

7304D - Acceptable Plan of Correction (Rev. 1, 05-21-04)

Except in cases of past noncompliance, facilities having deficiencies (other than those at scope and severity level A) must submit an acceptable plan of correction before substantial compliance can be determined. An acceptable plan of correction must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; and
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility in writing. If the plan of correction is acceptable, the State will notify the facility by phone, e-mail, etc. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance

If the Office of Inspector General (OIG) receives a plan of correction that is considered unacceptable, the OIG must re-issue the original statement of deficiencies and an explanation of why the plan of correction does not meet the required acceptance criteria. The most common reasons for seeking additional information from facilities include the following:

1. **Criteria #1.**

When a facility's plan of correction addresses how corrective action will be accomplished for those residents found to have been affected by the deficient practice, the facility should provide the specific corrective action taken for each resident cited in the deficient practice. Grouping all of the residents together on the corrective action plan is considered unacceptable.

2. **Criteria #2.**

When a facility's plan of correction addresses how the facility will identify other residents having the potential to be affected by the same deficient practice, the facility must explain in detail why other residents are not expected to be affected if the facility asserts that there is no potential for other residents to be affected by the deficient practice.

Additionally, a facility's plan of correction must address the regulation. Often, facilities only address the example in the deficient practice. For example, a physician's order for TED hose not followed; facility fails to ensure all physicians' orders are being implemented. The facility only looks at residents with TED hose orders and overlooks all other physician orders.

3. Criteria #3.

When a facility's plan of correction addresses what measures will be put into place or what systemic changes should be made to ensure the deficient practice will not recur, the facility's plan of correction must address the regulation, not just the example cited as a deficient practice.

Remember, facilities must identify the action taken to correct the deficient practice or what systemic change has been implemented to correct the deficient practice. An example of an unacceptable plan of correction occurs when the plan specifies that staff have received in-service training, but the plan fails to list the names of the staff who received the training, training content, name of the individual providing the training, and date the training was conducted.

The plan of correction must also address how the deficient practice is corrected. For example, the plan may indicate that the facility has changed policies or procedures, or even changed systems, but fails to include enough detail for the OIG to determine whether the identified problem has been corrected.

Often, plans of correction may lack key information, such as the staff person responsible for completing or carrying out the tasks for the correction.

Finally, if training is part of the plan of correction, a facility should explain how it will ensure that adequate and appropriate staff is trained.

4. Criteria #4.

When a facility's plan of correction addresses how it plans to monitor its performance to make sure that solutions are sustained, the facility must explain how the corrective action will be carried out. For example, the facility should document who will monitor the facility's plan to assure that correction is achieved and sustained, how it will be monitored, what specific corrective actions will be monitored, when the monitoring will take place, and how many staff will be monitored.

The plan of correction should also address what actions will be taken if problems are identified during the monitoring process, and identify facility administration's role in the monitoring.

Finally, sometimes a facility indicates that there will be a random review of charts. Often, more detail is needed such as the number of charts to be reviewed and how often.

5. Criteria #5.

Facilities must not use the date of compliance when corrective action is still being taken, such as education conducted on the same date of the compliance date. According to CMS, the correction date must be the date after every corrective action is completed. For example, if a facility's plan included in-service and the last in-service was completed on 1-1-10, the correction date would be 1-2-10.

If deficient practice is identified, facilities are considered out of compliance during the survey and up to the date of exit. Therefore, facilities must not use the date of compliance on the actual exit date, i.e. survey team exits on 1-1-10. The earliest date compliance can be alleged is 1-2-10, the day after exit.