a center has self-identified a concern, implemented a plan of correction and enough time has not passed to demonstrate sustained
improvement, an alternative solution other than citing a deficiency should be possible. Perhaps in a follow-up survey there could be validation of sustained improvement.

- Refine the plan of correction process to be QAPI-focused and truly get to a systematic approach for improving quality of care rather than the routine responses on the plans of correction (i.e., root cause analysis).
- There should be a clear, confidential process for centers to perform a root cause analysis that is not used to cite deficiencies and is not available to the public, either in a plan of correction of otherwise in the federal records.
- CMS should establish a voluntary process for a facility to self-identify concerns and implement corrective measures through interaction with the survey agency but without this turning into a self-reported complaint process.

13) When enforcement actions are necessary and remedies are imposed, is the process clear and is it fair? (e.g., timelines; amount of CMPs; etc.)

Recommendations:
- Create more consistency in imposition of CMPs (both amount and when CMP is imposed). CMPs, as with all enforcement actions, are intended for remediation NOT as a punitive measure.
- Create more consistency in citations- several respondents identified “elopement without injury” as an occurrence which is interpreted very differently between states and regions: some may cite this as an IJ, while another may cite a very low scope and severity tag.
- CMS must enforce the SOM timelines for delivery of a survey report, enforcement notice and revisits. Many respondents identified receiving a 2567 forty-five or more days post-survey which leads to short timeframes for imposition of remedies. Also, lack of timely re-survey places a center in DPNA if corrections have been made and sustained but re-survey is 30 or more days out.
- Ensure that “remedy” letters to centers: 1) provide specifics about how and why CMPs are calculated; and 2) very clearly state the type of appeal(s) are available.
- Design and enforce an IDR process that is fair and unbiased.
- CMS should study the effectiveness of CMPs: are resident outcomes positively impacted when CMPs are imposed?
• Consider a mechanism for directing facilities to use CMP amounts to
directly improve care – for example: hiring expert consultants; additional
staff; or purchasing patient-care equipment.

14) Please make recommendations about how to improve the process for review and
acceptance of the plan of correction.
Recommendations:
• Electronic 2567 and plan of correction process would improve
efficiencies.
• Provide an equal amount of time for the state agency to provide the 2567
and the center to submit the plan of correction and hold both entities
responsible for meeting this timeline.
• Require the surveyor (state agency) and the center to conduct a joint
review and dialogue about any plan of correction issues in order to
expedite needed revisions or addendums to have an acceptable plan of
correction.
• Require the state agency to notify a center, within a specified period of
time that the plan of correction is acceptable. Some state agencies never
notify a center and other state agencies may take months to notify a center
that their plan is acceptable. A 2567B is an essential component of
completing the survey cycle.

15) Please make recommendations about how the nursing home survey can be changed so
that facilities are incentivized to achieve and maintain the highest quality care for all
residents.
Recommendations:
• Provide and publicize the positive aspects of care as well as the aspects
where there is opportunity for improvement.
• High-performing centers should have a full standard survey only once
every two or three years. In the other years, review data already submitted
to CMS (e.g., QMs) and provide a minimal on site review. Complaint
surveys would also be conducted as required, which would allow
surveyors to observe any unexpected changes to the quality of care in a
center. Another possibility is to periodically conduct an appraisal visit of
a high - performing center to ensure continued high performance.
• Expedite implementation of QIS to improve consistency.
• Eliminate zero tolerance with the exception of IJs with actual harm or
negative outcome. The surveyor should use systems approach to evaluate
compliance including the determination of scope and severity.
• Review the previous plan of correction during the current survey. It doesn’t appear that any further review is conducted by surveyors to ascertain that the plan of correction was ever activated.
• There needs to be room in regulations (and interpretation of those regulations) that allows for human error. There is a vast difference between an individual who makes a mistake and actual deficient practice.
• Conduct a pilot project and compare a survey process based on an education/evaluation/support approach versus an enforcement/punishment approach.
• Develop a culture of collaboration and education that recognizes that surveyors and centers are focused on the same goal: the best quality care provided to residents. (Joint Commission approach was mentioned many times as an example.)
• Emphasize care outcomes and resident satisfaction rather than paperwork compliance.

16) Do you believe surveyors are familiar with current standards of practice, or in the case of life safety surveyors, the Life Safety Codes and Standards?
   Comments:
   • No – surveyors are not always aware of new CDC guidelines or other updates in standards of practice.
   • Deficiencies are frequently written based on surveyor opinion rather than standard of practice.
   • There are surveyors who do not support innovations related to “culture change” initiatives.
   • There is considerable concern about consistency of life safety interpretations of codes and standards between state agencies and Regional Offices.
   Recommendations:
   • Provide regular, required surveyor training (to which providers are also invited) that updates any federal health guidelines (e.g., CDC) and standards of practice.
   • Provide additional training to surveyors on writing deficiencies that cite noncompliance with the regulation, not surveyor guidance or personal opinion.
   • Incorporate “culture change” and person-centered care concepts in all surveyor and provider training.
• CMS Central Office must provide clear guidance to surveyors and providers – in writing - about interpretations of the Life Safety Code and Standards. These guidelines must be adhered to.
• Surveyors that have specific credentials (e.g., RN or Pharm. D.) should be permitted to investigate only within their scope of practice.

17) What recommendations do you have for improving the investigative and decision-making process for citing deficiencies?
Recommendations:
• When a deficiency statement includes allegations of statements made by facility staff and others, develop a process requiring surveyors to review the alleged statements with the center staff and administration to assure that the surveyor’s interpretation is factual.
• Provide more clarity to the definition of “potential for harm”.
• Consider using decision trees to assist providers in reaching an objective decision regarding a finding of noncompliance.
• Modify the scope and severity grid and SOM definitions to mirror the language of the regulations at section 488.404(b) (1)(iii) & (iv): Whether a facility’s deficiencies constitute—(iii) Actual harm that is not immediate jeopardy; or (iv) Immediate jeopardy to resident health or safety.
• Re-educate surveyors on all data that must be considered when citing a deficiency, including observation, documentation, and interviews.
• When the survey team has identified a potential deficiency citation, include in the survey process a discussion with center staff allowing for an opportunity to explain their decision-making process which led to a particular care approach.

18) If there are other comments you would like to make about the survey process that have not been covered above, please include them here.
• It is very important that the survey revisit process be addressed. In some states, when there is a G or F/SSQ deficiency or greater, and that deficiency is corrected but there are lower level repeat deficiencies, there is no revisit and the POC is accepted as substantial compliance so the survey track is stopped. In other states, where there is a G or F/SSQ or higher deficiency in a survey cycle, revisits occur over and over to review lower deficiencies. This is a waste of surveyor resources looking at lower level deficiencies that never would justify a revisit. When higher deficiencies are cited and cleared, revisits should not occur.
• There is a major problem with the standard for getting off the SFF list. Presently, a survey does not clear a SFF unless it is no higher than an E. Thus,
there are deficiencies at F level that are not substandard quality of care, which keep the center in SFF status, even though an F level deficiency that is no SSQ does not even need a revisit and can be cleared on acceptance of a POC. This makes no sense. The process should be consistent so an F level deficiency that is not SSQ does not keep the center on the SFF list.

- The survey process should be restructured to focus on systemic problems that are resulting in poor resident outcomes.
- More collaboration, discussion, and education.
- The regulations are fair and promote resident-centered care and quality care and life. The survey process is too often unfairly and inconsistently applied by the surveyors and the survey agency.
- The most important thing is consistency and teamwork. Surveyors need to be able to offer ideas and solutions if they’ve seen best practices that work.
- Surveyors and providers need to be focused on improvement of care and work toward the common goal of improvement.
- All surveyors should have work experience in a long-term care setting.
- Recommendation that CMS “deem” the VA survey for nursing centers.