Congregate Living Health Facility Survey Activity Guide

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Center for Improvement in Healthcare Quality
www.cihq.org

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INTRODUCTION

Welcome to the CIHQ Congregate Living Health Facility Accreditation Survey Activity Guide. This document has been developed to assist you in preparing for your accreditation survey.

SCOPE OF THE SURVEY

CIHQ will survey all services and sites of care noted on your State license. CIHQ will also survey any contract services that provide care, treatment, or service on-site within your facility.

DETERMINING THE LENGTH / COMPLEMENT OF YOUR SURVEY / TEAM

Once your application has been submitted, staff at CIHQ will determine the necessary length of your survey and complement of your survey team. In most cases, a single surveyor will be assigned. CIHQ shall verify that all members of the survey team have confirmed that there is no present conflict of interest and they have in no manner assisted the hospital in preparation or otherwise served in the capacity as a consultant or as a former (within the past five years) or current employee. In the event a conflict of interest is apparent or suspected, CIHQ will remove any surveyor and replace that individual with another surveyor free of any conflict of interest. A template survey schedule will be provided. This will assist you in general planning activities.

DETERMINING YOUR SURVEY DATES

CIHQ will work with your facility to determine when your survey will occur. If there are specific dates that would pose a hardship to the organization should a survey occur during that time; CIHQ should be notified. CIHQ will attempt to honor such requests to the extent feasible and consistent with policies and survey requirements.

PREPARING FOR SURVEY

CIHQ strongly encourages organizations to have the documents requested in Attachment A of this survey activity guide fully prepared and ready for review prior to your survey. In addition, organizations are encouraged to pre-designate where surveyors will be housed and have pre-arranged how to accept the surveyors into your facility and get the process started.

Organizations are also strongly encouraged to review CIHQ accreditation policies so that you have a thorough understanding of the following:

- CIHQ policy on use of CIHQ surveyors to provide consulting services
- CIHQ policy on falsification and misrepresentation
- How CIHQ identifies and scores deficiencies
- Expectations for submittal of a corrective action plan(s) for identified deficiencies
- The process to appeal deficiencies and/or accreditation decisions
- CIHQ accreditation decisions

WHAT WILL HAPPEN ON THE FIRST MORNING OF THE SURVEY

On the first morning of the survey, the survey team will present themselves at approximately 0815 in the lobby of the main hospital. They will present their credentials, announce that your survey is occurring, and will ask to be directed to Administration. After introductions with your administrative personnel, the survey team should be escorted to an area that you have prepared for their use throughout the survey. This area should have a phone, sufficient electrical outlets for the surveyor's computers, and internet access if possible.

ASSISTING SURVEYORS

Each surveyor should be assigned an escort for the duration of the survey. The escort should be knowledgeable about the location of services, sites of care, and able to facilitate access to care areas and requests by the surveyor.

LUNCH

Due to the compressed nature of the survey, unless otherwise indicated, the surveyors will have a "working lunch". The organization is requested to allow surveyors this time. A simple lunch provided to the survey team would be most appreciated.

SURVEY ACTIVITIES

CIHQ strongly encourages that you use this survey guide to prepare for your survey. Specific survey activities are described. This includes:

1. What the survey activities are
2. Where it is recommended each survey activity be held
3. Who is recommended to be in attendance when the survey activity occurs
4. What documents – if any – are required
5. A brief description of what will occur during the survey.

Survey Activity	Location	Documents Required	What Will Occur
1. OPENING CONFERENCE / REVIEW OF SURVEY SCHEDULE	Determined by Organization	Copy of the survey schedule	Surveyors will introduce themselves and review the purpose of the survey. The organization will be asked to provide a brief informal overview of services provided. The survey schedule will be reviewed and any preliminary questions answered.

Survey Activity	Location	Documents Required	What Will Occur
2. REVIEW OF PREPARED DOCUMENTS	This should occur in an area that will need to be reserved for surveyor use for the entire duration of the survey.	Please see Attachment – A	Surveyors will review key policies, reports, plans, and other documents necessary for the organization to demonstrate compliance to a wide range of standards and regulations.
3. TOUR OF THE FACILITY / CARE ENVIRONMENT	The entire facility	None	Surveyors will tour the facility focusing on resident care and support areas
4. MEDICAL RECORD REVIEW	If all -or portions of – the closed medical record are electronic; the surveyors will need uninterrupted access to a computer work-station that is able to access all electronic aspects of the record. Preferably, this should not be in a patient care area. If the closed medical records are completely paper-based, then a conference room is all that is required.	The specific medical records pulled for review will be determined at the time of survey. Records will be pulled based on the following: • The scope and complexity of services provided • The organization's average daily census • The patient populations served In general, closed records will be pulled anywhere from six months to one year prior to survey.	Surveyors will review the medical records.

Survey Activity	Location	Documents Required	What Will Occur
5. HUMAN RESOURCES / COMPETENCY REVIEW	Location At the organization's discretion	The surveyor will review the following documents: • Agenda and content of new hire orientation • Personnel files of staff requested throughout the survey. For each staff person requested, the following should be provided: o Current job description o Primary source verification of any professional license or certification o Evidence of new-hire and department specific orientation o Evidence of any education and training o Initial and ongoing assessments of competency o Additional information as requested Note: Information should encompass the three years prior to survey.	The surveyor will review the requested documents and interview personnel to assure compliance to key Human Resources accreditation standards.

Survey Activity	Location	Documents Required	What Will Occur
6. MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW	At the organization's discretion	The surveyor will review the following documents: • Credential files of medical staff requested throughout the survey. For each file requested, the following should be provided for the most recent appointment or reappointment: o Current professional licensure verified from the primary source in the State in which the organization is located o Current Drug Enforcement Agency (DEA) number if the practitioner prescribes or furnishes medication o Results of a National Practitioner Data Bank (NPDB) query. o An attestation by the practitioner that he/she is physically and mentally capable of exercising the privileges requested o Criteria used for the granting of clinical privileges o Other information as requested	The surveyor will review the requested documents and interview personnel to assure compliance to key Medical Staff accreditation standards
7. EXIT CONFERENCE	At the organization's discretion	None	The survey team will present a high-level summary of survey findings and compliance issues.

AFTER THE SURVEY

Once the survey is concluded, the survey team will submit their preliminary report to senior staff at CIHQ. No written report will be issued to the organization at the exit conference. Senior staff at CIHQ will carefully review the report to assure that findings have been correctly adjudicated and modification made to the report as necessary.

RECEIPT OF FINAL REPORT

Organizations should expect to receive their final report within 10 business days following survey.

SUBMITTING A CORRECTIVE ACTION PLAN

Any deficiencies that have been identified will require a corrective action plan (CAP). The CAP must be completed and returned to CIHQ within 10 business days from the date the report was sent to your organization. The report will be sent electronically to the contact person listed on your application.

A CAP must be developed and submitted for each deficiency identified in this report. In order for the CAP to be accepted, it must address at least the following:

- The plan for correcting the specific deficiency. The plan must address the processes that led to the deficiency cited;
- The procedure for implementing the CAP for the specific deficiency cited;
- The monitoring procedure to ensure that the CAP is effective and that the specific deficiency cited remains corrected and/or in compliance with standards. Documentation must include the frequency and duration of monitoring, sample size, and target thresholds:
- The title of the person responsible for implementing the CAP; and
- The date the CAP was or will be implemented. Due dates for completion of corrective actions should not exceed 60 days for standard level deficiencies, and 45 days for condition level deficiencies, from the date that the CAP is submitted to CIHQ. If specific actions require a longer timeframe, please notify CIHQ for assistance and direction.
- How the CAP will be integrated into the organization's Quality Assessment & Performance Improvement (QAPI) program

Failure to ultimately submit an acceptable CAP will result in denial or revocation of accreditation by CIHQ.

APPEALS PROCESS

CIHQ has established an appeals process for accredited organizations wishing to contest a deficiency and/or accreditation decision. Detailed information on how to file an appeal is located in the CIHQ Accreditation Policy Manual. Senior staff will review the appeal, contact the organization for any questions, discussion, further information, etc. and issue a determination in writing of the organization's compliance to the standard/requirement in question.

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ATTACHMENT – A
Documents to be Prepared and Available for the "Review of Prepared Document" Survey Activity

Directions
For each document requested below, please provide the most current or most recent iteration available. Documents should be organized into binders as requested.
For your convenience, the CIHQ standard number addressing the document has been provided for your reference. The attachment has also been formatted to serve as a checklist for you to assure that the documents are survey ready

Note: Please assure the documents are prepared in separate binders and in the order requested within each binder. It would be helpful to have each document labeled with the corresponding CIHQ standard reference.

BINDER ONE

CIHQ Standard Reference	Title of Document	Survey Ready
Gl-1	Organizational chart or other document showing the governance structure of the organization	
GL-1	Organizational chart or other document showing the leadership structure of the organization	
GL-2	Copy of the organization's State license or other document to operate the facility	
GL-7	Evidence of an annual review and approval of the operating and capital budget	
GL-8	List of all contracted services	
QA-1	Quality Assessment & Performance Improvement Plan	
QA-2	Evidence that the organization collect, analyze and use data to monitor the effectiveness, safety, improvement in health outcomes, and quality of care and services provided	
PS-1	List of physicians or other providers currently credentialed to care for residents	
HR-1	List of employees by name, title, and date of hire	

BINDER TWO

CIHQ Standard Reference	Title of Document	Survey Ready
CE-2	Any records of building inspections performed in the past 12 months	
CE-4	Smoking policy	
CE-5	Written procedures for cleaning up a medical waste spill	
CE-11	Evidence that emergency power generators have been tested in accordance with State law and regulation	
CE-12	Evidence that fire safety systems are inspected, tested, and maintained in accordance with State law and regulation.	
CE-12	Evidence of an annual inspection of the facility to identify structural and operational deficiencies in complying to State fire safety law and regulation.	
CE-12	Evidence of regular inspection and approval by State or local fire control agencies	
CE-13	Written fire response plan	
CE-14	Fire drill records for the past 12 months	

BINDER THREE

CIHQ Standard Reference	Title of Document	Survey Ready
MM-4	Policy addressing access to medication storage areas	
MM-7	Policy on unsafe abbreviations	
MM-8	Policy addressing medication orders	
MM-10	Policy addressing medication administration	
MM-11	Policy addressing resident self-administration of medications	

BINDER FOUR

CIHQ Standard Reference	Title of Document	Survey Ready
MR-2	Policy addressing timeliness of entries into the medical record	
MR-2	Policy identifying those types of individuals who are permitted to make entries into the medical record.	
MR-2	Policy identifying what is considered a legible entry into the medical record	

BINDER FIVE

CIHQ Standard Reference	Title of Document	Survey Ready
RS-1	Policy addressing the use of restraint	
QS-2	Policy addressing pain management	
LB-1 / LB-2	Current CLIA certificate for any laboratory services performed on site – including waived testing	
AN-3	Policy addressing the provision of moderate sedation / analgesia	