

SURVEY GUIDE

HOSPITALS AND OTHER HEALTH SERVICES PROVIDERS (Excluding Home Health and Hospice Agencies)

**WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
Bureau of Health Services**

http://dhfs.wisconsin.gov/rl_DSL/Providers/pde2033.pdf

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CONTACTS

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Bureau of Health Services
Acute Care Compliance Section
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Madison, WI 53701-2969
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http://dhfs.wisconsin.gov/ri_DSL/Providers/pde2033.pdf

Email Address: Plicnsghomesfdds@dhfs.state.wi.us

Surveyors: _____

Surveyors' Telephone Numbers: _____

Surveyors' Supervisor: _____

Supervisor's Telephone Number: _____

SURVEY INFORMATION

Entity Name: _____

Entity Type:

License #: _____ **Certification #:** _____

Location: _____

Entrance Date: _____ **Exit Date:** _____

SURVEY GUIDE HOSPITALS AND OTHER HEALTH SERVICES PROVIDERS

This survey guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the state and federal legal requirements for hospitals and other health services providers, please rely on the applicable legal requirements.

I. INTRODUCTION

The following information has been prepared to serve as a guide to the survey process for hospitals and other health care providers in the state of Wisconsin. The Bureau of Health Services (BHS) has the responsibility to conduct unannounced surveys at hospitals and other health care providers. The purpose of all surveys is to ensure that the provider entity meets state approval and federal certification requirements. See the Appendix in this booklet for a list of entity types surveyed by the Acute Care Compliance Section of the BHS.

II. OVERVIEW OF THE SURVEY PROCESS

Depending on the entity under review, the survey team will consist of one or more of the following: a registered nurse, social worker, engineer or architect, dietitian, or pharmacist. The purpose of the survey is to determine whether the entity meets applicable state administrative codes and federal regulations. Survey types include initial certification surveys, recertification surveys, follow up or verification visit surveys, validation surveys for deemed status providers, and complaint surveys initiated by an allegation of entity noncompliance with state or federal regulations.

A. Off-site Survey Preparation

1. The surveyor(s) reviews the historical file of the entity kept in the BHS file center.
2. As part of a complaint investigation, the surveyor(s) contacts the complainant for additional information.

B. On-Site Survey Activities

1. Entrance Conference
 - **Staff Introductions:** The surveyor(s) and other BHS staff will make formal introductions to entity staff. The entity will identify a member of their staff who will serve as a liaison/contact person during the survey.
 - **Explanation of Visit:** The surveyor(s) will explain the purpose of the visit and the survey process. Time frames for the survey process will also be outlined.
 - **Audio/Video Taping:** Any audio or video taping without the express knowledge and consent of the surveyor(s) impedes the survey process. This could result in termination of the survey.
 - **Certification:** The surveyor(s) will explain the federal certification process and how it differs from the state process.

- Survey Results and Statement of Deficiencies: The surveyor(s) will explain general ramifications of citations that may be issued to an entity.
 - Request for Information: The surveyor(s) will request information needed to conduct the survey. The entity will also be asked for a current and accurate list of all locations within the primary facility and satellite facilities, where the entity's Medicare/Medicaid provider number is used.
2. Orientation Tour (if necessary)
 - The orientation tour allows the surveyor(s) to be introduced to essential staff members and become familiar with the layout of the entity's facilities.
 - Surveyors may separate by discipline for the orientation tour depending on the number of surveyors participating in the survey.
 3. Environmental Assessment (when appropriate)

The purpose is to observe physical features in the entity's environment that affect patients' quality of life, health and safety.
 4. Quality of Care Assessment
 - Patient Care Review: Assessment of the quality of patient care may include observations, interviews with staff and patients, review of relevant policies, procedures, bylaws and committee meeting minutes, review of quality assurance activities and medical record reviews.
 - Personnel Records: Personnel records of a representative sample of employees, including physicians, are reviewed for compliance with rules and regulations, including caregiver background checks as applicable to the provider. Peer review records are not exempt from review by the surveyor(s). The surveyor(s) may request these documents but will not make photocopies.
 5. Satellite Facilities Visit
 - To ensure that both quality of care and necessary supervision are being provided, visits may be conducted at satellite locations if the entity's Medicare/Medicaid provider number is used at these facilities.
 6. Service Systems
 - The surveyor(s) verifies regulatory compliance of all service systems that are addressed in the State Regulations and/or Conditions of Participation for the provider (e.g., dietary, medical records, nursing, pharmacy, discharge planning, patients' rights, etc.) by observation, interview and record review.

C. Information Analysis and Decision Making

The surveyor(s) reviews and analyzes all collected information to decide whether the facility has adhered to all applicable federal and state regulations. Decision-making is an ongoing process throughout the survey.

1. Daily Communication

The surveyor(s) will maintain ongoing communication with the entity's liaison. This occurs informally as questions arise. Surveyors will conduct a daily report of findings.

2. Exit Conference

During the exit conference, the surveyor(s) summarize their findings regarding regulations that are not in compliance and the facts or examples that prove the deficiencies. The entity is given the opportunity to discuss the findings and supply additional information. Because of the ongoing dialogue between surveyor(s) and entity staff during the survey, there should be few instances when the entity is not aware of concerns of the surveyor(s) before the exit conference.

The entity administrator determines which staff, board members, etc. should attend the exit conference. The facility may have an attorney present but should give advance notice of this to the survey team. Surveyors have been instructed not to answer any questions from the facility attorney.

A court reporter may not attend the exit conference. If an entity wishes to make an audio or video tape recording of the exit conference, they must first obtain permission and consent from the surveyor(s). An identical, simultaneous recording is to be given to the surveyor(s). Any audio or video taping or eavesdropping, without the express knowledge and permission of the surveyor(s), is considered impeding the survey process. This may result in termination of the survey.

State survey findings will be served on site or sent via certified mail within 10 calendar days following the exit conference. If a Condition of Participation/Certification is found out of compliance or if the survey was a hospital validation survey, the provider will receive the federal survey findings report (CMS-2567) from the Centers for Medicare and Medicaid Services (CMS), Region V office in Chicago, Illinois.

III. EXPLANATION OF SURVEY FINDINGS

The surveyor(s) will summarize their findings in a final report. If there are findings that the entity is out of compliance with rules or regulations, the surveyor(s) will document and justify their findings to serve as a basis for the entity to analyze its deficient practices or system failures and to develop a plan of correction. Federal survey findings are documented on a CMS-2567. State findings are documented using the same documentation software.

A. State Rules and Standards of Noncompliance

A violation exists when a facility fails to comply with a state rule or standard. The Department of Health and Family Services promulgates and enforces rules and standards necessary to provide safe and adequate care and treatment of patients and protect the health and safety of the patients and employees of the entities. The department authority is derived from the following statutes and administrative rules:

Wisconsin Statutes, Chapter 50: Uniform Licensure

Wisconsin Statutes, Chapter 51: State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act.

Wisconsin Administrative Code Chapter HFS 12: Caregiver Background Checks

Wisconsin Administrative Code Chapter HFS 13: Reporting and Investigating Caregiver Misconduct

Wisconsin Administrative Code, Chapter HFS 94: Rights and Resolution of Patient Grievances

Wisconsin Administrative Code, Chapter HFS 124: Hospitals

Wisconsin Administrative Code, Chapter HFS 129: Certification of Programs for Training and Testing Nurse Assistants, Home Health Aides and Hospice Aides

B. Federal Deficiencies

A federal deficiency exists when a provider/supplier fails to comply with a federal regulation. Entities electing to participate in the federally sponsored Title XVIII (Medicare) and Title XIX (Medicaid) programs will be surveyed for compliance with federal regulations. A table with federal regulation citations is attached to this guide. There are four categories in which federal deficiencies are recorded, beginning with the most severe:

1. **Statutory Requirements:** A statutory requirement created by an Act of Congress. Noncompliance with a statutory requirement may subject an entity to termination of its provider agreement with Medicare and/or Medicaid.
2. **Conditions of Participation/Conditions for Coverage:** The essential requirements of each of the major divisions of administration and other services are known as Conditions of Participation/Certification. A failure to meet a Condition of Participation/ Certification indicates a breakdown in one of the major health care systems of the provider. Any existing agreement may be subject to cancellation or termination if a Condition of Participation/Certification is not met.
3. **Standards:** A standard is a major subdivision of the requirements in the Conditions of Participation/Conditions for Coverage. Noncompliance with a standard may be so serious that it causes noncompliance with the Condition of Participation/Certification.
4. **Requirements:** A requirement is a subdivision of a standard in some provider types, including hospitals.

IV. PLAN OF CORRECTION

A. Content

1. The provider's plan of correction (POC) should be submitted on the original statement of survey findings and signed by an authorized representative of the provider.
2. To be considered complete, each action plan should include the following:
 - What the entity will do to correct the citation and ensure continued compliance in the future.
 - How correction will be accomplished and monitored.
 - Who will implement the plan and monitor for future compliance.
 - When correction will be completed.
3. Correction should be accomplished within 60 calendar days of the exit conference or less; serious situations require a correction date of 45 calendar days or less. If the completion date

extends beyond 60 calendar days, benchmark dates, detailing when correction stages will be accomplished, must also be included. The date of correction must be entered in the appropriate column on the survey findings form.

B. Correction of State Violations

1. The entity will receive a Wisconsin statement of survey findings from BHS following the exit conference. If the entity has questions regarding the survey findings, it may consult with the surveyor's supervisor informally concerning compliance and noncompliance with rules and standards. [Wis. Stat. 50.36(4)]
2. An entity found out of compliance with rules and standards is requested to submit a plan of correction concerning the state violations. Failure to submit a POC is subject to public disclosure under public record disclosure rules. The POC should be submitted to the attention of the surveyor involved. Additional sheets of paper may be attached to the survey findings if more space is necessary.

C. Correction of Federal Deficiencies

A plan of correction is required for all federal deficiencies to retain certification in the Medicare and/or Medicaid programs.

A federal plan of correction from a non-accredited facility that does not meet content standards will be rejected. In such cases, the Bureau will identify why the POC was not acceptable, return the original documents along with the Plan of Correction review—Non-Long Term Care Providers (form DDE-2045), and request that an acceptable plan be submitted. The amended plan must again be signed and dated by an authorized representative of the provider. Upon receipt, the amended POC will be stamped "original" to designate the plan as current.

A federal plan of correction must be submitted to the office that served the statement of deficiency. The entity should carefully review the cover letter to determine whether the plan should be submitted to CMS Region V or the BHS surveyor.

Failure to submit an acceptable POC within 10 calendar days could result in nonrenewal of the entity's Medicare or Medicaid provider agreement.

D. Verification of Correction

BQA will verify correction of all citations after the accepted completion dates have passed through an unannounced surveyor onsite visit, or, when appropriate, through desk review. The surveyor determines which deficiencies may be reviewed by facility submission of documentation to the surveyor that provides evidence of correction of the deficiency.

E. Failure to Correct Deficiencies

Failure to correct a deficiency may result in the following adverse actions:

1. The entity may be subject to license non-renewal, license revocation or may be issued a conditional license.
2. Psychiatric hospitals with repeat citations may lose Title XIX (Medicaid) funding if the deficiency remains uncorrected for a period exceeding six months.
3. Entities participating in the Medicare and Medicaid programs are subject to termination of

certification when certain criteria are not met, e.g., Conditions of Participation/Certification not corrected within 45 calendar days or less from the date the deficiency is served.

4. The Department of Health and Family Services may, in the event of an emergency condition that imminently threatens the health or safety of patients of a hospital, suspend new admissions to all or a part of the hospital until the Department decides that the hospital has removed or corrected the causes of deficiencies creating the emergency. [Chapter 50.39(5)(a)]

V. WAIVERS AND VARIANCES

An entity may ask the Department of Health and Family Services to grant a waiver or variance. The Department may grant the waiver or variance if the Department finds that the waiver or variance will not adversely affect the health, safety, or welfare of any patient. Please see the entity administrative code for specific language. Federal and state approval authority for waivers and variances functions differently and are explained in this section.

A. State Waiver or Variance

1. Definitions

- "Waiver" means the granting of an exemption from a requirement of Chapter HFS 124, Wisconsin Administrative Codes. The Department of Health and Family Services may limit the duration of any waiver.
- "Variance" means the granting of an alternate requirement in place of a requirement in Chapter HFS 124, Wisconsin Administrative Codes. The Department of Health and Family Services may limit the duration of any variance.

2. Requests

Waivers and variances may be requested at any time and should be made in writing to Bureau of Technology, Licensing and Education, Division of Quality Assurance, P.O. Box 2969, 1 W. Wilson Street, Madison, WI, 53701-2969. If a deficiency is cited during a survey, and a waiver/variance is part of the proposed plan of correction, then a written waiver request must also be submitted separately from the plan of correction

3. Granting or Denying a Waiver or Variance Request

- The Department of Health and Family Services will grant or deny each waiver or variance request, in writing, within 60 calendar days of receipt of a completed request. Notice of denials will contain the reason for denial.
- The terms of a requested variance may be modified upon agreement between the Department and an entity.
- The Department may impose such conditions on the granting of a waiver or variance that it deems necessary.
- The Department may limit the duration of any waiver or variance.

4. Hearings

Denials of waivers or variances may be contested by requesting a hearing as provided by Chapter 227, Wis. Stats. The entity will sustain the burden of proving that the denial of a waiver or variance was unreasonable.

5. Waiver or Variance Revocation

The Department may revoke a waiver or variance if:

- It is determined that the continuance of the waiver or variance is adversely affecting the health, safety or welfare of the patients; or
- The entity has failed to comply with the condition imposed on the variance as granted; or
- The entity notifies the Department in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or
- It is required by a change in law.

B. Federal Regulation Waivers

1. Waivers of federal code requirements may only be granted for:

- Life Safety Code 42 CFR 482.41(b) – Hospitals
- Life Safety Code 42 CFR 416.44(b) - Ambulatory Surgical Center
- RHC Code 42 CFR 491.8(a)(6) - Rural Health Clinics

2. Waivers may be granted only if an entity can demonstrate that the waiver will not adversely affect the health, safety or welfare of the patients/clients.

3. The federal Centers for Medicare and Medicaid Services, Regional V, have the authority to grant waivers for all Medicare-certified entities for the above federal regulations. All requests for waivers of federal regulations must be submitted in writing. Life Safety Code waivers must be requested by letter and in the plan of correction area of the statement of deficiency form. The entity must provide annual justification for continuance of the waiver. Waiver requests are mailed to the Bureau of Technology, Licensing and Education, Division of Quality Assurance, P.O. Box 2969, 1 W. Wilson Street, Madison, WI, 53701-2969. The Bureau of Technology, Licensing and Education, will forward the federal waiver request to the CMS for their final approval or denial.

V. APPEALS PROCESS

The following information is for general purposes only. An entity should refer to the applicable legal requirements in effect at the time it receives notice of a Department or federal action that may be subject to appeal.

A. State Appeals

An entity may appeal state adverse actions or decisions of the Department of Health and Family Services in accordance with Chapter 227, Wis. Stats. A statement of survey findings may not be appealed. However, the entity is offered an opportunity to consult with a supervisor regarding survey findings before submitting a corrective action plan.

1. A written hearing request must be sent within 10 calendar days of receipt of the notices of an adverse action. Submit requests to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. The request must include a copy of the notice of action that is being contested.
2. A written request for a hearing on termination/non-renewal of Medicaid certification must be sent within 20 calendar days of receipt of the notices of action. A written request for a hearing on revocation or non-renewal of a license must be sent within 10 calendar days of receipt of the notice. Send hearing requests to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. Include a copy of the notice of action that is being contested.

B. Federal Appeals

An entity that does not believe a CMS decision is correct may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. A hearing must be requested no later than 60 days from the date of receipt of the statement of deficiency. The request for a hearing should state why the decision is considered incorrect and should be accompanied by any evidence to be brought to the attention of the hearing examiner. The request for a hearing should be sent to CMS, Region V, Division of Survey and Certification, Suite 600, 233 North Michigan Avenue, Chicago, Illinois, 60601.

VII. COMPLAINTS

A. Entity Patient Complaints

The Bureau of Health Services responds to two types of health care complaints: facility practices and caregiver misconduct. The Acute Care Compliance Section of the Bureau receives complaints and conducts complaint surveys for facility practice concerns such as inappropriate or inadequate health care, lack of entity staff training, understaffing, poor quality care, etc. For complaints concerning hospitals and other health services providers, contact the Acute Care Compliance Section of the Bureau of Health Services at (608) 264-9888.

Hospitals or other health services providers licensed under Chapter HFS 124 or HFS 83 are required to provide clients/patients with the written address of the Bureau of Health Services to allow clients/patients to submit complaints directly to the Bureau. Complaints may be submitted in writing to the Acute Care Compliance Section, Bureau of Health Services, 1 West Wilson Street, P.O. Box 2969, Madison, WI 53701-2969.

Medicare participating hospitals, including CAHs, must meet the federal Emergency Medical Treatment and Labor Acts (EMTALA) statute and regulations found in 42 CFR 489.24 and related requirements at 42 CFR 489.20(l), (m), (q), and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. EMTALA prescribes requirements for appropriate transfer of individuals with an emergency medical condition. All hospitals are expected to be familiar with, and in compliance with, this set of regulations. BHS surveyors conduct EMTALA investigations as fact-finders for CMS. CMS determines, with the assistance of expert physician review when indicated, whether an EMTALA violation has occurred. Hospitals that violate the EMTALA provisions are subject to civil monetary penalties. If the conditions leading to the EMTALA violation are not corrected, CMS may terminate the hospital's Medicare certification.

B. Caregiver Misconduct

Complaints about caregiver misconduct relate to specific incidents between a caregiver and a patient or client, including but not limited to:

- Abuse—hitting, slapping, verbal or sexual actions;
- Neglect—intentional carelessness or disregard of policy or care plan;
- Misappropriation--theft, using property without consent such as telephone or credit cards.

All entities regulated by the Division of Quality Assurance (DQA) must:

- Immediately protect clients from subsequent incidents of caregiver misconduct
- Investigate all allegations of caregiver misconduct
- Document the results of their investigation
- Report allegations/incidents to DQA as appropriate

Refer to DQA Memo 04-028, [Revised Caregiver Misconduct Reporting Requirements for DQA Entities](#):

- Use the Worksheet or Flow Chart to assist in making the reporting determination.
- Use the DDE-2447 Incident Report form to report misconduct allegations.

For **allegations involving all staff** (noncredentialed and credentialed), submit the Incident Report to DQA at:

Department of Health & Family Services
Division of Quality Assurance
Office of Caregiver Quality
P.O. Box 2969
Madison, WI 53701-2969

Note: In the past, you were required to submit the report either to DQA or to the Department of Regulation and Licensing (DRL). This process has been streamlined to eliminate reporting to two different agencies. All caregiver misconduct reports are submitted to DQA, who will forward reports involving credentialed staff (doctors, RNs, LPNs, social workers, etc.) to DRL for review.

Please see the Department's website at

<http://dhfs.wisconsin.gov/caregiver/contacts/Complaints.htm> for more information. Contact the Office of Caregiver Quality at caregiver_intake@dhfs.state.wi.us or 608-261-8319 with any questions.

C. Adult at Risk Incidents

State statutes 46.90(4)(ab)1 and 55.043(1m) (a) require that **any employee of any entity report** allegations of abuse, neglect or exploitation if the adult-at-risk is seen in the course of the person's professional duties and one of the following conditions is true:

- The adult-at-risk has requested the person to make the report;
- There is reasonable cause to believe that the adult-at-risk is at imminent risk of serious bodily harm, death, sexual assault, or significant property loss and is unable to make an informed judgment about whether to report the risk.

- Other adults-at-risk are at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by the suspected perpetrator.

Refer to OQA Memo 06-028, [Adult-at-Risk, including Elder Adult-at-Risk, Reporting Requirements for Entities Regulated by the Office of Quality Assurance](#)

For **allegations involving all perpetrators** (family member, friend, visitor, resident, stranger, etc.), submit the Incident Report to DQA at:

Department of Health & Family Services
Division of Quality Assurance
Office of Caregiver Quality
P.O. Box 2969
Madison, WI 53701-2969

This new reporting process is streamlined to eliminate reporting to different agencies. All incident reports are submitted to DQA staff who will forward reports to other agencies such as the county department, the elder/adult-at-risk agency, state or local law enforcement agency, or the board on aging and long-term care, as appropriate. Reports may also be submitted directly to one of these agencies.

Contact the Office of Caregiver Quality at caregiver_intake@dhfs.state.wi.us or 608-261-8319 with any questions.

APPENDIX

**REGULATIONS/RULES/STATUTES ENFORCED BY
Division of Quality Assurance
Bureau of Health Services
Acute Care Compliance Section**

<u>Provider Type:</u>	<u>Federal Regulations:</u>	<u>State Administrative Code:</u>
Ambulatory Surgical Center	42 CFR 416	N.A.
Comprehensive Outpatient Rehabilitation Facility	42 CFR 485.51 to 485.70	N.A.
Critical Access Hospitals	42 CFR 485.608 to 485.645	HFS 124
End Stage Renal Disease	42 CFR 405.2131 to 405.2171	N.A.
Hospital General & Specialty	42 CFR 482.1 to 482.62	HFS 124
Psychiatric & Rehabilitation Prospective Payment Exempt Unit	42 CFR 412	N.A.
Rehabilitation Agency	42 CFR 485.701 to 485.729	N.A.
Rural Health Clinic	42 CFR 491	N.A.
Swing Bed	42 CFR 482.66	N.A.

Note: - N.A. means Not Applicable
- HFS means Wisconsin Administrative Code
- CFR means Code of Federal Regulations