NEW YORK STATE DEPARTMENT OF HEALTH

A Request for Proposal for

The Office of Long Term Care (OLTC) and
The Office of Health Systems Management (OHSM)

RFP No. 0802151214

Quality Assurance for
Nursing Homes, Intermediate Care Facilities, Home Care Services Agencies, Adult Care Facilities, Hospitals and Diagnostic and Treatment Centers

Schedule of Key Events

RFP Release Date          July 7, 2008
Letter of Interest Due (optional)    July 18, 2008
Registration for Bidders Conference Required by July 18, 2008
Written Questions Due for Bidder’s Conference    July 18, 2008
Bidders Conference       July 24, 2008
Final Date to Submit Written Questions    August 18, 2008
Response to Written Questions and Questions Received at Bidders Conference     August 18, 2008
Proposal Due Date         September 15, 2008

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Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 1**  
Adult Day Health Care Program Quality Activities  
Desk Audit

10 NYCRR Parts 425 and 759  
[http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm](http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm)

Relevant portions of 10 NYCRR Part 415  
[http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm](http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm)
Attachment 2

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 2
Adult Day Health Care Program Quality Activities Survey

10 NYCRR Parts 425 and 759
http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm

Relevant portions of 10 NYCRR Part 415
http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm
Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

## Unit 3
Adult Day Health Care Program Quality Activities
Complaint Investigation

10 NYCRR Parts 425 and 759
http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm

Relevant portions of 10 NYCRR Part 415
http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm
Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 4**

Adult Day Health Care Program Quality Activities
Complaint Intake

10 NYCRR Parts 425 and 759
[http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm](http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm)

Relevant portions of 10 NYCRR Part 415
[http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm](http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm)
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Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 5
Adult Care Facility Quality Activities
Complete Inspection – ACF, ALR, SNALR

Adult Care Facility Quality and Surveillance Operations Manual – Inspection Process
Policy: INSPECTION PROCESS
Basis: SSL 461, 18 NYCRR 486

Overview: Inspections of adult care facilities are mandated by Social Services Law to ensure that these facilities are in compliance with both Department regulations and Social Services Law. Through an on-site survey, ACF inspectors determine whether minimum standards for program, fire/safety and nutrition are met. Based upon the results of the inspection and subsequent evaluation, operating certificates are either renewed, limited, suspended or revoked. In addition, civil penalties, additional monitoring and other actions may be taken by the Department.

All adult care facilities in NYS are required by law to have a complete inspection at least every eighteen months. Facilities with serious compliance problems must be inspected at least annually. The law also requires prompt investigation of all ACF complaints.

Types of Inspections

Complete (Full) Inspections – These inspections determine compliance in detail for Medical, dietary, and social services records, as well as physical environment, Equipment, personnel, care and services. The inspection includes a complete review of Facility operations utilizing the expertise of three disciplines: program, fire/safety and Nutrition. Inspectors conduct extensive reviews of all regulations pertaining to a Specific type facility in each operational area to ascertain the level of operator Compliance with minimum standards. Checklists are used by inspectors to indicate Areas of compliance and non-compliance.

Summary Inspections - These are shortened inspections that focus on key Regulatory provisions in all areas of ACF operations. Checklists are utilized only for the Specific regulations of concern.

Partial Inspections - These inspections include a review of facility operations in a Specific, pre-selected area. Depending on the need, other inspection components may be added at the discretion of the Regional Office.

Complaint Inspections - Written or verbal complaints to the Department initiate an Investigation of the facility to determine the validity of the complaint. Complaint Inspections are integrated into normal inspection schedules unless the nature of the Complaint warrants a prompt investigation.
A. Inspection Scheduling and Assignments

1. As required by SSL §461-a(2)(a), each adult care facility must receive a full, i.e., complete, inspection at least once every 18 months. In determining this 18-month interval, month one is the month with the date of the exit conference. The exit conference for the next full inspection must occur by the end of month 18.

Facilities may be placed on an 18-month schedule if their last full inspection (or follow-up inspection if there was one) resulted in a determination that the facility: (1) was in compliance, (2) was in substantial compliance, or (3) had no more than two violations neither of which harmed or had the potential to harm a resident’s health, safety or welfare. Such facilities may, however, be placed on a 12-month schedule at the discretion of Regional Office staff based on such factors as number of deficiencies cited.

Facilities that are in enforcement may be placed on an either a 12-month or an 18-month schedule at the discretion of the Regional Office.

Facilities whose last full inspection (or follow-up inspection if there was one) did not result in one of the above three determinations must be inspected within 12 months of their last full inspection.

Regional Office staff may change a facility’s compliance status and inspection interval after the full survey is completed, based on follow-up activities and/or the N/POC.

Central Office and Regional Program Managers determine inspection priorities on an on-going basis.

2. Within the priorities, a determination is made of the types of inspection and when inspections will be done to ensure that each facility is inspected at least once every 12 or 18 months, as appropriate to the results of the facility’s last inspection.

3. A schedule of inspections is prepared by the Regional Office on a quarterly basis and submitted to Central Office for review. The schedule of inspections is generated and may be modified by the Regional Office to accommodate inspectors’ travel schedules and leave time, report preparation, weather, complaint investigations, etc.

4. The inspector is given his or her monthly assignments, at which time any special problems concerning the assignment can be discussed.

5. Inspections must be completed within 30 days. Day one of this timeframe is the day of the entrance interview. The inspection is complete on the day of the exit interview.
6. If the inspection is not completed the supervisor and Program Manager should be notified of the reason and the inspection should be rescheduled.

7. An inspection interval is entered in SP tools and the Control Log, based on the results of the full (or summary) inspection. The inspection start date is also verified and/or corrected. Upon completion of follow-up activities, if any, SP tools and the Control Log are updated if the inspection interval has changed. (NOTE: SP tools and the Control Log should also be updated if the inspection interval changes as a result of a complaint investigation.)

B. Pre-Inspection

Prior to the inspection, the facility file is reviewed (e.g., complaints, CQC visit reports, OMH joint inspections, pending death investigations, any pending or approved waivers, agreements with mental health providers, previous inspection reports and corrective action) and collateral letters mailed and collateral contacts made (e.g., local fire departments, local health departments). Collateral contacts, if made, should be carefully conducted so as to avoid giving the facility advance notice of an inspection.

Participation in the Quality Improvement Program (QUIP), Infrastructure and/or Enable grants programs are also ascertained. Central Office provides to each regional office a list of the facilities that receive QUIP, Infrastructure and/or Enable funds, the amount received and the approved use of the money.

Checklists as appropriate to facility type (i.e., adult home, enriched housing program, residence for adults, ALP) and data collection forms for each discipline (i.e., resident interview, resident room review and resident record review; staff interview; and facility records checklist) are downloaded from Minerva and the appropriate identifying information is keyed into the header for each. For follow-up inspections and complaint investigations, only the relevant portions of the checklists need be downloaded, printed out and completed.

C. On-Site Inspection

1. Entrance Interview

The entrance interview has several functions, including:

- Inform those in charge of the facility that an inspection has begun and inform them of the purpose of the inspection.
- Introduce inspectors to facility staff.
- Arrange for a place for the inspectors to meet, share notes and review records and other material.
- Obtain basic information about how the facility operates, such as when meals are scheduled, that inspectors need to schedule their observations, interviews and record reviews.
- Obtain the information necessary to identify at least the initial resident sample.

The inspection team should not let the entrance interview interfere with initiating the tour promptly upon entering the facility. Two possible ways of doing this are as follows. Upon first entering the facility, team members introduce themselves and announce that an inspection has begun, and then proceed with the tour. After the tour, the team reconvenes with facility staff at a prearranged time and place to finish the entrance interview. Alternatively, one or two team members can conduct the entire entrance interview while the rest tour the facility.

2. Tour

Inspectors tour the facility to obtain an overall picture of the environment, residents and staff and the interactions between them, etc. Each inspector decides what activities and parts of the facility need to be included in his/her tour. Notes on what is observed during the tour may be recorded on the appropriate checklist or survey tool. Inspectors should compare notes following the tour if more than one inspector tours the facility, or if some inspectors did not do a tour but instead conducted the entrance interview.

3. Sample Size

The following guidelines should be used regardless of how many inspectors are assigned to the inspection. All sample sizes may be expanded with the approval of the Program Manager or his/her designee.

a. Resident record sample size for each discipline (medications/nutrition, fire/safety and program), regardless of number of beds or occupancy, is 15 records or 15%, whichever is less. The records reviewed need not but may be the same for all disciplines.

b. Resident room sample size is:
   - 0 – 20 beds     100%;
   - 21 – 40 beds    50%;
   - 41+ beds        25% up to a maximum of 50 beds.

c. Resident interview sample size for each of the three disciplines (program, nutrition/medications and fire/safety) is five residents. SSI-eligible residents, if any, should be included in the sample. Residents interviewed may be the same for each discipline.

d. Staff record sample size is five.
4. Checklists

There are four checklists that inspectors use on site to ensure that facilities are inspected in all required areas (depending on the type of inspection): fire/safety, nutrition, program and medications. The program and fire/safety checklists have addendums for facilities that have or are ALPs. The checklists show regulatory requirements and their tag numbers. For each regulatory requirement, there are columns in which the inspector indicates whether the facility is or is not in compliance with the regulation, and a space for writing comments and observations.

For full or complete inspections, inspectors must check either “Yes” (in compliance) or “No” (not in compliance) for each regulation and tag in the checklist, with the following exception. Not all regulations are applicable to all facilities. If a regulation is not applicable to a specific facility, the inspector enters "NA" in the comments space. Thus either “Yes” or “No” will be checked for each tag, or “NA” will be written in the comments space for the tag. No tag or regulation is without one of these designations if the inspection is a full or complete inspection.

For inspections that are other than full or complete inspections, only the checklist pages that include the regulatory areas to be inspected need to be printed and completed. Inspectors must check “Yes” or “No” for each regulation and tag that is subject to inspection.

When “No” is checked, the inspector indicates in the Comments box for that tag the location of his/her notes on the compliance issues if the notes are not recorded on the checklist.

Each inspector completes his/her discipline’s checklist as per the above instructions prior to the exit interview unless there are extenuating circumstances. However, even if there are extenuating circumstances, the checklists should be substantially completed prior to the exit interview.

5. Data Collection Forms

Each discipline records information collected from resident and staff interviews, environmental and resident room reviews, resident record reviews and facility records review, on the appropriate form.

Inspectors also record in their notes information from interviews of family members and community providers, and observations of meals, medication management, activities, resident council meetings, fire drills, etc.
6. Resident Interviews

The residents of the facility are the key to determining the quality of care that is provided. How well the facility responds and reacts to residents can often be detected best through conversation on a one-to-one basis with the residents. Residents will relate how comfortable they feel in their environment both by conversation and demeanor. In addition to the sample of residents interviewed by each discipline, the President of the Resident Council must also be interviewed by one inspector. This interview should take place as early as possible during the onsite inspection because the information gained could highlight specific issues and concerns that should be investigated.

It must be taken into consideration that residents interviewed may not remember accurately what has recently occurred in their lives. Short-term memory loss, depression and preoccupation with reminiscing may discolor or alter what has actually happened. Additionally, some residents may not be able to communicate to any degree. Finally, an inspector should be sensitive enough to detect whether a resident is comfortable in answering questions. Discretion and sensitivity is essential.

The interview questions included in this section address many of the issues that inspectors should explore with residents. These questions can be considered initial questions. Additional follow-up questions (not included below) should be posed if the resident’s response to initial questions raises any concerns. From time to time, certain regulatory requirements may be of special concern to the Department of Health and inspectors may be required to pose specific questions to all residents that they interview and to record residents’ answers on the resident interview form.

a. Program Questions

i. How long have you lived here? (Even “a few months” or “a few years” will establish a good base.)

ii. Do you feel like you get enough help with the things that you need help with, e.g., bathing, dressing, getting to meal or activities, or housekeeping.

iii. Tell me what you think of the food. Do you get enough to eat? What about snacks?

iv. Tell me what you think of the activities program. Is there a good selection of events to choose from? Are there resources for individual things, like a daily paper, reading material, etc.

v. Does the facility keep spending money for you? How do you get your money? (Probe on signing, receive receipts, etc.)
vi. Does the staff check on you at night? Will staff check to see if you don’t come for meals or your medications?

vii. How would you describe the people who work here?

viii. Whom do you go to if you have a problem or a question about something?

ix. If you had a complaint about a staff person or other issue, who would you talk to? How would you register a complaint if staff doesn’t do anything about it?

x. Do you think the staff treats you well? Do they respect you and your privacy? Are they courteous to you?

xi. Do staff members knock on your door before entering your room?

xii. How do you get your mail?

xiii. How often do you see your doctor? Does staff make sure that you see your doctor if you’re not feeling well or are sick?

xiv. If you could change one thing about this place, what would you change?

xv. What would you do in case of an emergency or the sounding of the fire alarm?

xvi. Have had to use your call system for help?

xvii. Is there a resident organization that meets monthly and do you attend those meetings?

xviii. Were you given a copy of your admission agreement upon admission?

xix. Were the facility rules and regulations explained to you when you were admitted?

xx. Were you given a copy of the facility rules?

xxi. Did you receive a copy of the statement of resident rights?

b. Fire/Safety Questions

i. How long have you lived here?

ii. Do you like it here?
iii. Is your room comfortable?
iv. Do you have any problems, concerns or complaints?
v. Have you spoken with staff regarding your problems or concerns?
vi. Is everything working OK?

vii. How often do they clean your room/apartment? Do they do a good job?

viii. Do you get enough supplies such as toilet paper, soap, towels and bed linens, etc.?

ix. What do you do when you hear the fire alarm going off?

x. Is the fire alarm loud enough for you to hear?

xi. Have you participated in any fire drills?

xii. Do you think you would have any problems using the stairs if you had to evacuate in an emergency?

xiii. Do you leave the building during a fire drill? Where do you go?

xiv. Do you have any problems getting around the building?

xv. What about maintenance? If you need something fixed or a bulb replaced, how long does it take to get it done?

xvi. Have you had any problems with the heat or air conditioning?

xvii. Is the hot water hot enough?

xviii. Is there enough hot water when you need it?

xix. Do you have somewhere to secure valuables? Do you have lockable storage?

c. Nutrition Questions

i. How do you like the food?

ii. Do you know where the menu is posted?

iii. Does the kitchen served what is posted on the menu?

iv. Do you know what is on the menu today?

v. Do they offer you an alternate or substitute if you do not like the planned meal?
vi. When do you get to pick the alternate if one is offered?

vii. Are the portions of food sufficient for you?

viii. Have you asked to be served smaller portions, if regular portions are too large?

xiv. Are you offered seconds, or do have to ask for seconds if you are still hungry and do they actually serve them?

x. Is the hot food served hot and the cold food served cold?

xi. Do you know if you are on a special diet?

xii. Do you know what foods you can and cannot have on your diet?

xiii. Does the facility follow (serve) your diet plan?

xiv. Do you ever not follow your diet, as you know you should?

xv. Do you have any allergies?

xvi. Do they serve you food that you are allergic to?

xvii. What does the staff do if you refuse to follow your diet?

xviii. Are the meals served at the scheduled times?

xix. Does staff assist you if you need help with cutting food, etc?

xx. Do they rotate tables or do they always start service with the same table?

xxi. Are the tables, chairs, etc. clean when you go to the dining room?

xxii. Do they serve you a tray in your room when you are sick?

xxiii. Are the servers (staff) friendly and courteous?

d. Medications Questions

i. Do you take care of your own medications or does the facility do them for you?

ii. Do you keep your medications stored in a safe (secure) place?

iii. Do you inform the staff of the medications you are taking and when your physician changes the instructions/dosage for those medications?

iv. Does the facility help you in ordering medications (refills)?
v. Do you know what medications you are taking and what the medications are for?

vi. Does the facility give you the right medications at the right times?

vii. Do you get enough water or juice to take with your medication?

viii. Does the facility ever run out of your medications?

ix. Does the staff handle your medication in a sanitary manner?

x. Does the staff people who gave you your medication stay and watch you take it?

xi. Do you have to wait in a line for your medications?

xii. How long do you have to wait?

xiii. Do you have trouble swallowing your medications?

xiv. Does the facility split or crush your medications?

7. Facility Records

Each discipline determines compliance with regulatory and other requirements that govern the records and reports relevant to the discipline.

8. Personal Needs Allowance and Resident Property

In addition to resident interview questions on the personal needs allowance and resident property and valuables, the inspector assigned to this area also reviews facility records, such as Statement of Offering (DSS-2853), Personal Allowance Summary (DSS-2855), Personal Allowance Ledger and Inventory of Resident Property (DSS-3027) or their equivalents if the facility has a waiver to use other forms. The inspector also reviews a sample of five resident accounts to determine accuracy.

Inspectors also conduct a review any money retained by the facility on the behalf of private pay residents.

9. Facility Policies and Procedures

For each area in which a violation may be determined, inspectors must review facility policy and procedure relevant to that area.
10. Quality Improvement Program Funds (QUIP), Infrastructure Grants and Enable Grants

If the facility received QUIP, Enable and/or Infrastructure funds, inspectors verify whether the funds were spent as approved by the Department. Verification activities depend on how the funds were approved to be spent. For example, if specific equipment was to be purchased, inspectors would check to see if the equipment was present in the facility. If the funds were approved to be used on quality of life improvements, such as a training program for residents to improve their independence, inspectors would verify that the training program took place and that residents attended the program. If funds were to be spent on capital improvements, inspectors would verify that the improvements were completed. As part of the Resident Council interviews, inspectors ask if the Council had input into how the funds were spent and whether the facility spent the funds on approved items.

11. Exit Interview

At the conclusion of each inspection, there is a single exit interview with the operator, administrator, or person in charge, during which all items of non-compliance are discussed. For complete or full inspections, at least two inspectors must participate in the exit interview. While one inspector must conduct the exit interview while onsite at the facility, additional inspectors may participate via telephone. Exit interviews for other types of inspections may be conducted by a single inspector only if the inspection was conducted by a single inspector. Otherwise, as with full or complete inspections, at least two inspectors must participate. The inspectors that participate in the exit interview present all items of non-compliance found by the entire inspection team including those determined by inspectors who do not participate in the exit interview.

D. Post Inspection

1. Preparing the Inspection Report

   a. Inspectors complete the Inspection Report, rosters, 670, UCTS/ACTS write-up, all notes and collateral information and submit them to the supervisor for review within the timeframes determined by each regional office.

   b. Each inspector prepares an Inspection Report (following the Principles of Documentation) indicating all areas of non-compliance, areas of compliance, and the resident and employee roster. All citations should be concise, complete, understandable and supported by notes. The rosters list the names in numerical order and correspond to the numbers in the violations/findings in the actual Inspection Report. If there are violations, the Inspection Report must identify the steps that must be taken to correct them and include the timetable for correction.
2. The required information is entered on SP tools, Control Log and ASPEN. ASPEN data entry must be completed within 30 calendar days of the last day of the inspection. The last day of the inspection is the day the exit interview occurs. The date of the exit interview is entered in ASPEN as the last day of the inspection.

3. Follow-up Activities

   a. Follow-up activity is required whenever violations are found during a full inspection. Each region decides on the basis of the scope and severity of the violation(s) whether follow-up activities should include an onsite visit. One inspector may complete all follow-up activities, including an onsite inspection, provided that the violations are of such a nature that his/her competency is not compromised.

   b. The results of follow-up activities, including inspection if one is conducted, are noted on a hard copy of the full Inspection Report. This copy is retained in the files. Each inspector annotates each item of non-compliance on a copy of the Inspection Report with corrected or uncorrected, the date and his/her initials.

   c. If the inspection interval for the facility changes as a result of follow-up activities, the SP tool should be updated to reflect the change. The Control Log and ASPEN should also be updated with the results of follow-up activity. Each Regional Office should determine a reasonable timeframe for completing these updates, but in no case should updates be done later than the seventh calendar day of the next month.

   d. Each inspector shall submit to the supervisor his/her annotated Inspection Report and all inspection-related materials.

E. Report Processing

1. The supervisor controls and coordinates all incoming inspection report components.

2. The supervisor reviews each Inspection Report for accuracy, language, spelling, correct citing of regulations and presence of any repeat citations that warrant a referral to enforcement. The supervisor also determines whether all supporting documents are included and whether any additional investigation is needed. Inspection tools are reviewed for documentation as well as all other documentation and notes gathered by the inspection staff.

3. The criteria for determining whether an item of non-compliance is a violation or a finding are outlined in Adult Care Facility Informational Letter No.1-95. Each Regional Office develops its own discussion and decision-making
process for determining whether an item of non-compliance is a finding or violation. However, the inspector makes the initial recommendation. The final decision is made following discussion with the supervisor and Program Manager. Violations are listed in the Inspection Report. Findings are listed in a separate section of the Inspection Report.

4. The supervisor assigns the appropriate compliance status (see Section F below). If necessary, the supervisor consults with the inspectors to determine this status. The appropriate cover letter is identified.

5. The Program Director or Program Manager reviews the Inspection Report and cover letter and signs it. The ASPEN survey report is “closed” in the system to prevent any loss or modification of information.

6. The cover letter and Inspection Report are sent to the facility operator and/or administrator by certified return receipt mail.

7. The Inspection Report is also sent to the Office of Mental Health (Central Office) and to the Commission on Quality of Care for the Mentally Disabled if at least 25% of the facility’s residents or 25 residents (whichever is less) have a psychiatric diagnosis.

8. Within 30 calendar days of the date that the Inspection Report is received by the facility, the facility must either correct the violation(s) or, in the event that corrective action requires more than 30 days, submit an acceptable Plan of Correction (POC) and timetable for correction. Regional office staff may require that corrective action be completed in fewer than 30 days if the violation is severe. More than 30 days may be allowed if the facility’s POC provides sufficient justification. However, if the facility cannot correct the violations within 30 days and the Regional Office approves an extension, the Regional Office must track the facility to verify that the violations have been corrected within the approved timeframes.

9. The facility must submit a Notice of Correction (NOC) to the regional office within one week after completion of corrective action. The POC and NOC may be the same.

10. The POC, if required, must be submitted to the regional office within 30 days of the date that the facility receives the SOD. A preliminary due date for the Plan of Correction is the number of days determined by the supervisor and Program Director plus two to five working days to allow for Inspection Report mailing time, beginning with the date on the cover letter. The preliminary due date is entered in the facility control log. If the return receipt card is indeed returned to the Regional Office, then the actual due date is determined according to the day recorded on the return receipt card. In the event that the return receipt card is not returned to the Regional Office, the preliminary due date becomes the actual due date for the POC.
11. Notice of acceptance of the POC and NOC must be made to the operator.

F. Compliance Status

The supervisor must assign a compliance status to the facility. There are five options:

1. Compliance: the inspection confirmed no violations and no findings.

2. Substantial compliance: the inspection confirmed only findings. There were no violations.

3. Non-compliance: the inspection confirmed violations either with or without findings.

4. Non-compliance with continuing violations, with or without new violations and/or findings.

5. Endangerment.

G. Summary of Timeframes

1. Each adult care facility receives a full inspection at least once every 18 months. Facilities may be placed on an 18-month schedule if their last full inspection (or follow-up inspection if there was one) resulted in a determination that the facility: (1) was in compliance, (2) was in substantial compliance, or (3) had no more than two violations neither of which harmed or had the potential to harm a resident’s health, safety or welfare. Such facilities may, however, be placed on a 12-month schedule at the discretion of Regional Office staff based on such factors as number of deficiencies cited.

Facilities that are in enforcement may be placed on an either a 12-month or an 18-month schedule at the discretion of the Regional Office.

Facilities whose last full inspection (or follow-up inspection if there was one) did not result in one of the above three determinations must be inspected within 12 months of their last full inspection.

Compliance status and the inspection interval may change after the full survey is completed, based on follow-up activities and/or the N/POC.

1. All inspections must be completed within 30 calendar days.

2. Within 30 days of the last day of the inspection, the complete Inspection Report must be entered into Aspen and a copy must be mailed to the facility.
3. Within 30 days of the date that the Inspection Report is received by the facility, the facility must submit to the Regional Office a Notice/Plan of Correction and correct the violations. This timeframe may be fewer than 30 days at the discretion of the supervisor and Program Manager, depending on the severity of the deficiencies. The timeframe to correct violations may be more than 30 days if a longer period is required based on an approved Plan of Correction submitted by the facility.

H. Enforcement Procedures

1. Overview of Process

If violation(s) remain uncorrected or endangerment is cited, the Regional Office may refer the facility to the Bureau of Adult Care Facility Quality and Surveillance (BACFQS) in Central Office for enforcement. The BACFQS prepares certain required documentation and coordinates the Department's review and approval process with the Director of Regulatory Compliance and the Division of Legal Affairs, both of which have a defined role and responsibilities in the enforcement process.

2. Regional Office

   a. The Regional Office initiates referrals for enforcement under the following conditions:

      i. violation(s) remain uncorrected after the timeframe for correcting them expires and meet a defined threshold of scope and severity. This timeframe is 30 calendar days from the day the facility receives the Report of Inspection unless the Regional Office has specified an alternative timeframe (which may be more or less than 30 calendar days); and/or

      ii. endangerment.

   b. With the exception of endangerment, which can be referred to BACFQS immediately, the Regional Office must review any submitted corrective action plans before completing the Summary for Regulatory Compliance and the Enforcement Transmittal Form. The Enforcement Transmittal Form identifies information that Central Office must have before it can proceed with an enforcement action. All of the fields on the form must be completed before it is submitted to BACFQS.

   c. The Enforcement Transmittal Form and the Summary for Regulatory Compliance are submitted via e-mail, fax or mail to BACFQS within 45 calendar days of the date that the facility receives the Report of Inspection, assuming that the facility was given 30 days to correct the violations. The 45-day timeframe includes 15 calendar days for the
Regional Office to review and approve the facility's Plan of Correction. If the Regional Office specifies an alternative timeframe for correction, the 15-day review period would be added to this number.

3. Bureau of Adult Care Facility Quality and Surveillance (BACFQS)

a. Designated staff enters the referral in the ACF database within three days of receipt. The ACF database is a tracking tool that identifies all pertinent information on referrals. Assigned staff enters the pertinent dates and information regarding status and outcomes as the referral proceeds through the review and approval process and is resolved.

b. Designated staff prepares the case file and gives it to the Enforcement Coordinator within three working days of receipt of referral. The case file contains the following:

i. Enforcement Transmittal Form,
ii. Referred Reports of Inspection,
iii. Corrective Actions,
iv. Enforcement summary prepared by regional office,
v. Copy of Operating Certificate, and
vi. Any additional material submitted by the Regional Office.

c. The Enforcement Coordinator will assign referrals to reviewers based on level of difficulty, caseload, availability, etc. The Enforcement Coordinator will enter information in the “date assigned” and “assigned to” fields in the ACF database. This is done within five working days of the receipt of referral.

d. Reviewers will review the case file and submit it to the BACFQS Director within 21 calendar days. This review includes current Commission on Quality of Care and Office of Mental Health reports.

e. If the reviewer recommends enforcement:

i. Referral for Enforcement Action will be prepared by the reviewer and submitted to the BACFQS Director for review and signature. An electronic copy of the Referral for Enforcement Action is provided to the designated support staff at that time. The Referral for Enforcement Action consists of the following:

- Letter to the Operator,
- Interoffice Memorandum to the Bureau of Administrative Hearings, Division of Legal Affairs, (enf-1),
- Facility Data, (enf-2),
- Terms of Settlement, (enf-3), and
- Interoffice Memorandum to Deputy Commissioner for Administration and Public Affairs, (enf-4).

ii. Reviewers will enter the “date to Bureau Director” and the tags/violations being referred for enforcement in the ACF data base and put a copy of the ACF database form in the case file.

iii. After the BACFQS Director completes the review of the case file, he/she will either return it to the reviewer if it needs additional work, or approve and forward it to the Director of the Division of Home and Community Based Care for review and signature. The BACFQS Director or support staff will enter the date it is sent to the Division Director in the ACF data base and put a hard copy of the form in the case file and place the case file in Division Director’s in-basket.

iv. If the Division Director disapproves the Referral for Enforcement Action, it is returned to the BACFQS Director who will forward it to the reviewer for additional work.

v. If the Division Director approves the Referral for Enforcement Action, support staff make appropriate entries in the ACF data base and forward the case file to the Director of Regulatory Compliance. After review, the Director of Regulatory Compliance returns the case file to designated staff for processing. Staff dates the Referral for Enforcement Action (letter to operator, enf-1 and enf-4) and distributes the Referral for Enforcement Action to the appropriate parties. The date of distribution is entered as “Date to DLA” in the ACF database.

vi. Support staff file copies of the Referral for Enforcement Action in the case file, the Enforcement Daybook and the BACFQS Director’s Daybook. A copy is also provided to the reviewer. Support staff file the case in the enforcement file cabinet.

vii. When the Enforcement Action is resolved, the BACFQS Director reviews it and gives it to support staff for processing. Support staff check the correct resolution box in the ACF data base, put a copy of the disposition in the Stipulation and Order Book and the case file, fax a copy to the appropriate Regional Office Program Director and Program Manager and give a copy to the reviewer.

f. If the reviewer recommends that the referral be withdrawn:

i. Comments/reasons are prepared and sent to the BACFQS Director for review. Reviewers will enter the “date to Bureau Director” in the ACF database.
ii. At the same time, the comments/reasons submitted to the BACFQS Director are sent to the Regional Office for review and comment.

iii. If the Bureau Director, after reviewing the response from the regional office, concurs with the decision to withdraw, she/he or support staff will update the ACF database and forward the file and recommendation to the Division.

iv. If the Division Director approves of the withdrawal, support staff make the appropriate entries in the ACF database and return the case file to the reviewer.

v. The Regional Office is notified regarding the reasons for withdrawal.

g. The Enforcement Coordinator and reviewer review the file and assure that all appropriate entries have been made in the ACF database. The reviewer gives the case file to support staff who will place it in the facility file.

h. The ACF database has queries for all pertinent issues regarding the status of referrals for enforcement. These queries are reviewed on a regular basis by staff to ensure that all the information is accurate and that the referrals are being processed in a timely manner.

i. Monthly meetings are conducted with the Division of Legal Affairs to discuss the status of cases and other enforcement issues.

j. The Enforcement Coordinator and reviewer review the case file. The reviewer organizes the case file and gives it to support staff for filing.

k. Support staff incorporate the case file into the facility file.

4. Division of Legal Affairs (DLA)

a. Upon receipt of referral from BACFQS, an attorney is assigned to the case.

b. BACFQS staff coordinate with DLA regarding the Statement of Charges. After review and follow-up discussion with appropriate staff, and obtaining any additional information that it feels is needed, DLA will prepare a Statement of Charges and forward it to the facility. A hearing is scheduled at the same time that the Statement of Charges is forwarded to the operator.
c. If the facility responds during this time frame, a determination will be made by DLA and BACFQS regarding the necessity of an additional inspection or possible settlement prior to hearing.

I. Provider Surveillance Activity Time (ASPEN 670 Data)

Provider surveillance activity time is entered in ASPEN for all types of ACF inspections, i.e., complete or full, summary, follow-up, partial and complaint investigations. The major categories of activity in the inspection and enforcement process (as defined on the ASPEN 670 Data Checklist - ACFs) are:

- pre-survey preparation;
- travel;
- onsite inspection activity;
- off-site inspection report preparation;
- clerical activity and data entry; and
- supervisory review.

The ASPEN 670 Data Checklist – ACFs provides a list of specific tasks for each of the major categories. As tasks are completed, staff enters the amount of time spent on each. Designated supervisors review all ASPEN 670 data for accuracy and completeness using the ASPEN 670 Data Checklist - ACFs.
Attachment 6

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, may be found at the following website addresses or are set forth below:

Unit 6
Adult Care Facility Quality Activities
Complete Inspection EALR

Adult Care Facility Quality and Surveillance Operations Manual – Inspection Process
set out in full in
Attachment 5
Attachment 7

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 7**

Adult Care Facility Quality Activities
Partial Inspection, including ALR, EALR, SNALR

Adult Care Facility Quality and Surveillance Operations Manual – Inspection Process
set out in full in
Attachment 5
Attachment 8

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 8**
Adult Care Facility Quality Activities
Complaint Intake, including ALR, EALR, SNALR, ALP

Adult Care Facility Quality and Surveillance Operations Manual – Complaint Process
OVERVIEW OF THE COMPLAINT INTAKE PROCESS

SSL 461, 18 NYCRR 486.2

Procedure:

I. Complaint Identification

A. ACF CCIP is responsible for all contacts received via the hotline related to any complaints about any licensed adult care facility (ACF) and/or any unlicensed operation that is suspected as operating as an adult care facility.

B. If a region receives information by telephone, e-mail, or written correspondence related to a possible ACF complaint, the regional office will either refer the complaint to the ACF CCIP Hotline or respond to the complaint directly. The complaint and all relevant information will be entered into UCTS within one business day. Information received about a suspected unlicensed facility will be referred to the ACF CCIP hotline for processing and triaging.

C. During the course of a survey, if the onsite survey team is presented with a complaint, the team will either investigate the complaint at that time or refer the complaint to the ACF CCIP Hotline for processing into UCTS upon their return.

D. BACFQ&S staff will access the Department’s complaint e-mail account daily to receive consumer complaints that have been forwarded to DOH electronically. The complaint will be entered into UCTS and triaged, as best as possible, with the provided facts of the case. An electronic message acknowledging the complaint will be sent back by BACF Q&S staff.

E. Written complaints regarding ACF’s mailed to the DOH Central Office will be directed to the BACF Q&S to be date and time stamped upon receipt. ACF CCIP staff will contact the complainant, when possible, to obtain any additional information needed to triage the complaint and enter it into UCTS.

F. Complaints received from the Executive Correspondence Unit (ECU) will be date and time stamped upon receipt. Staff will contact the complainant to obtain any additional information needed to triage and enter it into UCTS.

G. All complaints received via ground mail, e-mail or ECU will triaged and
entered into UCTS within one business day of receipt of the complaint.

H. All non-complaint calls regarding a licensed facility will be recorded as a separate entry under the Inquiry Screen of UCTS. A separate notice will be sent to the regional office Program Manager regarding the subject matter.

II. Complaint Intake

A. For all calls to the hotline number (1-866-893-6772):
   1. Staff will answer the telephone the following way: “Good Morning or Afternoon). You have reached the New York State Department of Health, Adult Care Facility Complaint Hotline. How may I help you today?”
   2. Staff will speak gently and clearly. Staff will listen to the caller’s comments without interruption. Staff should be understanding and supportive and may need to take extra time as many callers are upset, frightened and/or angry.
   3. After the caller has had the opportunity to review his/her concerns, staff should ask for specific, clarifying information while entering the information directly into UCTS while the caller remains on the telephone.
   4. Intake staff should use the caller’s own words whenever possible when entering the intake narrative into UCTS. Staff should try to keep the conversation focused while affording the caller adequate time to tell his/her story, while recognizing that other callers may be on hold.
   5. In order to assure that correct information has been recorded, staff will repeat all pertinent information back to the caller to confirm dates, times, names, addresses, spelling, etc., prior to hanging up.
   6. The caller will be informed that the complaint information will be forwarded to the appropriate regional field office and that he/she will receive a letter, that includes an ID number, acknowledging receipt of the complaint.
   7. Although the preferred procedure is to complete the triage process immediately following the telephone call, it may be necessary to defer triaging for a short time during high volume periods. The amount of time between a telephone call intake and final triaging will not exceed one hour.

B. For complaints received on the 1-866 number voice mail after hours:
   1. Beginning every workday at 8:00 a.m. ACF CCIP staff will retrieve any complaints left on the 1-866 number since 4:45 PM of the previous evening. All complaints received will be assigned to ACF CCIP staff for processing.
   2. Any complaint received into the hotline voice mail after 4:45 PM Friday through 6:00 PM Sundays will be retrieved two times on Saturday, Sundays and all legal holidays at 12:00 noon and 6:00 pm.
   3. When an after hours complaint is picked up, the ACF CCIP staff person on standby status will complete a preliminary triage that includes the following:
      a. Identification of the complaint and priority status.
      b. The staff person who reviewed the call will process the complaint into
C. For complaints left on the 1-866 voice mail during business hours:
   1. ACF CCIP Intake staff will take overflow complaints off the ACF CCIP voice mail during business hours in the order in which they were received.
   2. If necessary, Intake staff will contact the caller by telephone or elicit any additional information needed to initiate the complaint and will proceed with UCTS entry and triage per policy.
   3. All such complaints will be retrieved and processed prior to the ACF CCIP staff’s daily departure.

D. For complaints received via DOH’s e-mail address:
   1. BACF Q&S Central Office staff will monitor the ACF Quality and Surveillance Bureau BML Mailbox. ACF CCIP staff during normal business hours to identify complaints that have been lodged in this manner will monitor the ACF Hotline BML Mailbox.
   2. When a DOH web site complaint is noted by BACF Q&S Central Office staff, the complaint e-mail is forwarded to the ACF CCIP Unit. The ACF CCIP Intake staff will contact the sender by telephone or e-mail, if needed to elicit any additional information necessary to initiate the complaint and will implement triage and UCTS entry procedures per policy.

E. For complaints received from the Executive Correspondence Unit (ECU):
   1. When ACF CCIP staff receives a complaint via the ECU, an e-mail will be sent to the ECU and the staff person responsible will acknowledge the receipt of the complaint within “72” hours of receiving the information.
   2. If necessary, intake staff will contact the complainant by telephone to elicit any additional information necessary to process the complaint, and will proceed with triage and UCTS entry per policy.

III. Complaint Acknowledgement

A. All complaints via the hotline including voice mail, written correspondence, electronic mail messages into the Bureau’s Mail Log and the Department’s Executive Correspondence Unit will be acknowledged in writing, whenever
possible or requested. Specific procedures are listed separately under the Acknowledgement Letter Policy.

IV. Complaint Triage Process

A. Upon receipt of a complaint from any source against either licensed or unlicensed facilities, ACF CCIP staff or regional office staff will follow the established complaint procedures to ascertain the allegation code(s) and priority level to be assigned to the complaint prior to entering it into UCTS.

B. ACF CCIP intake staff will review the triage decision with the unit supervisor, or person assigned such duties in the supervisor’s absence, as necessary.

C. ACF CCIP staff or support staff will prepare and mail a complaint confirmation letter to the complainant within one business day of receiving the complaint.

D. Complaint triage includes assigning a priority status that determines when the investigation of a complaint must start after receipt of the complaint. The three codes include: a) “within 72 hours”, b) between 4 and 120 days, or c) at or before the next standard survey.

E. A priority status of “within 72 hours” is where resident health and/or safety are imminently at risk or waiting to investigate jeopardizes the integrity of the complaint. In addition to entry into UCTS, hotline will notify the regional office via e-mail or telephone call of the complaint and triage decision the same day.

F. The assigned regional office may change the initial priority status assigned at intake when additional information warrants the change in status. In addition to changing the priority status in the Investigations Screen, the staff assigned to the case will also note the change in the Actions Screen. Under the Intake Menu select “investigation milestones” and under the Description menu select “revised priority.” Staff will record their initials or user ID in the adjoining box.
Policy: INFORMATION TO COLLECT

Basis: SSL 461, 18 NYCRR 486.2

Procedure:

Relevant Information to be Collected at the Complaint Intake:

- Complainant name, address and telephone number?
- Names of others who can collaborate the allegation(s)?
- Residents involved/affected and room number?
- Other residents involved?
- Facility name and address?
- Incident reported to operator/staff?
- Specific allegations?
- Date/time of the incident?
- Frequency and/or previous history?
- Names of staff involved?
- How and why incident may have occurred?
- Were actions initiated?
- Complainant’s expectations?

Intake Interview Questions:

1. Please describe the situation on which you are reporting. (Include date, time, location and circumstances of the incident?)

2. Do you have reasonable cause to believe that abuse/neglect took place? (If so, why?)

3. Are there any witnesses?

4. Is resident alert and oriented?

5. Were there any injuries? (List treatment given and what the time frame.)

6. Has this happened before? (Is there a history with this resident or type of incident?)

7. Are you aware of any action taken by the facility to address this situation?
8. If we have additional questions whom should we call, what time and what number?
Policy: ON CALL DUTIES FOR WEEKEND AND HOLIDAY PERIODS

Basis: SSL 461, 18 NYCRR 486.2

Procedure:

1. ACF CCIP staff will check the hotline voice mail system for complaints made into the hotline on weekends and holidays.

2. The days in question are Saturdays, Sundays and all legally recognized holidays that state offices are closed and fall between the days Monday through Friday.

3. Staff will be assigned on call duty on a rotating basis. The assigned staff will retrieve calls twice a day, at 12:00 PM and 6:00 PM, respectively from the hotline’s CAPNET voice mail system by dialing 473-2999, and then following the system’s instructions for call retrieval.

4. Information from all retrieved calls will be recorded on an after-hours call log.

5. All complaints will be screened and triaged for priority status. For those meriting a “72 hour” status, the on call person will contact the caller, if known, to confirm the allegations and then contact the hotline supervisor to review the matter further. The supervisor will then contact the appropriate regional office manager or regional office duty officer to report receipt of the complaint. All other complaints will be addressed the next business day.

6. Complaints will be recorded into UCTS the next business day. Follow-up will be made with the regional office, when necessary. Acknowledgment letters will be issued at that time.

7. If staff cannot return to their office on the next business day, regional offices will be notified via voice mail/telephone call of the complaint pending the ACF CCIP unit’s ability to process the complaint for investigation.
Policy: AFTER BUSINESS HOURS COMPLAINTS WITH A 72 HOUR PRIORITY

Basis: SSL 461, 18NYCRR 486.2

Procedure:

1. Seventy-two Hours Priority Status is interpreted as a crisis situation in which the health and/or safety of resident(s) are at risk as defined under “Overview of the ACF CCIP Intake Process.”

2. In a situation where the determination is made that Seventy-two Hours Priority Status may be present and ongoing, the Regional Office (RO) is required to begin an investigation of the situation within 72 hours of the receipt of the complaint.

3. ACF CCIP on call staff must take the following steps to ensure that all necessary regional office staff are notified in a timely manner:
   - Notify the ACF CCIP Director.
   - The ACF CCIP Director will place a phone call to the appropriate Regional Office Complaint Coordinator/Duty Officer.
   - Follow up with an e-mail to the regional office Program Manager, the regional office Program Director and the BACF Q&S Director the next business day.
   - The regional office contacts are:
     1. Capital District Regional Office
        Martin McMahon: mdm09
        (518) 408-5400

     2. Western Regional Office
        Jay Dorney: jfd02
        (585) 238-8185

     3. Central Regional Office
        Lynn Shannon: lcs01
        (315) 477-8422

     4. Metropolitan Area Regional Office
        William Conron: wvc01
        (212) 268-7912
**Policy:** WRITTEN COMPLAINTS

**Basis:** SSL 461, 18 NYCRR 486.2

**Procedure:**

1. Upon receipt of any written complaint either by letter or fax goes to supervisor.

2. Supervisor assigns to staff for entry into UCTS.

3. Case completed per ACF CCIP Intake Process.

4. Written complaints received into the regions will be handled in the same way and entered into UCTS in the manner prescribed in the ACF CCIP Intake Procedure.

5. ACF CCIP will monitor UCTS and review all complaints entered by the regions for accuracy, completeness and correct triaging.

6. The office receiving the written complaint will maintain the original letter on file. In instances where the letter is received by the ACF CCIP, a copy of the letter will be sent to the appropriate region at the time the complaint is entered into UCTS.
Policy: COMBINING AND DELETING CASES
Basis: SSL 461, 18 NYCRR 486.2

Procedure:

1. Determine source of complaint; if same complainant:
   - Case may be deleted if the information is a duplicate complaint.
   - If new information is given, this new information may be added or combined as an addendum. All addendums must be dated and initialed by the staff member.
   - Supervisor will delete duplicate case if indicated. Staff member must ask Supervisor to delete the case.

2. The ACF CCIP supervisor must first approve any request for deletion or combining of complaint records.

3. If same complaint but different complainant:
   - Generally in this circumstance, the cases will remain as two different, distinct cases/complaints, as complainants receive their own case number and acknowledgement letter. Also the complainants may be providing different information that is helpful to the investigation of the case. Nevertheless, depending on the individual circumstances, the Investigator(s) may be investigating these connected cases as one case.
Policy:  ACF CCIP COMPLAINT ACKNOWLEDGEMENT LETTER

Basis:  SSL 461, 18 NYCRR 486.2

Procedure:

1. ACF CCIP staff will process and send a complaint acknowledgement letter for all calls received into the hotline, where anonymity is not requested.

2. Regional Office staff will send out an acknowledgement letter for all complaint calls received into their respective office via a word processing template.

3. Upon the completion of a complaint investigation, the appropriate Regional Office will send a letter to the complainant (where possible) regarding the results.

4. The process for ACF CCIP staff to send out an acknowledgement letter includes the following steps:
   a) go into UCTS under the region for which you want to print acknowledgment letters and click on menu heading “Modules,
   b) from the drop down menu choose “Reporting” then “Report Selection,
   c) double click on the first letter category. A box entitled “Date Selection” will appear prompting you to enter a date. Enter the intake date for the reports you are working from and hit OK,
   d) a new screen will appear with an acknowledgment letter. Click on “Print.” When the print screen appears, choose the correct printer and hit OK,
   e) repeat this step with the next two categories. If there are no reports in a particular category, a box will appear that says, “No data was found for the selected report.” Hit OK,
   f) repeat above steps for each region. Be sure to click on all three letter categories for each region. If a letter prints and does not have a corresponding case, this indicates an agent may have forgotten to print a case report.

Quality Assurance

1. Once the letters are printed, proof them for complete addresses. If the person making the complaint is a resident and wishes to have the letter sent to him at the facility, look up the facility in the Adult Care Facility Locator for an accurate mailing address. The address for all other complainants receiving an acknowledgment letter should be confirmed for accuracy during the intake call.
2. If the complainant is a resident, he/she should only be sent an acknowledgment letter if specifically requested, and include this point in the narrative of the report.

**Customized Letters**

In some instances, it is necessary to customize an acknowledgment letter. For example, if a resident requests a letter be sent to an address other than the adult home, a customized letter will need to be created. This is due to the fact that the UCTS system will only print an acknowledgment letter for a patient using the nursing home address.

**Corrected Letters**

To be done on a as needed basis due to incorrect information on intake, clerical error or due to combining of 2 existing cases which may generate a new case number.

**Mailing Letters**

Make two copies of each letter.

1. Mail original to complainant in DOH window envelopes and print “0922” under the return address. This will inform the mailroom where to forward undeliverable mail.

2. **Resident Letters:**

   If the letter will be sent to the resident at the adult care facility, use a plain white envelope and hand-write the resident’s address. If the resident requests a letter be sent somewhere other than the facility, use a window envelope.

3. Staple the second copy to case report. Sort all reports by region (in case # order), clip each region together and replace in proper folder.

4. Fax a copy of the acknowledgment letter with the case detail report to the appropriate regional office the same day.
**Policy:** COMPLAINT WITHDRAWAL

**Basis:** SSL 461, 18 NYCRR 486.2

**Procedure:**

1. Determine that the complainant wishes to withdraw/retract the complaint, including the reason(s). Collect any additional relevant information.

2. Inform the complainant that the request will be reviewed by the assigned regional office and that any perceived impact due to the allegation(s) made may have a bearing on whether the investigation is ended.

3. Review intake narrative to determine the level of impact as a result of the allegations and add an addendum to the UCTS case, including date and initials detailing the complaint is withdrawn.

4. Notify the regional contact person by e-mail that the complainant has requested the complaint be withdrawn and the reasons provided. Include the case ID number.

5. Attach copy of the e-mail to the original case detail report.

6. If there is agreement by the regional office that the allegations do not require further investigation, the complaint will be closed as unsubstantiated on UCTS.
Policy: COMPLAINT INTAKE QUALITY ASSURANCE

Basis: SSL 461, 18 NYCRR 486.2

1. All cases will be reviewed by staff for accuracy and completeness before checking finished box and printing out the case detail report.

2. All questionable cases are discussed with supervisor.

3. All cases are reviewed by the unit supervisor for completion and proper triaging at the intake phase.

4. When needed, cases will be returned to staff for correction and discussion.

5. Either CCIP or regional office personnel can make corrections of the triage decision when indicated by case reviews or when additional information is received about the complaint.

6. All changes to priority status shall be recorded on the Actions Screen under Intake and Assignment and include the staff’s initials.

7. Staff making the changes will notify all parties of the changes by email. In the case of CCIP staff, a copy of the email will be attached to case detail report.

8. QA cases will be reviewed and discussed at Bureau staff meetings.

9. Intake quality issues will be clarified with Regional Office staff during monthly Program Manager’s meetings and in conference calls in between meetings, as needed.
Complaints

1. Complaints will be reviewed on a monthly basis by ACF CCIP staff for completeness and accuracy in all Provider Screens regarding menu selections and meet the established time frames.

2. All complaints, particularly ones assigned a priority of 72 hours, will be reviewed to ascertain that investigations are initiated and completed within the required time frames. Cases not meeting the standards will be shared with the ACFQ&S Bureau Director, who will then review the same with the regional Program Manager for resolution.

3. In conjunction with individual case reviews, the director will identify cases through the UCTS Reports Generator that do not meet the time standards for initiation and completion. In addition, any other anomalies identifying a complaint as incomplete will be identified in report form. The unit supervisor will share these reports with the ACFQ&S Bureau Director, who will also share with each regional office Program Manager at monthly meetings.

4. All complaints assigned a priority of 72 Hours and any other issues identified, as needing immediate attention, will be forwarded to the regional office Program Manager by e-mail or telephone call. A copy of the e-mail will be attached to the case detail report on file.

5. All QA cases and system reports will be reviewed at the monthly Program Manager’s meetings or via conference call, on an as needed basis.

6. The ACF CCIP hotline will also serve as the source for operators to consult for clarification of changes to certain specific policy issues that may occur.
Policy: QUESTIONABLE OPERATIONS (Q-OPS)

Basis: SSL 461, 18 NYCRR 486.2

Procedure:

1. When receiving inquiries or complaints regarding operations that are not listed as a certified adult care facility in the ACF Locator Database, ACF CCIP staff will research the Central Office Q-Op database for any history of the operation. Staff will also attempt to ascertain if the operation in question is under the regulatory authority of Family and Children Services, OMH or OMRDD. If the inquiry proves negative, ACF CCIP staff will consult the Bureau of Certification and the appropriate regional office to ascertain if there is a pending application for certification or if there is an active investigation underway. If the questionable operation is known to the Department in this manner, the complaint will be entered into UCTS.

2. Before the complaint can be logged into UCTS, ACF CCIP staff must first data enter the operation into UCTS, including the name, address, region and other identifiable information. A new Facility ID (Aspen) number will be assigned at this time. The facility will be listed as a Q-Op in the Investigation Screen, as well as, within the complaint entry area of UCTS.

3. ACF CCIP staff will process the complaint with the same standards established for complaints against licensed facilities, including data collection, triaging and priority assignment. Complaints triaged as “72 Hours,” the ACF CCIP supervisor will also notify the region Program Manager, via telephone or e-mail to advise of the complaint.

4. During the intake process, if it is learned that the operation is licensed as a home health care agency and there are allegations regarding care of residents, the complaint will also be referred to the Central Office Home Care Bureau, who will then refer the matter to the appropriate regional office Home Care unit for investigation. The complaint intake will document that the regional office ACF and Home Care units have been informed of the complaint to assure coordination of the investigation, such as the scheduling of a joint visit.

5. When possible, the caller will be referred to the appropriate agency with oversight for those operations deemed not to be under the authority of either the BACF Q&S or BHC/HS&QI.
6. Should the Q-Op ultimately become licensed as an adult care facility, it will retain the same Facility ID# assigned at the time the original complaint was received and entered into UCTS.
OBTAINING FOREIGN LANGUAGE ASSISTANCE FOR CALLERS

SSL 461, 18 NYCRR 486.2

Procedure:

Requests for foreign language assistance should be made to the Bureau of Employee Benefits and Human Resource Information Systems (518-473-3333) or faxed (518-486-7374.) See DOH News Memo Foreign Language Database dated 06/06/2001.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translator Name</th>
<th>Telephone #</th>
<th>Located</th>
</tr>
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<tbody>
<tr>
<td>Russian</td>
<td>Larisa Stepansky</td>
<td>518-474-4104</td>
<td>Wadsworth Lab</td>
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<tr>
<td>Russian</td>
<td>Irina Birman</td>
<td>518-402-7650</td>
<td>Flanigan Square</td>
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<td>Spanish</td>
<td>Virginia Reyes</td>
<td>518-474-2012</td>
<td>Commissioner’s Office</td>
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<tr>
<td>Spanish</td>
<td>Rafael Acosta</td>
<td>585-423-8023</td>
<td>NYC MIS</td>
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<tr>
<td>Spanish</td>
<td>Elizabeth Ramos</td>
<td>716-423-8027</td>
<td>NYC AIDS</td>
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<tr>
<td>Spanish</td>
<td>Michael Waring</td>
<td>518-402-0820</td>
<td>Troy</td>
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</tbody>
</table>

See Language sheet: For assistance with other language or communication barriers, consult reference lists.
Policy: MAINTAINING CONFIDENTIALITY

Basis: SSL 461, 18 NYCRR 486.2

Procedure:

1. When receiving inquiries about cases from the public, no information of any kind can be provided to the caller.

2. It is permissible to indicate the Department is aware of the matter, but ACF CCIP staff must not indicate how or who reported this information.

3. If a caller states that he/she is the complainant and wishes to know the status of the complaint, refer him/her to the Regional Office for assistance.

4. If the caller wishes to add information to a previous complaint, take the information from the caller, including their name, and add an addendum to the complaint. Always date and initial the addendum.

5. When you are returning calls to the general public or to residents, do not identify yourself as an employee of the Health Department until you have reached your caller.

6. Do not leave case information out for public view on desks, or in any other location or room.
Policy: UNPLANNED EMERGENCY EVACUATION

Basis: SSL 461, 18 NYCRR 486.2

Procedure:

1. When ACF CCIP staff receive notice to vacate building, the supervisor or designee will take an on-call packet including cell phone when exiting.

2. Staff person assigned will retrieve messages and record on log.

3. Messages will be returned immediately if there is a suspected emergency.

4. Complaints are recorded on intake report for UCTS entry next business day.

5. If staff are unable to return to the office the next business day, regional offices will be notified via voice mail/telephone call and of action to take pending the ACF CCIP team’s return.
MEDICAID FRAUD REFERRALS

SSL 461, 18 NYCRR 486.2

**Procedure:**

1. Appropriate complaints will be faxed to Medicaid Fraud Control Unit.
   - Examples include: changing records, billing for non-covered services, etc.

2. Review with Supervisor if needed.

3. Add in Actions Screen in UCTS with date.

4. Fax copies of the Case Detail Report and acknowledgement letter.

5. Copies of such referrals will be sent to BACFQ&S and the Director and Assistant Director of the Division of Home and Community Based Care.

6. Regions will be notified of such cases by recording the information as an FYI in the UCTS complaint record.
REFERRALS TO OTHER AGENCIES

SSL 461, 18 NYCRR 486.2

Procedure:

1. When a complaint is received and entered into UCTS and there are allegations involving other programs, determine whether a referral is needed.

2. The following are examples of programs we may need to refer to:
   - Hospital
   - OMRDD
   - Nursing Homes
   - Licensing

3. Contact the appropriate agency by phone, fax or e-mail and provide a description of the specific allegations made, unless the caller prefers to contact the other agency.

4. Attach your message or fax to the case detail report and place it in the daily file as a record of the referral.

5. In UCTS under the Actions Screen, add the date that case was referred to the appropriate agency by choosing "Intake and Assignment Action" from the drop down menu. For the Description code, choose "other intake specify______" and list the agency or program to which the case was referred.

6. When a hotline phone complaint is not an adult home complaint, refer the caller immediately to the appropriate program or agency. In these instances, there is no need of documentation of the referral.

7. Written complaints that are not adult home issues will be addressed with a written response informing the complainant what agency to contact.
Attachment 9

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 9
Adult Care Facility Quality Activities
Complaint Investigation Survey, including ALR, EALR, SNALR, ALP

Adult Care Facility Quality and Surveillance Operations Manual – Complaint Process
set out in full in
Attachment 8
Attachment 10

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 10
Adult Care Facilities Quality Activities
Pre-opening Survey, including ALR and ALP

Adult Care Facility Quality and Surveillance Operations Manual – Inspection Process
set out in full in
Attachment 5
Attachment 11a

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 11
Adult Care Facility Quality Activities
Questionable Operations (Q-Op) Investigation

Adult Care Facility Quality and Surveillance Operations Manual – Complaint Process
set out in full in
Attachment 8
Attachment 11b

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 11
Adult Care Facility Quality Activities
Questionable Operations (Q-Op) Investigation

Additional Standards
In addition, the Bidder shall take into consideration the following procedure in developing the Unit price for this Unit. Some or all of these activities may be assigned by the Regional Office to the Contractor:

1. Complaints of unlicensed facilities/agencies referred to the Central Office of the Department of Health are reviewed to determine if there is sufficient evidence to indicate the facility may require licensure.
2. Q-Op file is opened and the facility is placed on the Q-Op database for tracking. If there are 5 or more residents, the complaint is referred to the Regional Office to conduct a Q-Op investigation.
3. The Regional Office issues a notification letter with a questionnaire to the facility within 30 days of receiving the complaint from Central Office. Complaints which include allegations of serious resident care issues or imminent danger are prioritized and receive an immediate site visit.
4. Upon receipt of the completed questionnaire, the information is reviewed to determine the need for additional action.
   a) If it is determined that the organization is not an ACF, Central Office will notify the organization by letter with a copy to the BLC and the Region within 30 days.
   b) For organizations appearing to require licensure based on information obtained on the questionnaire, an unannounced on-site investigation must be scheduled within 45 days by the Regional Office.
   c) If the RO is unable to obtain a complete questionnaire within the required time frame, then a site visit must be scheduled.
5. Site visits include:
   - An interview is conducted with the Operator or the Operator’s designee/representative during the Q-Op inspection.
   - Resident assessment forms are completed based on interview with and observation of the resident, and should also include information obtained from interviews with staff or community agency representatives, family, outside service providers, etc. as necessary. If it is determined from the sample chosen that licensure is required, and the operator refuses to file an application, it may be necessary to conduct assessments of all the residents to determine appropriate action.
6. Within 30 working days the RO sends copies of the on site report to the Bureau of Adult Care Facility Quality and Surveillance with a summary indicating their findings and recommendations (closure, enforcement, etc.)
7. BACFQS may request additional information from the Region as necessary. Once all information is obtained; BACFQS will indicate agreement/disagreement within 10 days and advise the RO of our determination. The region will continue to investigate complaints or re-inspect the facility upon request from Central Office if necessary until the facility is either certified or closed.
8. If it is determined that the operator is providing services which require licensure, BACFQS will advise the operator in writing, notifying the Operator of the need to file an application for certification or submit a plan for closure of the facility.

9. Based on the Q-Op investigation, referrals may be made to the local Adult Protective Service Unit, Bureau of Home Care/Hospice Surveillance, may be required.

10. If it is determined that the residents have needs that require a higher level of care that is permitted in an ACF, the Regional Office will assist the Operator in obtaining assessments on each resident to determine the appropriate level of care required and will assist with the transfer of the residents if necessary.

11. If licensure is not required, BACFQS will notify the organization. The Q-Op file is then closed.

12. For unlicensed facilities where the operator does not take the appropriate corrective action within the time frames specified, BACFQS will prepare an enforcement referral to DLA.

13. When BACFQS requests the scheduling of a Q-Op or the Operator requests a hearing subsequent to the denial of their application, DLA prepares charges which are reviewed and approved by BACFQS and returned to DLA for the scheduling of the hearing. BACFQS will coordinate review and approval of SOC’s, stip and settlement actions with the RO and DLA. If a hearing is scheduled RO/CO staff will provide testimony as appropriate.

If the operator files an application for certification, the Q-Op file will be closed and BACFQS will periodically follow-up with BLC to assure that the application has not been denied or withdrawn. If the application gets denied or withdrawn, BACFQS will initiate enforcement actions as indicated in #10 above and re-open the Q-Op file.
Attachment 12a

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 12
Adult Care Facility Quality and Surveillance Operations Manual – Death Investigations
Policy: Protocol for Investigating Deaths or Attempted Suicides of Residents Residing in Adult Care Facilities including Assisted Living Programs and Assisted Living Residences (ACF/ALP/ALR)

1. SSL 461-M
2. 18 NYCRR Parts 487.7(d)(8), 488.7(b)(8), 490.7(d)(8),
3. PHL 46-B

Purpose:
The immediate reporting of all resident deaths and attempted suicides is mandated under the authority of Social Services Law. This policy has been developed to ensure that all operators of ACFs/ALPs/ALRs are in compliance with Social Services Law, Public Health Law and Department regulations.

Procedures:

1. Operators of all ACFs/ALPs/ALRs must immediately telephone or fax the appropriate regional office on the day of learning of a resident death or attempted suicide. The operator must also submit an Incident Report regarding the event. The incident report (DSS-3123) must be received by the Regional Office within 24 hours of the operator learning of the death or attempted suicide. The operator must also notify the resident’s next of kin and coroner. Deaths of a suspicious nature must also be reported to local law enforcement officials.

2. Telephone calls to the ACF CCIP Hotline reporting a death will be immediately forwarded to the regional office. The confidentiality of the notification will be assured.

3. The DOH staff person receiving the initial report will clarify whether it is a resident death or attempted suicide that is being reported. The staff person will also request information on the resident, including name, age, sex, and medical history and conditions. In addition, information on how the death or attempted suicide was discovered, the circumstances and events surrounding the death or
attempted suicide, involvement of law enforcement and/or the coroner’s office and cause of death will also be requested.

4. The Regional Office will record the reported death onto the Death Reporting Form database in accordance with procedures (attached).

5. The Regional Office will obtain the incident report for both deaths and attempted suicides from the Operator, review the report and obtain additional information as necessary. If sufficient information has been obtained to determine that the death was by natural causes, a more specific reason for the death will not be required; however, the region should assure that the death report includes the source used to make this determination.

6. The designated Regional Office staff members shall review the deaths with Supervisory staff or the Program Manager on a monthly basis or as necessary if there are unusual circumstances surrounding the death. Issues and good investigative strategies will be identified.

7. Based upon the information provided, the Regional Office will determine if further investigation of any of the circumstances surrounding the death or attempted suicide is warranted. The Regional Office will determine if further follow-up or an on-site investigation is necessary.

➢ The review of material submitted by the facility shall determine if follow-up will be initiated; follow-ups may include telephone interviews, faxes, mailings, or on-site visits.

An on-site investigation must be done when one or more of the following exists:

- Suicides, suspected suicides or attempted suicides;
- Unusual circumstances previous to death, e.g. resident presents unusual behavior leading up to death, death resulting from the actions of another, accident, etc.

The Regional Office should consider specific factors to determine if an on-site investigation should be conducted when:

- Deaths are not reported to DOH (reason for not reporting)
- A resident under age 60 dies (not in hospice) or
- There are five or more deaths at facility over a six-month period of time.

➢ Specific factors to be considered are:
- Specific reason for death
- Specific age of resident
- Special considerations (ALP, Hospice, AIDS)
• Percentage of deaths per occupied beds (census)
• Inspection history/large volume of complaints or incidents
• Concerns for protection of other residents’ health and safety
• Information indicates the possibility of significant non-compliance

The investigation of resident deaths that occur 6 or more weeks after a transfer from the facility for residents still on the census will be based on the facilities’ actions or lack thereof that may have contributed to the death.

If the Region does not conduct an on-site investigation when indicated above, they will be required to include a brief justification in the narrative section field of the mortality database.

8. Additional information used for follow-up may include but not be limited to, resident and facility record reviews, interviews with facility staff and residents, family members, the resident’s attending physician, officials from the coroner’s office, law enforcement and the contracted funeral director or others. In the event the resident had a mental health diagnosis, interviews may also be conducted with the attending mental health clinician or case manager and staff from any mental health program attended by the resident.

9. The regional office will obtain a copy of the resident death certificate and any autopsy or toxicology report as a part of investigations if warranted, e.g., where it appears that the facility failed to take required steps to insure resident health and safety resulting in a resident death. Whenever possible, the information contained in these reports should be reviewed by the regional office’s Medical Director.

10. Upon completion of the review or investigation of the death or attempted suicide, the Regional Office will determine if there was evidence of non-compliance. If so, the Regional Office will issue a survey report outlining the incidence(s) of non-compliance and if warranted make a referral to Central Office for enforcement action.

If during the investigation there is evidence of abuse or criminal activity, the Regional Office must ensure that the Operator notified the appropriate authorities. If the operator’s actions/lack of actions were determined to contribute to the resident’s death or attempted suicide (i.e. lack of supervision/ endangerment with evidence of criminal activity or abuse) the Regional Office must notify the appropriate authorities, i.e., police.

11. Central Office will do weekly reviews of data entries for completeness, accuracy and appropriateness of triage.

12. During each survey, the Regional Office survey staff shall cross check deaths recorded on the Chronological Admission/Discharge Form with those reported to the Regional Office.
13. Each Regional Office will have a designated liaison/contact person in the OMH Field Office. This person shall be contacted if the resident had a mental health diagnosis or was receiving mental health services. If contact is made, this should be documented in the narrative field in the mortality database.
Attachment 12b

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 12
Additional Death Investigation Standards
In addition, the Bidder shall take into consideration the following procedure in developing the Unit price for this Unit. Some or all of these activities may be assigned by the Regional Office to the Contractor:

1. Operators of all ACFs/ALPs/ALRs must immediately telephone or fax the appropriate regional office on the day of learning of a resident death or attempted suicide and submit an Incident Report regarding the event. The incident report (DSS-3123) must be received by the Regional Office within 24 hours of the operator learning of the death or attempted suicide.

2. Telephone calls to the ACF CCIP Hotline reporting a death are referred immediately to the regional office.

3. The DOH staff person receiving the initial report will clarify whether it is a resident death or attempted suicide that is being reported. The staff person will also request information on the resident, including name, age, sex, and medical history and conditions. In addition, information on how the death or attempted suicide was discovered, the circumstances and events surrounding the death or attempted suicide, involvement of law enforcement and/or the coroner’s office and cause of death will also be requested.

4. The Regional Office will record the reported death onto the Death Reporting Form database in accordance with procedures.

5. The Regional Office will obtain the incident report for both deaths and attempted suicides from the Operator, review the report and obtain additional information as necessary. If sufficient information has been obtained to determine that the death was by natural causes, a more specific reason for the death will not be required; however, the region should assure that the death report includes the source used to make this determination.

6. The designated Regional Office staff members shall review the deaths with Supervisory staff or the Program Manager on a monthly basis or as necessary if there are unusual circumstances surrounding the death. Issues and good investigative strategies will be identified.

7. Based upon the information provided, the Regional Office will determine if further investigation of any of the circumstances surrounding the death or attempted suicide is warranted. The Regional Office will determine if further follow-up or an on-site investigation is necessary.

- The review of material submitted by the facility shall determine if follow-up will be initiated; follow-ups may include telephone interviews, faxes, mailings, or on-site visits. An on-site investigation must be done when one or more of the following exists:
  - Suicides, suspected suicides or attempted suicides;
  - Unusual circumstances previous to death, e.g. resident presents unusual
behavior leading up to death, death resulting from the actions of another, accident, etc.

8. The regional office will obtain a copy of the resident death certificate and any autopsy or toxicology report as a part of investigations if warranted, e.g., where it appears that the facility failed to take required steps to insure resident health and safety resulting in a resident death. Whenever possible, the information contained in these reports should be reviewed by the regional office’s Medical Director.

9. Upon completion of the review or investigation of the death or attempted suicide, the Regional Office will determine if there was evidence of non-compliance. If so, the Regional Office will issue a survey report outlining the incidence(s) of non-compliance and if warranted make a referral to Central Office for enforcement action.

If during the investigation there is evidence of abuse or criminal activity, the Regional Office must ensure that the Operator notified the appropriate authorities. If the operator’s actions/lack of actions were determined to contribute to the resident’s death or attempted suicide (i.e. lack of supervision/ endangerment with evidence of criminal activity or abuse) the Regional Office must notify the appropriate authorities, i.e., police.

10. Central Office will perform weekly reviews of data entries for completeness, accuracy and appropriateness of triage.

11. During each survey, the Regional Office survey staff shall cross check deaths recorded on the Chronological Admission/Discharge Form with those reported to the Regional Office.

Each Regional Office will have a designated liaison/contact person in the OMH Field Office. This person shall be contacted if the resident had a mental health diagnosis or was receiving mental health services. If contact is made, this should be documented in the narrative field in the mortality database.
Attachment 13a

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 13

Facility Closure Plan Guidelines

These guidelines may also be accessed at https://commerce.health.state.ny.us/hpn/hco/guidelines/acf_closure_guidelines.pdf for those who have access to the HPN.
GENERAL INFORMATION:

This information has been prepared for all providers who are seeking approval to close a facility or discontinue services or programs that provide medical care and/or services to individuals in a community-based, residential or acute care (hospice, adult care facilities, nursing homes or hospitals) setting.

Verbal notification must be provided to the Department of Health’s (DOH) Regional Program Manager or Program Director as soon as any provider contemplates closure/service discontinuance (closure).  [Written notification of the possibility of closure must be provided to the regional office no later than 48 hours following the verbal notification.] Information on a potential closure may not be disclosed to the public, patients/residents or staff prior to notifying the DOH, submission of a closure plan to the DOH, and approval of such plan by the DOH.

The New York State Commissioner of Health must approve all closure plans in writing prior to issuing any public announcements related to a closure. Your closure plan should not be considered approved until you receive a written notification from the Commissioner or the Director of the Office of Health Systems Management. Any verbal comment from the Regional Office should not be considered as an approval.

Pursuant to Department regulations, the following requirements regarding closures must be met:

• 120 days prior notice of the intent to close must be provided to the DOH;
• prior written approval of the closure and the operator’s plan must be obtained from the Commissioner of Health.
• no announcements or actions related to the proposed closure should be taken prior to receiving approval.
• each patient, resident, next of kin, physician and sponsor must be notified immediately upon receipt of the Commissioner’s approval in accordance with the Plan approved by the Commissioner;
• the operator’s closure plan must include, among other things, provision for the maintenance, storage and safekeeping of patient/resident records;
• the provider’s operating certificate must be promptly surrendered to DOH upon discontinuance of operation with a list of residents and the location to which facility.

Providers may utilize their own format for the written closure plan, but the information submitted to the DOH must clearly and succinctly include all the attached information, in the order listed. Please note that a full range of appropriate services for all patients/residents must be provided throughout the entire closure process.

YOU MUST HAVE WRITTEN APPROVAL FROM THE DEPARTMENT OF HEALTH PRIOR TO IMPLEMENTATION OF A CLOSURE PLAN.

In the event the resident wishes to move, or the family wishes to move the resident prior to the closure plan being approved, you must contact the Regional Office and discuss the transfer with them before moving the resident.

Questions about this procedure may be addressed to your regional Program Director.
The following information must be included (in order) in the facility closure plan submitted for approval by the NYS Department of Health (DOH):

*Please include the date, name, address and telephone number of the facility/operator on all pages of the closure plan.

1. Evidence of verbal and written notification to the Regional Program Director or Manager at the time closure was contemplated.

2. Target closure date, facility capacity, current census

3. Name, title, telephone # and email address of the individual designated as the operator’s contact person throughout the closure process.

4. Name, title, telephone # and email address of the individual responsible for coordinating closure, if different from the individual identified in #3. If more than one individual has been assigned to separate closure duties (e.g., resident assessment, discharge coordination, directing care, media contacts, equipment disposal, record disposition etc.) all names and contact information must be included.

5. A narrative description of the proposed plan to notify residents, patients, next of kin, sponsors, staff and physicians of the closure plan. This should include written notification and meetings. Include dates and times of meetings, if available at the time of submission of the proposed plan, so that DOH staff may attend if desired.

6. A roster of all residents with a general profile of the resident population.

7. All Required reports e.g., Financial Reports and Census Reports have been submitted to the Department.

8. A description of the plan to manage media contacts initially and throughout the process. Media releases should be coordinated with the DOH prior to release.

9. A description of a plan to involve the other agency staff and providers serving the residents, if applicable.

10. The plan to discontinue admissions.

11. A summary of the facility’s current financial condition and description of the assets available to the operator to maintain appropriate services during the closure period.

12. The process to identify appropriate placement for current patients/residents. The process should include assessing the needs of the patients/residents, making determinations regarding bed availability at other area facilities, providing information about other facilities to patients/residents/families, insuring that the wishes of current patients/residents/families are respected when placement decisions are made; and insuring that concerns such as geographic location, public transportation, type of facility/provider, medical care etc. are addressed in identifying future placement options for residents/patients.
A referral package should be prepared for each resident which includes current assessments and medical evaluations, care plans, medication and treatment records, histories, discharge summaries, identifying information etc. For residents receiving OMH services, OMH must assure that the appropriate information is included in the package. The plan must insure that records are transferred to the new facility in a secure manner with the residents/patients who are being relocated. Resident records shall be retained for three years and facility records shall be retained for seven years. Include in the closure plans how and where these records will be maintained.

13. The plan to ensure that resident/patient belongings will be secured and transferred.

14. The plan to determine the appropriate method of transport to be utilized for patients/residents.

15. Include the process that insures the residents’ prorated rent and the plan for allocation and security of resident funds. The facility must complete a full accounting of resident funds, if any, on a resident-specific basis prior to closure. The plan must include a signed attestation by the operator that the accounting is accurate. The plan should describe how resident funds are being protected. The plan must also include a signed attestation that all resident funds are secure. The accounting should be sent to the DOH regional office upon request. Resident funds should be sent to the receiving facilities when residents are transferred.

16. A roster of resident final placement is required. Submission of the ACF Annual Statistical Form for the current year will also be required at this time. Submit with Operating Certificate.

17. The plan should include very specific reference to how the facility will establish and maintain ongoing communication with DOH throughout each milestone of the closure process.

18. The plan to ensure adequate staffing throughout the closure process, and to ensure that staff have information regarding other employment opportunities.

19. The operator of the facility closing shall indicate what the building will be used for once all the residents are transferred and the building is empty.
Attachment 13b

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 13

Facility Closure Plan Guidelines – Additional Guidelines for Q-Op Closures
In addition, the Bidder shall take into consideration the following procedure in developing the Unit price for this Unit. Some or all of these activities may be assigned by the Regional Office to the Contractor:

**Facility Closures – Q-ops**

If the Regional Office determines that an emergency exists within an uncertified ACF which constitutes a danger to the health, safety or welfare of the residents, a referral to Adult Protective Services (APS) in the County that the facility is located in and to DLA requesting action to close the facility immediately. If a Commissioner’s Order is needed, the following steps are taken:

1. Documents are prepared by DLA, reviewed by the RO and BACFQS. Once approved and appropriately signed, RO staff serve the order and notice on the operator.

2. RO staff will assist with the appropriate transfer of residents by:
   - Providing the operator with a list of licensed facilities in the immediate area and adjacent counties;
   - Contacting these facilities and agencies and identifying those with vacant beds or those able to accommodate additional residents/patients/cases;
   - Advise the operator of the operator’s responsibility to inform the residents and their families of the need for transfer by a specific date;  
   - Assist families with placement issues and process;  
   - Facilitate contacts with facilities and other outside agencies.

3. Once a legal action has commenced, questions regarding issues will be referred to the assigned attorney in DLA.

BACFQS and DLA will maintain a liaison with the Public Affairs Group in anticipation of requests for information from the public.
Attachment 14a

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 14
Home Care Services Agency Quality Activities
LHCSA Routine Operational Survey

LHCSA Article 36 Surveillance Process (Attachment 14-a)
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A. Overview of Survey Process

1. **Purpose**

   The purpose of the licensed home care services agency (LHCSA) surveillance process is to determine that the LHCSA personnel, equipment, rules, standards of care, quality improvement process and home care services are adequate and meet the requirements of Article 36 of the Public Health Law and applicable regulations.

   For purposes of the LHCSA surveillance process, the scope of survey activities will include a review of the following health care services: nursing, home health aide, personal care aide, physical therapy, occupational therapy, speech/language pathology, nutrition, social work, respiratory therapy, physician and medical supplies, equipment and appliances.

2. **Definition and Frequency of Surveys**

   Pre-opening survey – A full survey that is conducted prior to the issuance of a license. The full survey may lack the clinical record review if the agency is non-operational at the time of survey. The clinical record review will take place within six to nine months of the effective date of licensure. The area office program director will determine the need to conduct a pre-opening survey prior to the approval of a new license following the change of ownership of an existing agency.

   Full Survey – A survey conducted at the discretion of the Department, but at least once every three years, which includes a review of all services provided by the agency and the systems in place to support those services.

   The time interval between full surveys is determined as follows:

   - **Three years:**
     - No deficiencies cited on the last full survey.
     - Accreditation visit conducted since last full survey without negative findings.
     - No substantiated complaints since the last full survey.
     - No more than three complaints since the last full survey.
     - No addition of services to the license since the last full survey.
     - Less than 50 percent increase in patient census since last full survey.
     - No change in administrative and/or responsible RN staff.
     - All required notifications, reports and questionnaires have been submitted to the department.

   - **Two Years**
     - Less than five deficiencies cited as a result of the last full survey
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- No deficiencies cited on the last full survey that indicated negative patient outcomes.
- No complaint investigations resulting in the citation of deficiencies since the last full survey.
- All required notifications, reports and questionnaires have been submitted to the department in a timely manner.

- One Year
  - More than five deficiencies cited as a result of the last full survey.
  - Negative patient outcomes found on the last full survey.
  - Complaint investigation(s) resulting in the issuance of statement(s) of deficiencies.
  - More than three complaints received against an agency within a year.
  - Failure to notify the department as required of changes in the agency.
  - Failure to submit required reports and/or questionnaires in a timely manner.

Partial Survey – A survey that includes the review of one or more aspects of agency operation. A partial survey is conducted when there is:

- Need for a clinical record review as a post approval visit following a pre-opening survey which was conducted when the agency was non-operational;

- Need for a follow-up survey to verify agency compliance with a plan of correction from a previous survey or complaint investigation;

- A change in operator if a survey is indicated;

- A change in the delivery of services if a survey is indicated;

- Information coming to the attention of the Department such as complaints that lead the Department to believe the services may not be provided in accordance with the manner required by Section 3605 of the Public Health Law and the rules and regulations thereunder.

3. **Summary of Steps in the Full Survey Process**

A. **Pre-Opening Surveys**

The pre-opening survey process begins when the applicant notifies the Regional Office that the Agency is ready for survey and proceeds with the following steps:

- **Step 1** Regional Office staff mail out the pre-survey letter requesting materials and information to be submitted for review prior to scheduling the survey.

- **Step 2** Surveyor reviews the submitted materials and information, the agency file and project application. These materials may be reviewed on site (see Step 5) if this is more expedient for the surveyor.
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Step 3  Surveyor notifies applicant of any problem and requests corrective action.

Step 4  Upon determination that the pre-survey materials are in substantial compliance with the code, and on-site visit is scheduled with the application.

Step 5  On-site survey activities take place. Following completion of all activities, an exit conference is held with agency staff.

Step 6  Surveyor transmits the survey results to the applicant within 10 days of survey using Form DOH-1503, Statement of Deficiencies and Plan of Correction.

Step 7  If deficiencies are cited, the applicant returns the plan of correction to the Regional Office within 10 days.

Step 8  Surveyor reviews the plan of correction and either accepts the plan or requests an amended plan. If the plan of correction is unacceptable, an amended plan is requested within 10 days and the provider has 10 days to respond. Failure of the agency to submit an acceptable plan of correction may result in a recommendation of enforcement or an abandonment of an application.

Step 9  For the initial survey, surveyor recommends issuance of a license based on Agency Compliance or an acceptable plan of correction. The Survey report, statement of deficiencies and plan of correction, if applicable, are sent to the Bureau of Home Care Services (BHHCS) within 10 days of receipt in the Regional Office.

Step 10  A post approval survey visit may be conducted on-site to verify correction of deficiencies. This review should be conducted no later than one year after the pre-opening survey. For an initial survey, any regulations unable to be adequately judged during the initial survey process will be evaluated during the post approval visit.

B. Full Surveys

Step 1  The Pre-Survey Questionnaire is sent to the licensed agency by the Regional Office within the quarter that the survey is due to be conducted. (Appendix C). The completed questionnaire should be returned by the agency to the Regional Office within 30 days from receipt.

Step 2  Surveyor reviews the Pre-Survey Questionnaire, agency files and complaint investigations conducted since the previous survey.

Step 3  Surveyor notifies agency if pre-survey questionnaire does not contain required information. However, agency is not informed of date of scheduled survey.

Step 4  On-site survey activities take place, which include a clinical record review and possibly home visits. However, the agency is not informed of scheduled survey.

Steps 5-7  Same as Steps 6-8 for the Pre-Opening Survey process.
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Step 8 First page of survey report, statement of deficiencies and plan of correction, if applicable, resent to the BHHCS within 10 days of receipt in the Regional Office

B. FULL SURVEY ACTIVITIES 5/12/98

1. Correspondence to Providers

All correspondence regarding surveillance is sent to the Operator with a copy to the person administratively responsible for the agency. When a statement of deficiencies is sent out, the original letter and the statement of deficiencies is mailed to the operator. A copy of the letter and the statement of deficiencies is sent to the person administratively responsible for the agency to facilitate the development of the plan of correction.

2. Pre-Survey Activities

a. Pre-Survey Letter for Pre-opening Survey

Upon notification of approval of the application, the area office sends the pre-survey letter (Appendix A) to the applicant.

The requested materials should be returned to the area office within 60 days. If the materials are not received in that time, the agency is sent the follow-up letter. (Appendix B).

b. Pre-Survey Questionnaire for Resurvey

The Pre-Survey Questionnaire should be sent quarterly to the agencies scheduled for a full survey during that quarter as specified in the “Guidelines for Pre-Survey Questionnaire” in Appendix C. The Pre-Survey Questionnaire should be returned to the area office within 30 days of receipt.

3. Area Office Review

The survey process begins upon receipt of the requested materials. The first survey activity is the review of the following:

- Project application if this is the pre-opening survey;

- Area office file on the agency including any complaints received; and

- Materials submitted from the agency as listed in Appendix A, the Pre-Survey Letter or the Pre-Survey Questionnaire, (Appendix C).
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Once the surveyor determines that the pre-survey materials are substantial compliance with the regulations, an on-site visit is scheduled. The initial survey may be announced, but subsequent full surveys are unannounced.

If additional information is necessary, the surveyor will contact the applicant by letter, telephone or meeting to effectively obtain this information. If the agency fails to submit the materials requested in the pre-survey letter, the area office must conduct a site visit and review such materials onsite to ascertain agency readiness to operate in compliance with departmental regulations within one year from date of approval.

The completed Pre-Survey Questionnaire is reviewed; an evaluation of this information may result in delaying the survey visit for another year (if the criteria for a three-year interval are met).

4. On-Site Activities

The on-site activities include a review of the operational aspects of care delivery. Activities include the following:

- Interview with administrative person;

- Resolution of issues related to the pre-survey materials;

- Observance of office space to ensure that it is adequate to provide for maintenance of confidential files and the availability of a communication system for 24 hours/even days per week coverage;

- Review of agency grievance/complaint log. This may include a telephone call to a small sample of complainants to ascertain their satisfaction with the handling/resolution of their complaint;

- Review of agency patient admission packet including patient bill of rights.

- Review of Quality Improvement Committee meeting minutes since the last full survey.

- Review of the active patient roster including services provided;

- Review of the discharged patients roster if there are insufficient active patients;

- Review of active personnel list including title and function;

- Review the agency policy regarding the frequency of clinical supervision;

- Review any agency policy and procedures that have been added or revised since the last survey.
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- For full surveys other than the pre-opening survey, review and document to the Patient Record Review Form (Appendix O) a sample of patient care records including evidence of distribution of patients’ rights.

  - Using the agency’s list of patients, select five percent (5%) random sample of patient care records. Patient sample should exclude, whenever possible, patients serviced through contracts with Federal programs.

  - Review no more than 15 records or a minimum of two records for each trigger service and one for each other service provided unless the total patient census is below six. Should this be the case review all active records. Substitute up to five active records with closed records including patients discharged to a health care facility, by death or to self care. Whenever possible use the agency’s patient ID number to identify records reviewed.

  - If sample indicates problems, the surveyor should either cite deficiencies when the problem is clear or select a second sample of five records to obtain more information to verify the problem.

  - The Patient Record Review Form should be used to record survey results of the record review and as record identifiers.

- Review and document on the Personnel Record Review Form (Appendix P) a sample of personnel records as follows:

  - Using the agency’s list of personnel, select a sample of five percent (5%) of personnel providing health care services, assuring representation of all health care services provided, preferably to patients whose records are reviewed. Select a maximum of 15 personnel records;

  - A minimum of one personnel record from each of the services the agency provides and from administration should be reviewed.

  - If the review of the minimal sample identifies concerns or deficiencies, an additional sample should be reviewed that includes, when applicable: (a) recently hired staff; (b) staff employed more than one year; (c) personnel providing service via contract; (d) staff recently resigned/terminated; and © staff providing care under contract.

5. **Home Visits/Telephone Visits**

a. Determination of Need for Home/Telephone Visits as Part of a Survey

At the time of survey, home/telephone visits are conducted on a sample of patients if:

(1) the LHCSA is currently licensed and has multiple deficiencies in the areas of patients’ rights, plan of care, medical orders, clinical supervision, and/or patient care records;
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(2) the agency has had three substantiated complaints registered against it by three different complainants within the past two years; or

(3) to verify the agency’s implementation of their grievance/complaint procedure after a review of the complaint log.

The decision to conduct an on-site home visit or telephone interview would be made by the surveyor and based on information available and on the purpose of the visit.

b. Patient Selection

If it is determined that home/telephone visits are necessary, select a sample of at least three patients for home visits from those patients whose records have been reviewed and which have deficiencies in one or more of the following areas: patient rights; patient service policies and procedures; plan of care; medical orders; clinical supervision and patient care records. Home/telephone visits to additional patients may be made if survey findings so warrant. An on-site home visit should be scheduled with agency staff.

c. Patient Consent

The patient should be contacted by telephone to obtain verbal consent to be visited. If the patient is reluctant, the possibility of rescheduling the visit at a later time may be discussed. The patient should be told that the information collected during the visit will be confidential to the extent that the Department will not divulge any patient information to any unauthorized party. Upon arrival, request that the patient sign the Home Visit Consent Form (Appendix D). If the patient refuses to sign the consent form but is willing to be interviewed, proceed with the visit. If upon arrival for a prearranged visit, then patient states the visit is no longer convenient, you may try to schedule another date but do not insist on conducting the visit.

d. Preparation for the Home/Telephone Visit

In preparing for the home/telephone visit, review the agency’s clinical records, patient care plans, pertinent policies and procedures, and other relevant documents in order to perform a thorough comparison with what the surveyor observes and discusses in patients’ homes or during a telephone interview. As part of the home/telephone visit process, the surveyor should:

- Ascertain whether services are rendered according to plan of care;
- Determine whether the plan of care reflects the patient’s current status and is modified as the condition of the patient changes;
- Determine whether the number and frequency of supervisory visits reflects agency policy; and
- Determine whether supervisory visits are made to orient the aide to the plan of care; to provide required on-the-job training and to evaluate aide competency in the tasks performed.
e. Visit/Telephone Interview Procedure

In order to observe home care being given, attempt to schedule the home visits at a time when care is scheduled to be given, if possible.

At the patient’s home, explain that the visit/telephone interview is part of a routine review of the agency providing home care, to ensure that the agency is providing the quality of care required by state regulations. Observations of care being given or interviews with the patient or staff are methods used to evaluate adequacy of care provided and patient satisfaction.

f. Documentation of Home/Telephone Visits

The number of home/telephone visits is entered on the Licensed Home Care Services Agency Survey Report (Appendix X). Identify home visit deficiencies by adding “HV” after the code identification number on the Statement of Deficiencies (DOH-1503).

6. Exit Conference

The purpose of the exit conference is to provide an opportunity to summarize and discuss both the positive and negative survey findings in order to facilitate the agency’s understanding of code deficiencies.

In preparation for the exit conference, if more than one surveyor is surveying the agency, the survey team should meet to discuss the survey findings to make a determination on the deficiencies to be cited and the recommendations to be made. In making the determination on deficiencies to cite, the surveyor(s) should consider the number, nature and combination of findings, the presence of a pattern of patient care problems, the presence of a potential hazard to patient’s health and safely, the severity of the survey findings and the resultant impact on patient care.

The exit conference is held with the agency administrator or designee and all other invited staff. The surveyor or team leader chairs the meeting. The exit conference agenda should include:

- A presentation of positive survey findings;
- A presentation of proposed code deficiencies;
- A presentation of agency practices that, if continued will result in code deficiencies;
- A presentation of the procedure of issuance of a statement of deficiencies and agency submission of a plan of correction;
- An opportunity for agency staff to provide additional information which negate the surveyor’s findings;
- A response to agency questions;
- A presentation of the procedure for issuance of an initial license, if this is the initial survey.
The date of the exit conference is the last date of the onsite activities and is the “date of the survey” for any future reference to the survey.

7. **Survey Report Form**

The Licensed Home Care Services Agency Survey Report is completed to document specific information regarding the agency and the survey.

The Review of Personnel Form and the Patient Record Review Form are completed as documentation of the review of records during the survey process.

**NOTE:** It is extremely important to fully document cases that indicate a potential for enforcement action or denial of a license in order to substantiate the proposed action or decision made in the event of the hearing or court review.

8. **Statements of Deficiencies**

The purpose of the statement of deficiencies, documented on the Statement of Deficiencies and Plan of Correction, DOH-1503, (Appendix F) is to provide the agency with written notice of areas of agency functioning that are below acceptable parameters as established by State regulations. Each deficiency is a statement of a specific agency characteristic that does not meet a State regulation.

Each deficiency is written to accurately and clearly identify the problem and:

- is specific and draws a clear picture of what was observed;
- reflects a pattern of care from a representative sample;
- is concise, objective and quantifiable; and
- answers the questions: who, what, where, when, and how, when applicable.

An example of a correctly written deficiency is: “Ten out of 20 patient care records reviewed lack signed and dated progress notes by the physical therapist for biweekly visits conducted during the month of September. (10 NYCRR 766.6 (a) (5)).”

The statement of deficiencies will support conclusions in the event of a hearing or court review. Since the statement of deficiencies is available to the public under the Freedom of Information Law, the following are not included:

- Patient names. I.D. numbers for patients and position titles for staff members are used in lieu of patient or staff names.
- Medical information about any identifiable patient;
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- The identity of any informant who has given adverse information or has complaints about an agency;
- Information which could be considered defamatory toward any identifiable person; and
- The address of anyone other than the owner of the agency.

The deficiencies are documented on the left side of the Statement of Deficiencies and Plan of Correction, DOH-1053 and are grouped and titled according to the corresponding sections of 10 NYCRR. Following each deficiency, the specific reference for the state regulation is recorded (i.e., 10 NYCRR 766.1 (a) ). The statement of deficiencies is transmitted to the agency attached to the form letter for transmitting the Statement of Deficiencies (Appendix G), within 10 days of the survey.

If no deficiencies are found, and the agency is in compliance with all regulations, the form letter for Transmitting Compliance with the Regulations (Appendix H) is used to transmit this information to the agency.

If the agency was not fully operational at the time of the survey, the following statement is written on the statement of deficiencies: “This agency has not yet accepted patients for care, therefore, the regulations could not be adequately judged.” These regulations are to be evaluated during the post-approval visit.

9. Plan of Correction

The plan of correction is the agency’s plan of corrective actions to be taken to bring the agency into compliance for each deficiency cited. The agency will document the plan of correction on the Statement of Deficiencies and Plan of Correction, DOH-1053, and return it to the area office within 10 days of receipt of the statement of deficiencies. When the plan of correction is received in the area office, the surveyor reviews it to determine its acceptability. An acceptable plan of correction will include:

- Steps to be taken to correct the cited deficiency;
- Steps to be taken to prevent future occurrence of a cited deficiency;
- Person(s), identified by position, responsible for the correction;
- Anticipated completion date for achieving correction of each deficiency.

If deemed acceptable, the surveyor recommends acceptance of the Plan by initiating and dating each item. The Regional Home Care Program Director reviews the recommendation and notifies the Operator of this acceptance with the form letter in Appendix I. If the surveyor determines that a portion of (or the entire) Plan of Correction is unacceptable, the unacceptable portion is documented in a separate report for review by the program director. This report is sent to the agency attached to the form letter for Transmitting Unacceptable Plan of Correction, (appendix J) notifying the Operator of the unacceptable Plan of Correction and requesting an amended Plan. This letter is sent within 10 days of the receipt of the original Plan. An amended Plan of
Correction is returned to the area office within 10 days of the receipt of the letter. This sequence continues until an acceptable Plan of Correction is obtained. It may be advisable to have a meeting with the operator to reduce the number of multiple written requests and responses.

After two unacceptable Plans have been submitted, depending on the seriousness of the deficiencies, the region office may consider recommending to BHHCS implementation of possible enforcement action.

10. Post Survey Review

When an amended plan is acceptable (original plus amendments), the Operator is notified using the form letter for Transmitting Acceptable Plan of Correction (Appendix I). The purpose of conducting the post-survey review is to verify that the corrective actions documented in the Plan of Correction were taken to bring the agency into compliance with the regulations. In some cases, an on-site visit may not be required and a mail or telephone contact with the agency will suffice, e.g., in the areas of bylaws or policies and procedures. However, if the information reported by telephone or mail does not validate that the correction is adequate, an on-site visit to the agency must be made.

When an on-site visit is required to verify that the corrective actions were taken, the survey process is followed. For example, if personnel records did not meet the regulations on survey, the surveyor will measure the agency’s compliance with personnel requirements during the post-survey review by conducting another personnel record review.

For those agencies that were not fully operational at the time of the initial survey, an on-site visit is conducted to evaluate compliance with the regulations not addressed by the initial visit. The post-survey visit should be conducted no later than six to nine months after the survey.

The results of the post-survey review are documented on the Post Certification/approval Revisit Report, DOH 1504, (Appendix K). The number of the deficiency is listed in the left column under “Item No.” The surveyor records the status of correction of the deficiency and a brief description of the findings under Present Status”. For example:

- Item No. 3 Deficiency: “Of the 10 personnel records reviewed, five records do not contain health assessments.”

- At the post-survey visit, the status is documented as follows on the Post Certification/Approval Revisit Report (Appendix K):

- Item No. 3 Corrected – 10 personnel records reviewed. Nine records contained health assessments. One record had no assessment. The RN is following up on employee bringing in health assessment statement.

11. Transmitting Survey Records

The post-survey review should be conducted no earlier than the target date(s) in the plan of correction and no later than six to nine months after the survey unless major patient care concerns
require a more timely visit. Survey packets are sent to the Bureau of Home Health Care Services within 10 days when:

- A survey is completed and there are no deficiencies;
- A survey is completed, Statement of Deficiencies has been issued and the Plan of Correction is accepted; or
- The post-survey is completed.

The following materials are to be included in the survey packet:

- License Home Care Services Agency Survey Report;
- Statement of Deficiencies and Plan of Correction;
- Amended Plan(s) of Correction, if applicable; and
- Post Certification/Approval Revisit Report
  - Any documentation that supports change in ownership, d/b/a, legal status since original licensure approval or last survey, if applicable.

C. Licensure Activities

1. Protocols for Issuance or Revision of a Home Care Services Agency License

The Licensed Home Care Services Agency Transaction Notice is used to electronically transmit the required information to the Bureau of Project Management (BPM) so that an initial or amended home care agency license will be issued. This form is accessed in Lotus Notes by first selecting Healthcom on Notes, then DOH forms, then General Department Forms (Mini Forms) and lastly HHL.

2. Initial License

There must be a memorandum from the Division of Legal Affairs in the file stating the application is legally sufficient before the pre-organizing survey is conducted. When the pre-opening survey process is complete and the agency is determined to be in substantial compliance, the license transaction notice is electronically transmitted to BPM. Prior to issuance of a license, the area office may give permission to the agency to admit patients. Directions for the completion of the license transaction notice are in Section C-7. In order to complete the notice the Public Health Council (PHC) final approval letter and the Character and Competence Staff Review will be required. The name of the agency to be shown on the license must be the same as the name or the assumed name shown on the Public Health Council approval letter. If the name that the agency proposes during the survey process is different from the approved name, and executed certificate of amendment to the certificate of incorporation, stating that the name of the corporation has been
Licensed Home Care Service Agencies (LHCSA)
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changed, or a certificate of doing business under an assumed name, that has been duly filed, is
required. It should be noted that regulations require the operator to submit a written request for
the approval of a change of name prior to implementing that change. Any change in type of
ownership from that listed on the staff review requires additional Public Health Council approval.
A license cannot be issued without the federal tax ID number for the agency being entered on the
license transaction notice.

NOTE: A copy of the pre-opening survey packet is forwarded to the Bureau of Home Health Care
Services. (BHHCS).

3. **Additional Site**

A license for an additional site of an existing agency will require the completion of a license
transaction notice as outlined in Section C-7. The project/application number and ownership
information can be obtained from the transaction notice for the existing site.

4. **Change of Ownership – Simple Change of Operator**

The area office will determine if there is a need to conduct a pre-opening survey. The Federal tax
ID number should be verified. The transaction notice is completed as outlined in section C-7. The
effective date of the license will be the actual date that the ownership changed or if the change
took place prior to receiving Public Health Council approval, the date of the PHC approval. The
transaction notice is electronically submitted to both BPM and BHHCS for changes of ownership.
In order for the completed form to be forwarded to BHHCS it must be saved prior to sending to
PMU. It can be forwarded to BHHCS from the in-basket in Notes.

5. **Change of Ownership – Acquisition or Merger**

The license transaction notice is completed as for a simple change of operator with the additional
requirement that the license number of the acquiring agency be entered on the form as outlined in
section C-7. The Federal tax ID number should be verified.

6. **Revision (Amendment) of a License**

Submission of a license transaction notice is required if any of the following has occurred:

- A change in service area;
- The addition or deletion of any services; or
- A change in the name or address of the agency and/or operator.

When an agency wishes to add nursing, home health aide or personal care services, an application
is submitted to the regional office at least 90 days prior to the anticipated start of service to obtain
written approval from the department. Within 90 days of the receipt of the application, the
regional office will review the information provided and may conduct a partial survey to
determine agency compliance with the regulations.

When an agency wishes to add or delete any of the other health care services, written notification
is made to the regional office at least 30 days prior to commencing or discontinuing physical
Licensed Home Care Service Agencies (LHCSA)
Surveillance Process

therapy, occupational therapy, speech/language pathology, nutrition services, social work, respiratory therapy, physician services, or medical supplies, equipment and appliances.

When an agency wishes to change its address, written notification is made to the regional office at least 10 days prior to the change.

If the agency is in compliance with the regulations, the regional office will complete a transaction notice as outlined in section C-7 and electronically transmit the transaction notice to BPM.

7. Completion of the Licensed Home Care Services Agency Transaction Notice

In order to complete the transaction notice the Public Health Council (PHC) final approval letter and the Character and Competence Review Staff will be required. The name of the agency to be shown on the license must be the same as the name or the assumed name shown on the Public Health Council approval letter. If the name that the agency proposes during the survey process is different than the approved name, and executed certificate of amendment to the certificate of incorporation, stating that the name of the corporation has been changed, or a certificate of doing business under an assumed name, that has been duly filed, is required. It should be noted that regulations require that the operator submit a written request for the approval of a change of name prior to implementing that change.

The license transaction notice form is accessed in Lotus Notes by first selecting Healthcom on Notes, then DOH Forms, then General Department Forms (Mini Forms) and lastly HHL.

NEW LICENSE

SECTION A

• Click on New in the drop down box in Section A of the transaction notice and enter the application number in the appropriate space.

• Enter the effective date of the new license. This is the date the agency is determined to be in compliance with the regulations.

SECTION B

• Click on Proprietary Corporation, Voluntary Corporation, Partnership, Individual or Public. This information is found on the top portion of the Character and Competence Staff Review. Any change in type of ownership from that listed on the staff review requires additional Public Health Council approval.

SECTION C

• Agency Name – The name of the operator, which is either a corporation name, the individual names of partners of the individual owner’s name, is entered.

• Approved DBA – Enter the name under which the agency is doing business if this name is different from line one.
Licensed Home Care Service Agencies (LHCSA)
Surveillance Process

- Address – Enter the address of the site including the county in which the site is located and the telephone number and enter the Federal ID Number.

- Services – Click on Add then click on each of the services in the drop down box to be provided by the agency.

- Service Area – In the drop down box, click on Add then click on the names of the counties to be served by the agency.

SECTION D

- Enter the name of the person authorizing the transaction and click on the name of the area office in the drop down box.

NOTE: A copy of the pre-opening survey packet is forwarded to the Bureau of Home Health Care Services (BHHCS).

ADDITIONAL SITE

A license for an additional site of an existing agency will require completion of a license transaction notice following all the steps of initially licensing an agency with the exception that you click on Additional Site in Section A. The project/application number and ownership information can be obtained from the transaction notice for the existing site(s).

CHANGE OF OWNERSHIP – SIMPLE CHANGE OF OPERATOR

The transaction notice is completed for the issuance of a new license with the exceptions of clicking on Change of Ownership on the form’s Section A and the inclusion of the seven digit license number of the existing agency. The effective date of the license will be the actual date that the ownership changed or if the change took place prior to receiving Public Health Council approval, the date of the PHC approval. The transaction notice is electronically submitted to both BPM and BHHCS for changes of ownership. In order for the completed form to be sent to BHHCS it must be saved prior to sending it to PMU. It can then be forwarded to BHHCS from the in-basket in Notes.

CHANGE OF OWNERSHIP – ACQUISITION OR MERGER

The transaction notice is completed as for a simple change of operator with the additional requirement that, if the acquiring entity is currently operating as a LHCSA, its license number must be entered on the form in Section A.

REVISION (AMENDMENT) OF A LICENSE

- The agency must be in compliance with the regulations when the regional office transmits the transaction notice, which must include a completed Section A containing the information on the existing license.

- In Section C, enter the name of the agency as well as the actual item(s) presently on the license and the revision to be made as follows:
  ✓ Change of Name:
Indicate by clicking on Agency, Operator, or Agency/Operator to indicate if the change is to the name of the agency, the operator or both.

Enter the present name of the agency/operator in the current column and the new name in the change column.

✓ Change of d/b/a:

Click on Agency.
Enter the existing d/b/a in the current column or, if there is none, enter “none”.
Enter the new c/b/a in the change column.

✓ Change of Address:

Indicate by clicking on Agency, Operator, or Agency/Operator to indicate the change is to the address of the agency, the, the operator, or both.

Enter the present address of the agency/operator in the current column and the new address in the change column.

✓ Addition/Deletion of Services:

Click on Add or Delete in the drop down box, then click on the county name(s).

• Complete Section D and electronically transmit the license trisection notice to BPM.
1. Approval of New Sites

When the Area Office receives an inquiry from a Public Health Council approved Operator requesting to open an additional site, the Area Office sends out Application/Pre-Survey New Site, (Appendix M) requesting the submission of the LHCSA application (pages 2-6), the pre-survey checklist, (Appendix N) and/or materials. The Operator has 30 days to submit the requested information and materials to the Area Office. If the requested pre-survey materials are identical to those submitted for an existing agency or to another Area Office, it may not be necessary to resubmit these materials for review.

Within 90 days of receipt of the application and pre-survey materials the Area Office will review and act upon the application. This process includes:

- contact with other Area Office surveyors having sites of the same Operator to ascertain acceptability of pre-survey materials, results of the onsite surveys and agency track record, i.e., complaints or to request these materials for review;

- review of submitted pre-survey materials to determine level of acceptance of materials that have not been reviewed by another Area office or may differ from those previously submitted;

- conduct of onsite surveillance activities in accordance with the surveillance process for LHCSAs;

- issuance of the statement of deficiencies for areas of non-compliance;

- recommendation of issuance of a license when the plan of correction is acceptable and agency is in compliance;

- notification to the agency to become operational; and

- a post-survey visit conducted when the agency has a patient caseload sufficient to evaluate the patient care components of the regulations.

(Initial policy developed 10/87; revised 10/91)

2. Geographic Service Area/Exceptions

A LHCSA’s geographic service area must be limited to ensure the quality of home care services when recommending licensure and reviewing proposed geographic area expansions. The geographic area served by a single LHCSA site is generally limited to the geographic boundaries
Licensed Home Care Service Agencies (LHCSA)
Surveillance Process

of each Area Office of the Office of Health Systems Management in which services are provided with the following exceptions:

- The Department will permit a LHCSA site to provide services “in one additional county” within the jurisdiction of another Area Office without being required to open another site of service delivery in that region at the discretion of the two Area Offices having jurisdiction. The “one additional county” must be contiguous to the geographic boundaries of the Area Office in which the LHCSA site is located, but need not be contiguous to the specific county in which the LHCSA site is located. For example, an agency site located in Westchester County and serving all counties within the geographic boundaries of the New Rochelle Area Office may also service Greene County, located in the Northeastern Area. Greene County is contiguous to the New Rochelle Area Office geographic boundaries but is not contiguous to Westchester, the county in which the service delivery site is located. If a LHCSA wants to provide services in more than one county within the geographic boundaries of an additional Area Office, there must be at least one delivery site serving the counties within the geographic boundaries of that Area Office.

- The Department will also permit Home Infusion LHCSAs to serve up to 35 patients at any one time in an OHSM Area adjacent to the Area in which the site is located. For the purpose of this exception, a Home Infusion LHCSA is defined as a LHCSA whose services are strictly limited to home infusion therapy and whose only home care personnel are nurses with the sole responsibility of providing technical assistance and monitoring of infusion therapy procedures. It is assumed that a Home Infusion LHCSA wishing to extend its services in this way has already received approval of the two Area Offices involved to provide its services within one contiguous county beyond the OHSM area in which its site is located. The adjacent OHSM Area in which the up to 35 additional patients reside must be the same Area as that in which the contiguous county need not be counted in the 35. A Home Infusion LHCSA wishing to serve patients in more than two OHSM Areas must establish additional service sites as appropriate.

(Initial policy developed 10/89; revised 10/91)
| **ACRONYMS, ABBREVIATIONS and DEFINITIONS**  
12/91 |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency</strong></td>
<td>Licensed home care services agency or an applicant to become a licensed home care services agency.</td>
</tr>
<tr>
<td><strong>Agency Administrator</strong></td>
<td>Title used throughout the surveillance process to refer to the person administratively responsible for the agency.</td>
</tr>
<tr>
<td><strong>Branch Office</strong></td>
<td>A site from which the healthcare services are provided. Each site of service delivery will be licensed. Administrative control may be received from the principal administrative office (PAO), if the branch office is sufficiently close to receive administrative oversight on a daily basis. In this instance, each branch office is surveyed and licensed in conjunction with the PAO and together all regulations are met. The branch office and PAO are to be in compliance with the sections of the regulations that correspond to their function.</td>
</tr>
<tr>
<td><strong>Date of Survey</strong></td>
<td>This is the last day of the survey; the date of the exit conference.</td>
</tr>
<tr>
<td><strong>Department</strong></td>
<td>New York State Department of Health</td>
</tr>
<tr>
<td><strong>LHCSA</strong></td>
<td>License Home Care Services Agencies</td>
</tr>
<tr>
<td><strong>License</strong></td>
<td>The document that authorizes the agency to operate in the State of New York.</td>
</tr>
<tr>
<td><strong>Operator</strong></td>
<td>The policy making body of a government agency, the board of directors or trustees of a corporation or the proprietor or proprietors of the proprietary facility, agency or program to which the department has issued a license.</td>
</tr>
<tr>
<td><strong>POC</strong></td>
<td>Plan of Correction</td>
</tr>
<tr>
<td><strong>BHHCS</strong></td>
<td>Bureau of Home Health Care Services</td>
</tr>
<tr>
<td><strong>BPM</strong></td>
<td>Bureau of Project Management</td>
</tr>
<tr>
<td><strong>Principal Administrative Officer</strong></td>
<td>The office that develops and maintains administrative control of one or more branch offices</td>
</tr>
</tbody>
</table>
Licensed Home Care Service Agencies (LHCSA)
Surveillance Process

on a daily basis (see Branch Office). The PAO may also be the site from which health care services are delivered. In this instance, this office independently meets all licensure regulations and is a LHCSA.

SOD
- Statement of Deficiencies

Survey Results
- The notice to the provider that defines the results of the survey. The notice will be either a letter stating the agency is in substantial compliance with 10 NYCRR or a statement of deficiencies.

10 NYCRR
Title 10 of the New York Codes, Rules and Regulations
G. APPENDICES

A. Form Letter: Pre-Survey Letter
B. Form Letter: Follow-Up Letter
C. Pre-Survey Questionnaire
D. Home Visit Consent Form
E. Licensed Home Care Services Agency Survey Report
F. Statement of Deficiencies and Plan of Correction, DOH-1503
G. Form Letter: Transmitting the Statement of Deficiencies
H. Form Letter: Transmitting compliance with the regulations
I. Form Letter: Transmitting acceptable plan of correction
J. Form Letter: Transmitting unacceptable plan of correction
K. Post Certification/Approval Review Report, DOH-1504
L. License Transaction Notice (BPMLTN)
M. Form Letter: Application/Pre-Survey New Site
N. Pre-Survey Checklist
O. Patient Record Review Form
P. Personnel Record Review Form
Attachment 14b

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 14
Home Care Services Agency Quality Activities
LHCSA Routine Operational Survey

Expansion Activities (Attachment 14-b)
D. EXPANSION ACTIVITIES 12/91

3. **Approval of New Sites**

When the Area Office receives an inquiry from a Public Health Council approved Operator requesting to open an additional site, the Area Office sends out Application/Pre-Survey New Site, (Appendix M) requesting the submission of the LHCSA application (pages 2-6), the pre-survey checklist, (Appendix N) and/or materials. The Operator has 30 days to submit the requested information and materials to the Area Office. If the requested pre-survey materials are identical to those submitted for an existing agency or to another Area Office, it may not be necessary to resubmit these materials for review.

Within 90 days of receipt of the application and pre-survey materials the Area Office will review and act upon the application. This process includes:

- contact with other Area Office surveyors having sites of the same Operator to ascertain acceptability of pre-survey materials, results of the onsite surveys and agency track record, i.e., complaints or to request these materials for review;

- review of submitted pre-survey materials to determine level of acceptance of materials that have not been reviewed by another Area office or may differ from those previously submitted;

- conduct of onsite surveillance activities in accordance with the surveillance process for LHCSAs;

- issuance of the statement of deficiencies for areas of non-compliance;

- recommendation of issuance of a license when the plan of correction is acceptable and agency is in compliance;

- notification to the agency to become operational; and

- a post-survey visit conducted when the agency has a patient caseload sufficient to evaluate the patient care components of the regulations.

(Initial policy developed 10/87; revised 10/91)

4. **Geographic Service Area/Exceptions**

A LHCSA’s geographic service area must be limited to ensure the quality of home care services when recommending licensure and reviewing proposed geographic area expansions. The
geographic area served by a single LHCSA site is generally limited to the geographic boundaries of each Area Office of the Office of Health Systems Management in which services are provided with the following exceptions:

- The Department will permit a LHCSA site to provide services “in one additional county” within the jurisdiction of another Area Office without being required to open another site of service delivery in that region at the discretion of the two Area Offices having jurisdiction. The “one additional county” must be contiguous to the geographic boundaries of the Area Office in which the LHCSA site is located, but need not be contiguous to the specific county in which the LHCSA site is located. For example, an agency site located in Westchester County and serving all counties within the geographic boundaries of the New Rochelle Area Office may also service Greene County, located in the Northeastern Area. Greene County is contiguous to the New Rochelle Area Office geographic boundaries but is not contiguous to Westchester, the county in which the service delivery site is located. If a LHCSA wants to provide services in more than one county within the geographic boundaries of an additional Area Office, there must be at least one delivery site serving the counties within the geographic boundaries of that Area Office.

- The Department will also permit Home Infusion LHCSAs to serve up to 35 patients at any one time in an OHSM Area adjacent to the Area in which the site is located. For the purpose of this exception, a Home Infusion LHCSA is defined as a LHCSA whose services are strictly limited to home infusion therapy and whose only home care personnel are nurses with the sole responsibility of providing technical assistance and monitoring of infusion therapy procedures. It is assumed that a Home Infusion LHCSA wishing to extend its services in this way has already received approval of the two Area Offices involved to provide its services within one contiguous county beyond the OHSM area in which its site is located. The adjacent OHSM Area in which the up to 35 additional patients reside must be the same Area as that in which the contiguous county need not be counted in the 35. A Home Infusion LHCSA wishing to serve patients in more than two OHSM Areas must establish additional service sites as appropriate.

(Initial policy developed 10/89; revised 10/91)
Attachment 14c

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 14
Home Care Services Agency Quality Activities
LHCSA Routine Operational Survey

Combined Appendix (Attachment 14-c)
G. APPENDICES

Article . Form Letter: Pre-Survey Letter
Article . Form Letter: Follow-Up Letter
Article . Pre-Survey Questionnaire
Article . Home Visit Consent Form
Article . Licensed Home Care Services Agency Survey Report
Article . Statement of Deficiencies and Plan of Correction, DOH-1503
Article . Form Letter: Transmitting the Statement of Deficiencies
Article . Form Letter: Transmitting compliance with the regulations
Article . Form Letter: Transmitting acceptable plan of correction
Article . Form Letter: Transmitting unacceptable plan of correction
Article . Post Certification/Approval Review Report, DOH-1504
Article . License Transaction Notice (BPMLTN)
Article . Form Letter: Application/Pre-Survey New Site
Article . Pre-Survey Checklist
Article . Patient Record Review Form
Article . Personnel Record Review Form
APPENDIX A

FORM LETTER: PRE-SURVEY LETTER
USE REGIONAL/AREA OFFICE LETTERHEAD

Name of Operator
Street
City, State, Zip Code

RE: Project Number:
Agency Name:
Reply Required by:

Dear Operator:

Prior to the issuance of a license for your agency, an initial survey will be conducted by the staff of ________________.

To begin this survey process, please submit to the ________________ Office at the above address, the following requested information and materials within sixty (60) days of receipt of this letter:

• Names, addresses, and telephone numbers of all offices (principal administrative and branch) including directions to each site of service delivery;
• Name and title of person administratively responsible for each site;
• Name of registered professional nurse(s) responsible for direction and supervision of patient care and health services including a copy of current New York State Registered Professional Nurse license(s);
• Responsibilities (rules and by-laws) of the Governing Authority;
• Rules and by-laws of quality improvement and any other committee;
• Names and titles of the members of quality improvement and any other committee;
• Copies of contracts and agreements;
• Federal Tax identification number;
• Job description for each position;
• Materials available to public and agency;
• Patient Bill of Rights;
• Clinical record forms;
• Personnel record forms;
• Policies and procedures as they pertain to 10 NYCRR Parts 700, 765, and 766 for:
  X Revisions to license
  X Personnel;
  X Patient Rights;
  X Advanced Directives;
  X Admission, retention, and discharge of patients;
  X Clinical records;
  X Care of medical supplies, equipment and appliances;
  X Orientation of staff;
  X Supervision of home health aides and personal care aides;
  X Emergency/disaster preparedness plan;
Patient complaints/grievances;
HIV confidentiality; and
Advanced directives.

After this material is reviewed, a date for the onsite-portion of the survey will be scheduled with you.

The regulations governing licensed home care services agencies are found in Parts 700, 765 and 766 of Volume Ten of the New York Code of Rules and Regulations (10 NYCRR). Attached is a list of Department of Health Memoranda (DOHMs) that may be helpful in developing your policies and procedures as well as the telephone number for information on acquiring these documents.

If you have any questions about this process, please contact ________________________ at ____________.

Sincerely,

Name
Regional Administrator or Designee
Licensed Home Care Services Agency Regulations (Parts 700, 765 and 766 of 10 NYCRR) can be purchased from:

West Group
620 Opperman Drive
P.O. Box 64779, D-5-10
St. Paul, Minnesota 55123-4779
(800) 328-4880

Department of Health Memoranda (DOHMs) can be obtained by contacting the Records Access Office at (518) 474-8734. The numbers and titles of pertinent memoranda are as follows:

96-17  Updated Information on the Management of Occupational Exposure to Human Immunodeficiency Virus (HIV)

95-14  Supplemental Infection Control Guidelines for the Care of Patients Colonized or Infected with Vancomycin-Resistant Enterococcus (VRE) in Hospitals, Long Term Care Facilities and Home Health Care

94-21  Recent Legislation Affecting Home Care

94-32  Recommendations for the Management of Communicable Diseases among Employees in Health Care Facilities

92-03  Advanced Directives

92-24  Home Health Aide Scope of Tasks

92-26  Complaint Investigation in Home Care

92-32  DNR Law Changes

91-11  Patient Confidentiality

91-18  Provision of Medical Equipment and Appliances

91-56  Patient Confidentiality

90-01  Recommendations for the Prevention and Management of Bloodborne Disease Transmission in Home Care Setting

89-72  Role of Licensed Practical Nurses in Intravenous Therapy Procedures
FORM LETTER: FOLLOW-UP LETTER
USE REGIONAL/AREA OFFICE LETTERHEAD

Name of Operator
Street
City, State, Zip Code

RE: Agency Name Follow-up
to Requested Materials

Reply Required By:

Dear Operator:

Prior to the issuance of a license, you were requested to submit certain materials to the ____________ Office so that an initial survey could be conducted.

These materials have not been received. You are therefore, requested to either submit these materials within 10 days of receipt of this letter or contact (Name, Title, Telephone Number) within that time frame to discuss your survey schedule.

If you have any questions about this process, please contact me at ____________.

Sincerely,

Name
Regional Administrator or Designee

cc: Agency Administrator
All licensed home care services agencies (LHCSAs) are required to submit the attached Home Care Pre-Survey Tool to the New York State Department of Health. This form will be used as a data source document for determining compliance with Article 36 as a Licensed Home Care Services Agency.

The following instructions are to be followed:

1. Please read and carefully follow any specific instructions provided for each question.
2. Complete questions in accordance with the response options offered. Supply additional information only when requested or if necessary to clarify and/or explain your response to that question.
3. Please use ink or type your response. Unless otherwise specified, respond with a check mark or an “X” in the appropriate space.
4. The report period covered by this form shall be for the period from the last full survey to the present. The date of the last survey is provided on page 3. Please use this date when completing questions requesting information for the time period since the last survey.
5. If more space is required, attach additional sheets on which the agency name, page number and heading of the question are clearly specified.
6. The Home Care Pre-Survey Tool and accompanying documents should be returned within thirty (30) days of receipt to the area office of the State Department of Health from which it was sent. Failure to promptly submit this report may result in the issuance of a statement of deficiencies to the agency. The area office should be contacted if there is a need for an extension of the deadline for submission.
TO BE COMPLETED BY REGIONAL OFFICE

Agency Name _____________________________________________________________

Agency Address __________________________________________________________________

City/County/State/Zip __________________________________________________________

License Number _________________________ Date of last full survey ___________________

Counties for which this tool should be completed _________________________________________

TO BE COMPLETED BY AGENCY

I. ORGANIZATION AND ADMINISTRATION

A. Descriptive Information

1. Specify the counties served by the agency.__________________________________

2. Legal structure of agency (check one)

   Individual _________________ For profit corporation _________________
   Partnership _________________ Not for profit corporation_______________
   Other ______________________

3. Attach an organizational chart.

4. Specify the name and location of each office site under your core licensure number, if any, located within the counties listed in item 1 above.

<table>
<thead>
<tr>
<th>License Number</th>
<th>Agency Name</th>
<th>Agency Location</th>
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<tbody>
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</tr>
</tbody>
</table>
5. Has ownership changed since last survey? YES _____ NO ______

If yes, describe the transaction.

___________________________________________________________

Date of this change ________________ .

6. Is the agency accredited? YES ____ NO ____.

   If yes, identify the accrediting body. CHAP ____ JCAHO ____
   OTHER ___________

   Please attach a copy of the most recent accreditation visit report.

7. What is the current patient census of your agency? ____________

8. What was the number of unduplicated patients served for the last calendar year at this site? ________.

9. What type of services are primarily provided from this site? If your case mix includes more than one service, please approximate the number of each service provided:

   ________ Nursing
   ________ Pediatric Nursing
   ________ IV Nursing
   ________ Ventilator Nursing
   ________ Physical Therapy
   ________ Occupational Therapy
   ________ Respiratory Therapy
   ________ Speech-Language Pathology
   ________ Medical Social Work
   ________ Paraprofessional Services
   ________ Other (Please specify) _________________________

10. Does this site operate a home health aide training program? ____Yes ____ No
B. **Services Provided**

For each service listed on the agency’s license, check in the appropriate space below whether the service is offered and/or under contract arrangement as follows:

- Check “Directly” if the service is provided through salaried employees.
- Check “Under Contract Arrangement” if service is provided through contracted arrangement with other agencies, organizations or individuals.

In the column headed “Added Since Last Survey”, indicate the manner in which the service is being provided by writing “D” for “Directly” and/or “UCA” for “Under Contract Arrangement”. This column should be completed only for those services which appear on the license or for which final approval has been obtained.

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Directly</th>
<th>Under Contract Arrangement</th>
<th>Added Since Last Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Personal Care</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Medical Supplies, Equipment and Appliances</td>
<td>______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Medical Social Work</td>
<td>______</td>
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<tr>
<td>Nutrition Services</td>
<td>______</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Occupational Therapy</td>
<td>______</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Speech/Language Pathology</td>
<td>______</td>
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<tr>
<td>Physician Services</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Respiratory Therapy</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Other</td>
<td>______</td>
<td>______</td>
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</tbody>
</table>
C. **Governing Body**

1. List names and title of directors and officers of the governing body of the LHCSA.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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</table>

2. How often does the governing body meet? ________________________________

3. The most recent meeting of the governing body was held on ________________

4. Do written policies indicate that the governing authority:

   a. ensures responsibility for the management and operation of the agency?  
      YES  NO*

   b. ensures compliance of the home care services agency with all applicable federal, state and local statutes, rules and regulations?  
      YES  NO*

   c. ensures the prompt submission of all records and reports as required by the department?  
      YES  NO*

   d. adopts and approve amendments to written policies regarding the management and operation of the home care services agency?  
      YES  NO*

   e. adopts and approves amendments to written policies concerning the provision of health care services?  
      YES  NO*

   f. makes available to the public information concerning the services that it offers, and the geographic area in which these services are made available?  
      YES  NO*

   g. employs or contracts for a sufficient number of staff to coordinate, direct, or deliver services to patients accepted for care in accordance with prevailing standards of professional practice?  
      YES  NO*
h. employs at least one registered professional nurse to be responsible for the direction and supervision of all patient care services and other health care activities of the agency

i. accepts and retains for services only those persons whose health care needs can be safely and adequately met by the agency according to criteria specified in written agency policies?

j. ensures the development of a patient grievance or complaint procedure?

k. appoints a quality improvement committee to establish and oversee standards of care?

l. reviews all policies and procedures annually?

5. Regulations require an emergency and disaster plan.

a. Is an emergency and disaster plan currently in effect?

b. Does the plan provide for each of the following incidents:
   1. civil disturbance (e.g. labor action involving agency/program employees or employees of other health care provider(s) in the community?
   2. transportation stoppage
   3. natural disaster (e.g. fire, blizzard, power failure)?

c. Does the plan specify procedures, direction, and/or provision for each of the following:
   1. care of patients?
   2. communication and notification to employees, patients, physicians, and significant others
d. does the plan include each of the following informational lists: YES NO*

1. key staff including designated alternates as appropriate with home address, telephone numbers, and emergency related responsibilities? YES NO*

2. unions have contracts with the agency/program and termination dates of contracts including numbers and types of employees? YES NO*

For each “No” response, indicate below the question number and provide a brief explanation.

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<thead>
<tr>
<th>Question Number</th>
<th>Explanation</th>
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</table>

D. General Policies and Procedures

766.2

Indicate if written policies and procedures for the following areas have been developed, the status of annual review, and, as appropriate, revision. Complete columns for each service listed on the agency’s license, whether the service is provided directly or under contract arrangement. Then proceed with completion of all remaining questions. Attach a copy of all new and/or revised policies and procedures implemented since the agency’s last full survey.
<table>
<thead>
<tr>
<th>Policy/Procedure Present?</th>
<th>Date of Most Recent Review by the Governing Authority</th>
<th>Revised Since Last Survey?</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Service _________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Home Health Aide Service</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Personal Care Services</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Medical Supplies, Equipment &amp; Appliances</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Medical Social Work</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Nutrition Services _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Occupational Therapy</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Physical Therapy ________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Speech/Language Pathology Service</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Physician Services _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Respiratory Therapy ______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Patient Admission ________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Patient Discharge ________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Medical Orders ___________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Authorized Practitioner Notification of Change in Patient Status</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
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<tr>
<td>Service Charges _________</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Clinical Supervision _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Performance Evaluation of Staff</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Personnel Qualifications</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>Personnel Identification</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Employee Health Requirements</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Patient Care Record ______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Patient Grievance Procedure</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Quality Improvement Committee</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
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<tr>
<td>In-service Requirements:</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
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<tr>
<td>- Home Health Aides _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>- Personal Care Workers</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Emergency/Disaster Plan ______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Patient Rights _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>HIV/Infection Control Policies &amp; Procedures</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>HIV Confidentiality Education</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Policy for LPN Performance of IV Therapy (if applicable)</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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<tr>
<td>DNR _____</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
<td></td>
</tr>
<tr>
<td>Advance Directives _______</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td>Yes/No __________</td>
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</tbody>
</table>
II. PERSONNEL

A. **Administrative Staff**

766.9

Title of Registered Professional Nurse responsible for health services

_________________________________________________________________

Name of Individual(s) _______________________________________________

1. Expiration date of professional nurse registration __/__/__
2. New York State Registration Number

B. **Personnel Records**

766.11

1. Do all personnel records, including those for persons employed under hourly or per visit contracts, contain:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. professional licensure and current registration or certificate of approved training?</td>
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<td></td>
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<tr>
<td>b. verification of qualifications?</td>
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<td></td>
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<tr>
<td>c. two references?</td>
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<td></td>
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<tr>
<td>d. record of planned orientation?</td>
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<tr>
<td>e. form of personal identification?</td>
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<tr>
<td>f. current record of participation in in-service training including numbers of hours?</td>
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<tr>
<td>g. evidence of HIV confidentiality inservice at time of employment and yearly thereafter?</td>
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<td>h. evidence of a pre-employment health examination?</td>
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<tr>
<td>i. evidence of a health reassessment performed within the past year for persons employed for more than one year?</td>
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<tr>
<td>j. evidence of immunization to measles and/or proof of immunity as appropriate?</td>
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<tr>
<td>k. evidence of immunization to rubella and/or proof of immunity as appropriate?</td>
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<tr>
<td>l. evidence of current tuberculin test (Mantoux and/or appropriate follow up as indicated)?</td>
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<td>m. current performance evaluation?</td>
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<tr>
<td>n. signed and dated employment application?</td>
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</table>

C. **Staff**

766.11

1. Does the agency maintain a list of all staff?*  
2. Does this list contain title of the staff by discipline?*

* This list should be available at the time of survey visit.
III. CONTRACTS

A. Contract Components

1. If services are provided under contract arrangement with another agency or organization, and/or if personnel under hourly or per visit contract are utilized, are the responsibilities, functions, objectives and terms of agreement:

   a. defined in writing? ___ ___ ___ ___
   b. signed by an authorized representative of your agency? ___ ___ ___ ___
   c. signed by the contracting party? ___ ___ ___ ___
   d. currently in effect? ___ ___ ___ ___

2. Does each agreement clearly designate responsibility of your agency for:

   a. acceptance of patient for care? ___ ___ ___ ___
   b. services rendered to patients? ___ ___ ___ ___
   c. control, coordination and evaluation of services? ___ ___ ___ ___

3. Are procedures/policies stated in each arrangement for:

   a. specific services to be provided? ___ ___ ___ ___
   b. examination of personnel records of the subcontracting provider to determine personnel qualifications? ___ ___ ___ ___
   c. submission of clinical and progress notes? ___ ___ ___ ___
   d. determination of charges and reimbursement? ___ ___ ___ ___
   e. “Not withstanding” clause (766.10(d))? ___ ___ ___ ___
   f. access of physician orders, nursing assessment, social work notes and personnel in contracts with DSS and CHHA? ___ ___ ___ ___

4. Is there a description of how the above information can be obtained? ___ ___ ___ ___
For each “No” response, indicate the question number and the name of the subcontracting provider(s) under contract arrangement to which the “No” applies.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Name of Contracting Provider(s)</th>
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</thead>
<tbody>
<tr>
<td>________________</td>
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<td>________________</td>
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</table>

B. Contract Arrangements with Agencies of Organizations

For all services provided under contract with another agency or organization, list each agency, organization, or individual, and the service(s) provided under contract arrangement.

<table>
<thead>
<tr>
<th>Name of Agency/Organization</th>
<th>Service(s) Provided</th>
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</thead>
<tbody>
<tr>
<td>___________________________</td>
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V. QUALITY IMPROVEMENT COMMITTEES

This section is designed to obtain information about the composition and activities of the Quality Improvement Committee.

A. Quality Improvement Committee

<table>
<thead>
<tr>
<th>Name of Individual</th>
<th>Title. Disciple/Organization Representation</th>
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<tbody>
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</table>

1. Since the last survey, has the Quality Improvement Committee met?
   Specify frequency of meetings
   ____ ____

2. Has the composition of the quality improvement committee changed since last survey?
   ____ ____

3. Are meetings documented by dated minutes?
   ____ ____

4. Does the Quality Improvement Committee:
   ____ ____
   a. review policies pertaining to the delivery of health care services provided by the agency?
   ____ ____
   b. recommend changes in such policies to the governing authority for adoption?
   ____ ____
   c. identify problems, develop solutions, and monitor outcomes?
   ____ ____
   d. conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:
      • random selection of patients currently receiving services?
      ____ ____
      • random selection of patients discharged within 3 months?
      ____ ____
      • all records with identified patient complaints?
      ____ ____

5. Please attach Quality Improvement Committee meeting minutes and/or any studies related to quality improvement conducted by your agency within the last year.
   ____ ____
VI. PATIENT CARE RECORDS

A. Patient Care Record Protection and Retention

1. Are patient care records retained for six (6) years after discharge of the patient, or in the case of minors, six (6) years after the patient’s majority?  

2. Location of closed records __________________________________________

B. Records and Reports

Does the governing authority have a policy to ensure:

- that contracts and other agreements related to the delivery of patient care are retained at the Principal Administrative Office in New York State?  

- the retention of meeting minutes of the governing authority and the committees thereof for three years?  

- the retention of records of all financial transactions directly related to delivery of patient care for three years?  

- retention of personnel records for three years from the date of employee termination or resignation?  

- retention of records of written grievances and complaints for three years from date of resolution?  

Explanation and Abbreviations

State References

10 NYCRR: Title 10 (Health) Part 766 Volume C, Official Compilation of Codes, Rules and Regulations of the State of New York
Consent for Home Visits

This consent statement allows New York State Department of Health home health care survey staff to make a home visit as part of a survey or complaint investigation. I understand that my participation is voluntary and that a refusal will not affect future delivery of services. I agree to answer truthfully the questions the surveyor asks and understand that all information provided will be kept confidential.

Name of Agency

Name of Patient

Address of Agency

Surveyor’s Name & Title

Patient’s Signature

Date

If patient is unable to sign (child or disabled), a significant other may sign and note the relationship.
NEW YORK STATE DEPARTMENT OF HEALTH
LICENSED HOME CARE SERVICES AGENCY
SURVEY REPORT

Name of Agency:_____________________________________________________________

Address:____________________________________________________________________

City:___________________________________________County:______________________

License Number:________________________Telephone Number:______________________

Operator Name:_____________________________________________________________

Address:___________________________________________________________________

City:__________________________________Phone Number:________________________

Counties Served:______________________________________________________________

Services Provided:_____________________________________________________________

Responsible RN:____________________________License #:___________________________

Administrator/Owner:___________________________________________________________

Accredited: ___JCAHO___CHAP___Other___N/A  Federal ID Number:____________

Change in Ownership:___________________________________________________________

Current Patient Census:_________________________________________________________

Current Survey Dates:_______________________Previous Survey Dates:_______________

Type of survey:___ Pre-opening ___Additional Service Site ___ Full ___Partial

Number of Survey Days: ___ Number of Surveyors:____ Number Home Visits:____

Surveyor:____________________________________Title:_____________________________

Surveyor:____________________________________Title:_____________________________

06/98
APPENDIX F

Statement of Deficiencies and Plan of Correction, DOH-1503

This Appendix is a Form
that is unavailable in electronic format.
It will be available to the successful bidder.
FORM LETTER: TRANSMITTING THE STATEMENT OF DEFICIENCIES
DEFICIENCIES BEING ISSUED

USE REGIONAL OFFICE. LETTERHEAD STATIONERY

Name
Address
City State Zip Code

Re: Date of Survey:
Reply required by:

Dear Operator:

Enclosed is a copy of the statement of deficiencies resulting from the Article 36 survey of your agency by staff from our office. As Operator of the agency you are responsible for the agency’s compliance with all applicable rules and regulations. A copy of this letter and the deficiency report are being forwarded to the agency administrator.

It is your responsibility to ensure that a detailed plan of correction is completed, including the person (by title) responsible for the plan and the completion date for correction of each deficiency. This plan of correction is to be provided on the statement of deficiencies sent to the administrator.

Your plan of correction will be reviewed by this office. When deemed acceptable, a follow-up visit will be made to determine whether the deficiencies have been corrected in accordance with the plan of correction. If your plan of correction is unacceptable, staff from our office will contact the agency administrator to discuss the items involved.

Your plan of correction must be returned to this office no later than ten (10) days after receipt of this letter. A copy should be retained for your records.

Please do not hesitate to contact this office if you have any questions concerning this matter.

Sincerely yours,

Name
Regional Administrator or Designee

cc: Agency Administrator
FORM LETTER: TRANSMITTING COMPLIANCE WITH THE REGULATIONS

USE REGIONAL OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code

Re: Date of Survey

Dear Operator:

The results of the Article 36 survey of your agency by staff from our office indicate that all standards set forth in 700, 766 and 767 of 10 NYCRR were deemed to be in compliance. This is being sent to you in your capacity as Operator with ultimate responsibility for the agency. A copy of this letter is being forwarded to the agency administrator.

Please do not hesitate to contact this office if you have any questions about the survey visit.

Sincerely yours,

Name

Area Administrator or Designee

cc: Agency Administrator
FORM LETTER: TRANSMITTING ACCEPTABLE PLAN OF CORRECTION

USE AREA OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code
Re: Date of Survey

Dear Operator:

Please be advised that the plan of correction relating to the recent Article 36 survey of your agency has been reviewed by this office. All items were found to be acceptable, and it is expected that you will implement this plan within the time frames that were submitted. A post approval review will be conducted to verify the correction of deficiencies cited.

If you have any questions regarding this matter, please contact __________________________ at ______________________________

Sincerely,

Name
Regional Administrator or Designee

cc: Agency Administrator
Section .02FORM LETTER: TRANSMITTING UNACCEPTABLE PLAN OF CORRECTION

USE AREA OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City State Zip Code

Re:
Date of Survey:
Reply Required By:

Dear Operator:

Your plan of correction dated _____________, as submitted in response to our recent Article 36 survey, has been reviewed by the surveyors involved. The items found to be unacceptable are stated on the attached report.

It is requested that you submit an acceptable plan of correction for each of the deficiencies cited within ten (1)) days of receipt of this letter.

If you have any questions regarding this matter, please contact ________________________ at ________________________.

Sincerely,

Name
Regional Administrator or Designee

cc: Agency Administrator
APPENDIX K

Post Certification/Approval Revisit Report, DOH-1504

This Appendix is a Form that is unavailable in electronic format. It will be available to the successful bidder.
License Transaction Notice (BPMLTN)

This Appendix is a Form
that is unavailable in electronic format.
It will be available to the successful bidder.
APPENDIX M

FORM LETTER: APPLICATION/PRE-SURVEY NEW SITE
USE AREA OFFICE LETTERHEAD STATIONERY

Name of Operator
Street
City, State, Zip Code

RE: New site
Agency Name
Agency Address
Reply Required by:

Dear Operator:

Prior to the approval and licensure of an additional site of service delivery, the staff of the ____________ Area Office of the Office of Health Systems Management will conduct an initial survey.

To begin this approval process, please complete the enclosed licensed home care services agency (LHCSA) application (pages 2 - 6) with information pertinent to the new site you are requesting to open. Also complete the enclosed checklist and submit the pre-survey information and materials. If any of the requested pre-survey materials are identical to those submitted for an existing agency or to another Area Office, it is not necessary to resubmit these materials for review. Please indicate on the attached checklist the location and date that these materials were submitted.

The requested information and materials should be submitted to the Area Office within 30 days of receipt of this letter. A date for the onsite portion of the survey will be scheduled with you following receipt and review of this material.

The new site may not become operational until the approval of this office is obtained.

If you have any questions about this process, please contact me at _______________.

Sincerely,

Name
Area Administrator
Designee

cc. Agency Administrator
APPENDIX N

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOME HEALTH CARE SERVICES
New Site (Pre-Survey Materials)

Agency Name ___________________________ Agency Address ___________________________________

Provider Instructions: Complete the checklist and attach the requested pre-survey materials. If any of the requested materials have been previously submitted, list the specific Regional Office and date the materials were submitted, in the columns entitled Previously Submitted – Location and Date.

<table>
<thead>
<tr>
<th>Item</th>
<th>Enclosed</th>
<th>Previously Submitted – Location and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names and addresses of all offices (branch and principal administrative)</td>
<td></td>
<td></td>
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<tr>
<td>Name and title of person administratively responsible</td>
<td></td>
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<tr>
<td>For agency</td>
<td></td>
<td></td>
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<tr>
<td>Name and license number of registered professional Nurse(s) responsible for direction and supervision of Patient care and health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership of quality assurance and any other Committee</td>
<td></td>
<td></td>
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<tr>
<td>Contracts and/or other agreements</td>
<td></td>
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<tr>
<td>Patient’s rights</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job description for each position</td>
<td></td>
<td></td>
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<tr>
<td>Materials available to public about agency</td>
<td></td>
<td></td>
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<tr>
<td>Clinical record forms</td>
<td></td>
<td></td>
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<tr>
<td>Policies and procedures for:</td>
<td></td>
<td></td>
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<tr>
<td>- personnel</td>
<td></td>
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<tr>
<td>- patient’s rights</td>
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<tr>
<td>- patient services</td>
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<tr>
<td>- admission, retention, and discharge of patients</td>
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<tr>
<td>- clinical records</td>
<td></td>
<td></td>
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<tr>
<td>- care of medical supplies, equipment and appliances</td>
<td></td>
<td></td>
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<tr>
<td>- orientation of staff</td>
<td></td>
<td></td>
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<tr>
<td>- supervision of home health aides and personal care aides</td>
<td></td>
<td></td>
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<tr>
<td>- emergency/disaster preparedness plan</td>
<td></td>
<td></td>
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<tr>
<td>- patient complaints/grievances</td>
<td></td>
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</tbody>
</table>

I hereby certify that the __________________________________________ (address) site will be under the administration of the same operator that has been approved by the Public Health Council to operate other sites of service in New York State.

I understand that misrepresentation or falsification of any information contained on or submitted with this form may be punishable by fine and/or imprisonment under New York State law.

_________________________________________     ___________________________________________
Date                                              Signature and Title of Operator
## PATIENT RECORD REVIEW FORM

<table>
<thead>
<tr>
<th>Identification</th>
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</thead>
<tbody>
<tr>
<td>Start of Care/Payor Source</td>
<td></td>
<td></td>
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<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
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<tr>
<td>RN Approval of Admission</td>
<td></td>
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<tr>
<td>Receipt of Bill of Rights</td>
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<tr>
<td>Informed of Svc to be Provided</td>
<td></td>
<td></td>
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<tr>
<td>Complaint/Grievance Procedure</td>
<td></td>
<td></td>
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<tr>
<td>Informed of Financial Liability</td>
<td></td>
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<tr>
<td>Advanced Directives</td>
<td></td>
<td></td>
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<tr>
<td>Medical Orders (MD; DO; DPM; NP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed Within 30 days</td>
<td></td>
<td></td>
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<tr>
<td>All dx, meds, Rx, prognosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renewed every 6 months</td>
<td></td>
<td></td>
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<tr>
<td>Telephone orders signed</td>
<td></td>
<td></td>
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<tr>
<td>Nursing Assessment</td>
<td></td>
<td></td>
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<tr>
<td>Plan of Care including dx, px, Mental status, freq of serv, meds, Rx, diet, functional medications, And rehab potential</td>
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<tr>
<td>Therapy orders include specific Procedures and modalities and Amount of frequency and Duration</td>
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<tr>
<td>Reviewed every six months</td>
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<tr>
<td>Supervisory Reports</td>
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<tr>
<td>Aide Activity Sheets</td>
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<tr>
<td>Progress Notes</td>
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<tr>
<td>Discharge Summary</td>
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<tr>
<td>DC planning and MD Notification</td>
<td></td>
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<tr>
<td>Documentation of contact with Family and informal support</td>
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<tr>
<td>Assigned staff</td>
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<tr>
<td><strong>AGENCY:</strong></td>
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<tr>
<td><strong>SURVEYOR:</strong></td>
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<td></td>
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<tr>
<td>1. Employee</td>
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<td>2. Title</td>
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<td>3. Date of Birth</td>
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<td>4. Date of Hire</td>
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<tr>
<td>5. Qualifications Certificate/License</td>
<td></td>
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<tr>
<td>6. Application: Signed and Dated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Verified Reference Checks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Health Status: Pre/ Annual with Freedom Of Habituation Statement</td>
<td></td>
<td></td>
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<tr>
<td>9. Rubella: Titre/Immunization</td>
<td></td>
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<tr>
<td>10. Rubeola: Titre/ Immunization Born after 01/01/57</td>
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<tr>
<td>11. Mantoux: (Annually)</td>
<td></td>
<td></td>
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<tr>
<td>12. Personal ID</td>
<td></td>
<td></td>
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<tr>
<td>13. Administrative/ Performance/ Evaluation/ Home Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Orientation to Policy &amp; Procedures/ Specific Duties/ Emergency Disaster Plan</td>
<td></td>
<td></td>
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<tr>
<td>15. Inservice: (HHA 12 Hours/ PCA 6 Hours)</td>
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<td></td>
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<tr>
<td>16. HIV Confidentiality (Annually)</td>
<td></td>
<td></td>
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<tr>
<td>17. Universal Precautions (Annually)</td>
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<tr>
<td>18. Resignation</td>
<td></td>
<td></td>
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<tr>
<td>19. Criminal History Background Check</td>
<td></td>
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</tbody>
</table>
Attachment 14d

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 14
Home Care Services Agency Quality Activities
LHCSA Routine Operational Survey

Unit 14d -- HHATP DOHM 92-24 Home Health Aide Scope of Tasks
www.health.state.ny.us/professionals/home_care/
Attachment 15

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, may be found at the following website addresses or are set forth below:

**Unit 15**
Home Care Services Agency Quality Activities
LHCSA Pre-opening Survey

LHCSA Article 36 Surveillance Process; Expansion Activities; Combined Appendix.
HHATP DOHM 92-24 Home Health Aide Scope of Tasks

These standards are set out in full in Attachments 14a, 14b, 14c and 14d.
Attachment 16

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 16**

Home Care Services Agency Quality Activities  
LHCSA Policy and Procedure Manual Review

LHCSA Article 36 Surveillance Process; Expansion Activities; Combined Appendix.

HHATP DOHM 92-24 Home Health Aide Scope of Tasks

These standards are set out in full in Attachments 14a, 14b, 14c and 14d.
Attachment 17

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 17
Home Care Services Agency Quality Activities
Home Care and Hospice Complaint Intake

Home Health Care Complaint Investigation Policies And Procedures, Complaint Manual
HOME HEALTH CARE COMPLAINT INVESTIGATION
POLICIES AND PROCEDURES

New York State Department of Health

Division of Health Care Standards and Surveillance
Bureau of Home Care and Hospice Services and Quality Indicators

Original: May, 1992
Revision: June, 1998

DRAFT REVISION
12/1/06
# HOME HEALTH CARE COMPLAINT INVESTIGATION
## POLICIES AND PROCEDURES

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INTRODUCTION

In accordance with the provisions of Articles 36 and 40 of the Public Health Law and all applicable rules and regulations, the State Department of Health is responsible for monitoring the quality of care provided by certified home health agencies, long term home health care programs, licensed home care services agencies, limited licensed home care services agencies, and hospices and for conducting periodic inspections with respect to standards of service and care and regulatory compliance.

A major function of the home care surveillance program involves the investigation of complaints concerning home care services to ensure that all patients are offered adequate and safe quality care. This manual was prepared to assist Home Care Program staff in the conduct of this program by providing:

- Complete definitions and descriptions of the terms and policies used in the home care complaint investigation program.
- A comprehensive description of the procedures to be followed in the management and operation of the home care complaint investigation program.
- A clear description of the responsibilities of all participants in the home care complaint investigation program.

Complaint data are tracked by both the Uniform Complaint Tracking System (UCTS) for home care services agencies (LHCSA, LLHCSAs) and the Aspen Complaint Tracking System (ACTS) for certified home health agencies (CHHAs), long term home health care programs and hospices. These data enable the Department to ensure that home care agency administrators and their staff are aware of problems and have taken corrective measures to prevent recurrence of similar incidents. Accurate data and tracking systems also permit Department staff to respond appropriately and expeditiously to inquiries regarding complaints from legislators, other State agencies and interested parties and to assist the Regional Offices in prioritizing surveillance activity.

CONFIDENTIALITY

Department Staff will make every effort to protect the confidentiality of complainants to the fullest extent possible. In the Department’s on site investigation of complaints, the names of complainants may not be discussed with agency personnel. In such situations, agency staff may guess the identity of the complainant or the subject of the complaint based upon the nature of the investigation, but such information should not be volunteered or confirmed.

The initial letter to the agency directing its investigation of a non-serious or administrative complaint stresses that the name of the complainant must be kept confidential and that any evidence of retaliation against the patient involved will be further investigated by the Department.
Attachment 17
Home Health Care Complaint Investigation

RECEIPT OF COMPLAINTS

All complaints received regarding the provision of services by certified home health agencies, long term home health care programs, licensed home care services agencies, limited licensed home care services agencies and hospices should be processed according to the complaint investigation procedures. Complaints may be initiated by a patient or by anyone on behalf of a patient. The Central Office coordinates statewide complaint activities and maintains a tracking system on each complaint until it is resolved. Each Regional Office categorizes, investigates and resolves all home care complaints within its geographic region.

Since a critical part of the complaint investigation procedure is the initial categorization of the complaint in order to determine the extent to which the Department must become initially involved in the investigation, the complaint receipt procedures include a comprehensive intake and review process as follows:

- Regional Office staff, either professional or clerical persons specifically trained in interview techniques, will conduct an initial telephone interview with each complainant. The initial telephone interview may be conducted when the call is first received in the Regional Office, or the complainant may be called back if the complaint was initially received by the Central Office staff or by Regional Office clerical staff who have not been specially trained. The purpose of the initial telephone interview is to ensure that a complete and accurate portrayal of the home care situation about which the complaint is being made is obtained.

- The Area Home Care Program Director will categorize complaints in the following manner:
  - Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs and Hospices as Immediate Jeopardy, Non-Immediate Jeopardy – Medium, Non-Immediate Jeopardy – Low or Administrative review/offsite, Referral – Immediate, Referral – Other, and No Action Required.
  - Licensed Home Care Services Agencies (LHCSAs) as Serious Patient Care, Non-Serious Patient Care, Administrative or Other.

- Acknowledgements and responses to the complainant will be processed by the Area Office with the exception of those received by mail or home health hotline in the Central Office. In these cases, the Central Office will consult with the Regional Home Care Program Director to appropriately categorize the complaint and send the appropriate acknowledgement letter.

The initial telephone interview with the complainant must elicit all pertinent information on which a decision can be made as to the category and seriousness of the complaint. This information will include the name, address and telephone number of the complainant; name of the subject agency; applicable patient information such as diagnosis, current condition, physical and mental status; types and hours of service provided; living conditions and informal supports; names and addresses of other State agencies or home care agencies involved; pertinent dates; and other appropriate information relative to the complaint. The Complaint Intake Form, (Appendix A) includes space for the above information and is designed to assist staff in taking a telephone complaint.
CATEGORIZATION OF COMPLAINTS

Following the receipt of a complaint, all intake information should be reviewed and evaluated by the Regional Home Care Program Director or his/her designee to determine which complaint category is most appropriate. Since some complaints are more serious than others, it is imperative that complaint investigations be prioritized:

1. To determine the immediacy of the investigation.
2. To determine the extent to which the Department must become initially involved.
3. For statistical and tracking purposes.

The complaint category and a projected completion date will be determined prior to the initiation of an investigation. If a complaint has several components, which fall into more than one complaint category, the complaint should be designed according to its most serious component. Definitions of these categories in ranking order are as follows:

CHHA, LTHHCP and Hospice Complaints (SOM 5075):

1. **IMMEDIATE JEOPARDY** – A situation in which the provider’s noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient. (Appendix Q of the State Operations Manual (SOM) contains Guidelines for Determining Immediate Jeopardy). Intakes are assigned this priority if the allegation(s) indicates immediate corrective action is necessary.

2. **NON-IMMEDIATE JEOPARDY – MEDIUM** – Intakes are assigned this priority if the alleged non-compliance with one or more requirements or conditions caused or may cause harm that is of limited consequence and does not significantly impair the individual’s mental, physical and/or psychosocial status or function. An onsite survey should be scheduled to review these intakes.

   **NOTE:** Complaints for providers with deemed status require an onsite survey within 45 calendar days after approval by the CMS Regional Office (Region 2).

3. **NON-IMMEDIATE JEOPARDY – LOW** – Intakes are assigned this priority if the alleged noncompliance with one or more requirements or conditions may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage. In most cases, an investigation of the allegation can wait until the next onsite survey.

4. **ADMINISTRATIVE REVIEW/OFFSITE INVESTIGATION** – Intakes are assigned this priority is an onsite investigation is not necessary. However, an offsite administrative review (e.g. written/verbal communication or documentation) to determine if further action is necessary. The information should be reviewed at the next onsite survey. Agencies with deemed status may have offsite administrative complaint investigations regarding possible non-compliance with state regulations but not with the conditions of participation [SOM 5010.2].

5. **REFERRAL-IMMEDIATE** – Intakes are assigned this priority if the seriousness of a complaint/incident requires referral or reporting to another agency, board, or ESRD network without delay for investigation. When a referral is made by DOH a written report must be requested from the entity to which the matter is referred. [SOM 5075.6]
6. **REFERRAL – OTHER** – Intakes are assigned this priority when referred to another agency, board, or ESRD network for investigation or for informational purposes. When a referral of a complaint is made to another agency or entity (e.g. law enforcement, Ombudsman, licensure agency, etc.) for action, a written report should be requested on the results of the investigation. Regardless of who conducts the investigation, the Department has the responsibility to assess compliance with Federal conditions or requirements. The time frames for investigation are not altered by the referral to another agency. (Expressed requests by law enforcement that an onsite investigation be deferred should be reported to the Bureau who will discuss with CMS Region 2 as required in SOM 5075.7.)

7. **NO ACTION NECESSARY** – This applies only to providers with deemed status. If it is determined with certainty that no further investigation, analysis, or action is necessary. [SOM 5075.8]

**LHCSAS**

1. **SERIOUS PATIENT CARE COMPLAINTS** -
   Serious patient care complaints refer to complaints determined to require prompt intervention by Regional Office staff. Examples may include:
   - Patient Abuse.
   - Patient Neglect.
   - Patient Harm or Potential for Harm.

2. **NON SERIOUS PATIENT CARE COMPLAINTS** –
   Non serious patient care complaints are allegations about patient care which do not appear to threaten the patient's immediate well being. Examples may include:
   - Inconsistent aide services for a patient who has a good informal support system.
   - A delayed nursing assessment where a patient did not require skilled nursing care and had informal supports.
   - Reduction in services.
   - Dissatisfaction with care provided, such as with meals prepared, or with scheduling of activities or treatments.

3. **ADMINISTRATIVE COMPLAINTS**-
   Administrative Complaints are those which do not identify a patient care issue but include problems related to the general operations of the agency. Examples may include:
   - Personal Issues.
   - Policy and Procedure Issues.
   - Billing Discrepancies.

4. **OTHER COMPLAINTS**-
   Complaints that do not fit into the categories of patient care or administrative may be placed in this category. An example is an allegation of theft against a home care worker.

**ANONYMOUS COMPLAINTS**

Anonymous complaints should be handled as any other complaint, with the exception of acknowledgements and responses to the complainant.
COMPLAINTS WHICH INVOLVE AGENCIES WITH PENDING LICENSURE OR SCOFFLAWS

The same complaint investigation procedures apply as for an established operator when a complaint is received regarding an agency with a pending application for certification or licensure. Regional Office staff should keep Central Office staff apprised of information obtained as the investigation proceeds because this information is also factored into the agency operator’s character and competence review for licensure or certification.

Where applicable, Regional Office surveyors will cite deficiencies based on the state licensure regulations as minimum standards. It is the goal of the Department to obtain an acceptable plan of correction and to bring agencies into regulatory compliance so that a positive recommendation of character and competence can be made on pending applications. Failure of the agency to correct deficiencies cited, however, may result in a recommendation to disapprove the application.

COMPLAINTS INVOLVING ISSUES WHICH ARE NON-JURISDICTIONAL FOR THE BUREAU OF HOME CARE/ HOSPICE SURVEILLANCE AND QUALITY INDICATORS/EVALUATION

When a written complaint is received about a situation beyond the purview of the Bureau of Home Care/Hospice Surveillance and Quality Indicators/Evaluation, and Regional Home Care Programs, the complaint is referred to the agency or bureau having jurisdiction. The complainant is advised of the referral in an acknowledgement letter.

For verbal complaints that are beyond the purview, the complainant will be referred as appropriate and the name of a contact person, address and phone number will be provided. The complainant should be encouraged to contact the agency directly.

1. Referrals for additional action required by other State agencies or Department bureaus will be made by Central Office staff following review of the completed investigation report. However, if Regional Office staff identify an issue that should be investigated by a Local Social Services District (LDSS) or another Regional Office surveillance program, a referral may be made directly by Regional Office staff. A copy of any referrals made by the Regional Office should be included in the investigation package for future reference. In UCTS, referrals are entered on Area Office Actions and Outcome – E09. In ACTS, referral information is entered under the “Referral” tab. Some commonly required referrals should be processed as follows: Referrals to Office of Medicaid Management (OMM) or Local Department of Social Services (LDSS)/New York City Human Resources Administration (HRA).

   Referrals to the Office of Medicaid Management will be made by Central Office staff while referrals to LDSS/HRA may be made by Regional Office staff.


   Complaints, which deal with the potential misuse or abuse of Medicaid reimbursement funds, will be referred to the Office of the Medicaid Inspector General by Central Office. These complaints will not be investigated by the Regional Office unless the complaint also involves a patient care issue. If there is any question regarding this, Regional Office staff should consult with Central Office before proceeding.
3. Referral to Adult Protective Service (APS) or Child Protective Services (CPS), Office of Family and Children’s Services (OFCS)

If adult or child abuse is suspected during a complaint investigation, a determination should be made by Regional Office staff if the agency has reported the suspected abuse to the OFCS. If the agency has not reported the alleged incident, the surveyor should consult with the Regional Home Care Program Director and immediately report the circumstances to the Adult Protective or Child Protective Unit of the OFCS. The Area Administrator should be notified of such reports.

4. Referrals to the Office of Professional Discipline (OPD), State Education Department (SED).

Any complaint that involves apparent malpractice by a professional person licensed by the State Education Department should be brought to the attention of the Central Office. The investigation report will be sent to the OPD for its follow-up.

5. Complaint Referrals to the Department’s Office of Professional Medical Conduct (OPMC).

If an investigation reveals possible professional medical misconduct, the names of any physicians involved should immediately be brought to the attention of Central Office for referral to OPMC.

6. Complaints Regarding Possible Criminal Action.

If a complaint involves alleged criminal action, such as robbery or assault, and the complainant has not and will not report such allegations to the local police department, the Central Office should be notified. Central Office will consult with the Division of Legal Affairs as to the appropriate Departmental action.
CENTRAL OFFICE RESPONSIBILITIES

- **Intake of Complaints:** When intake of a complaint against a CHHA or LTHHCP is initiated in Central Office, Central Office staff will:

  1. For complaints against certified home health agencies (CHHAs), long term home health care programs (LTHHCPs) and hospices: Central Office staff will complete the intake information in ACTS, and obtain an ACTS log number, e-mail the log number and initial priority status to the regional office program director or designee on the day of intake;

  2. For complaints against licensed home care services agencies (LHCSAs), Central Office staff will provide the complainant’s name and telephone number to Regional Office staff for a return call and follow up as required in procedures.

  3. Central Office staff will refer telephone complaints received on the HOTLINE or in the Bureau directly to the appropriate Regional Office, providing the complainant’s name and telephone number to the Regional Office staff for a return call and follow-up as required in procedures.

  4. Immediately notify CMS Regional Office for complaints against providers with deemed status or fire in a facility (most likely hospice).

- Forward written complaints to the Regional Office and send the appropriate acknowledgement letter to the complainant (Appendix L).

  - Apprise the Bureau Director who will notify Division Executive Staff and Public Affairs Group, as appropriate, of any complaints which have resulted in, or have the potential to result in, serious negative patient care outcomes and/or which have attracted media attention.

  - Maintain statewide home care complaint tracking systems – the Aspen Complaint Tracking System (ACTS) for CHHA/LTHHCP and hospices, and the Uniform Complaint Tracking System (UCTS) for LHCSAs.

  - Review Regional Office findings through access to computer entries and complaint investigation reports.

  - Make appropriate referrals to other Bureaus or State agencies when necessary.

  - Analyze computer data through routine and ad hoc reports.

  - Review any complaint investigations, which have resulted in an appeal to Central Office and respond to the complainant with results of the appeal.

  - Finalize Regional Office enforcement referral packages and forward referrals to the Division of Legal Affairs.
REGIONAL OFFICE RESPONSIBILITIES

When the Regional Office receives a complaint from a complainant or by referral from Central Office, Regional Office staff will:

- Determine which complaint category or type is most appropriate. An assessment of each intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge and/or experience of current clinical standards of practice and Federal and State requirements.

- Determine for complaints to be investigated onsite if the agency has deemed status. If so, Central office must be notified immediately upon that determination. (SOM 5010.3)

- Notify Central Office if there is a fire in a facility. (in the home care/hospice program this would apply to hospice patients). (SOM 5010.3)

- Assign the complaint a Log Number if this has not been done.

- Data-enter Intake Information within appropriate timeframes.

- Send appropriate acknowledgement and response letters to complainants.

- Identify the investigator assigned in the appropriate database.

- Investigate or refer the complaint to the subject agency for investigation. An investigation determines if a deficient practice is or was present, and assesses the degree of harm.

- Develop complaint investigation reports or review agency reports for acceptability.

- Respond to the agency relative to investigative findings or agency reports.

- Issue statements of deficiencies and obtain acceptable plans of correction or adequate agency reports as appropriate.

- Data enter all investigative actions.

- Make referrals for enforcement, as necessary.

- Maintain tracking systems for ALL complaints.
For allegations categorized as **IMMEDIATE JEOPARDY, NON-IMMEDIATE JEOPARDY - MEDIUM, NON-IMMEDIATE JEOPARDY – LOW or SERIOUS PATIENT CARE COMPLAINTS (SOM 5075):**

1. Regional/Central Office staff will complete and data enter intake information including allegation category(ies) within two business days of complaint receipt (Appendix B). [CMS S&C-06-25 Attachments 2, 3 and 4].

2. Regional/Central Office staff will send an acknowledgement letter to the complainant within two business days of complaint receipt (Appendix C).

3. A Regional Office investigation plan will be developed by the investigator and approved by the Home Care Program Manager:
   - Investigations will be initiated within two working days or sooner depending on the seriousness of the complaint allegations.
   - Complaints against all agencies which appear to pose an immediate and serious threat to patient health and safety as specified in State Operations Manual, Section 3010, will be completed within three business days. Data entry linking the allegations to an onsite survey and investigative findings must be data entered within two working days of the investigation completed date. The investigation is completed when a decision is made that the complaint allegation(s) are either substantiated or not substantiated.
   - The investigation of a serious patient care LHCSA complaint that does not appear to pose an immediate and serious threat to patients will be completed within 30 days. The investigation is completed when a decision is made that the complaint allegation(s) are either substantiated or not substantiated.

4. Complaints prioritized as non-immediate jeopardy – medium must have an investigation initiated within 10 business days and completed within 30 business days. These complaints are those that may impact on outcomes of care due to a standard level non-compliance.

5. Complaints prioritized as non-immediate jeopardy – low would be investigated during the next re-certification survey if that is scheduled within three months of intake. These would be complaint allegations that may have impact on outcomes due to standard level deficiencies or are less serious but due to other factors such as number of complaints, changes in agency operation etc., would not be investigated off-site.

6. Investigation procedures may include unannounced visits to the agency, home visits, interviews of appropriate parties and record reviews.

**B. When an on-site investigated complaint is Substantiated, Regional Office staff will:**

1. Issue a Statement of Deficiencies (SOD) to the agency within 10 days of the determination of non-compliance.
2. Complete and data-enter UCTS/ACTS investigative information within two business days of completing the investigation.

3. Send a response letter to the complainant (Appendix D). A space is available on the form response letter to summarize the findings. It is not necessary to enclose a copy of the statement of deficiencies to the complainant.

4. Document findings from all reviews in the form of a complaint investigation report. The standardized reporting form may be used (Appendix E).

Additionally for complaint investigations resulting in the issuance of an SOD:

5. When the acceptable plan of correction is received, complete and data-enter as appropriate in UCTS, in ACTS. Note: A deemed status agency that is issued a statement of deficiency citing standard level findings is NOT required to submit a plan of correction but may choose to do so since the CMS 2567 will be made available to the public. (SOM 5100.2)

6. Send a letter notifying the agency of the acceptability of its plan.

7. Forward copies of this letter and acceptable plan of correction to the Central Office in Delmar.

8. For complaints against Federally regulated agencies, upload the complaint investigation kit in ACTS within 45 days from the last date of the onsite visit.

9. If Condition level non-compliance is determined, send all Federal forms specified in #8, above, the CMS-462 (Adverse Action Extract), the CMS-562 (Medicare/Medicaid Complaint Form) and any supporting documentation directly to the Bureau of Home Care/Hospice Surveillance and Quality Indicators/Evaluation within 30 days from the last date of the onsite visit.

10. Ensure completion of any statement of deficiencies in ASE or ACO within 10 days of completion of the investigation.

11. When the acceptable plan of correction is received, complete and data-enter on UCTS/ACTS.

12. Send a letter notifying the agency of the acceptability of its plan.

C. When a complaint investigated on site is Unsubstantiated, regional office staff will:

1. Complete and data-enter UCTS/ACTS within two business days of completion of investigation.

2. Send a response letter to the complainant (Appendix F).

3. Develop an investigation report and retain it in the Regional Office. Central Office will only need a copy in the event of an appeal.

4. Send a letter notifying the agency that no deficiencies were identified from the complaint investigation findings (Appendix G).
REGIONAL OFFICE INVESTIGATIVE ACTIVITIES FOR COMPLAINTS INVESTIGATED OFFSITE.

A. For complaint allegations categorized as administrative/offsite in ACTS or non-serious patient care in UCTS, investigative procedures will differ from those for onsite investigated patient care complaints since in most cases, the home care agency against which the complaint has been lodged will be responsible for conducting the initial self-investigation and submitting a report to the appropriate Regional Office. Following receipt of a complaint which has been categorized in this manner, Regional Office Staff will:

1. Complete and data-enter intake information into UCTS/ACTS within two business days of complaint receipt.

2. Send an acknowledgement letter to the complainant (Appendix H) within two business days of receipt which indicates that the Department:
   - Has reviewed the complaint and has forwarded a summary of the allegations to the home care agency for investigation.
   - Will maintain the confidentiality of the complainant.
   - Will respond directly to the complainant when an acceptable response has been received from the agency with their finding and resolutions.
   - Will issue deficiencies to the agency should there be any form of reprisal against a patient as a result of the complaint.

3. Send a letter (Appendix D), Agency Reporting Form (Appendix I – Enclosure) and, as appropriate, the intake summary (Appendix A), to the agency which:
   - Delineates the patient care allegations and issues as presented to the Department by the complainant.
   - Directs an agency investigation and resolution documented on the Agency Reporting Form noting findings on the computer form checklist within 10 days.
   - Indicates that confidentiality of the complainant is being maintained.
   - Emphasizes that the Department will take appropriate action if there is retaliation against the patient.
   - Indicates that the Department will validate complaint resolutions at the next survey.

B. For Completed investigations in which the agency submits an ACCEPTABLE report in response to offsite/administrative or Non-Serious Patient Care Allegations, Regional Office staff will:

1. Complete and data-enter all appropriate information into UCTS/ACTS within two business days of determining that an agency report is acceptable.

2. Send a response letter to the complainant within seven days of receipt of the agency report indicating that the Department considers the matter closed (Appendix J).
3. Send a letter to the agency within seven days notifying them that the report is acceptable.

4. File the agency report in the Regional Office surveillance file for the agency and review these issues during the next scheduled survey.

5. Data-enter results of investigation within two days of the determination that the agency report is acceptable.

C. If an agency **FAILS** to submit a report within 10 days or if the agency report submitted to the Department is **UNACCEPTABLE**, Regional Office staff will:

1. Send a response letter to the complainant which indicates that the Department is continuing to investigate the situation and will require additional time for resolution of their complaint. (Appendix K).

2. Determine what further steps are necessary to more fully investigate the allegations which may include, but are not limited to:
   - A request for further agency documentation of its investigation of the complaint.
   - Telephone interviews with the patient, complainant, agency staff, and other concerned persons.
   - Unannounced site visits to the agency.
   - Home visits as appropriate.
   - Issuance of a statement of deficiencies to the agency for failing to fully investigate the complaint and to take appropriate action to resolve the issue.
   - If Area Office staff have concerns about the agency’s investigation of a complaint designated as non-serious patient care, administrative or other, they should discuss their concerns with the Program Director and “CONVERT” the complaint to serious patient care for further investigation by Area Office staff.

3. Send a final response letter to the complainant within 2 days from the complaint resolution. (Appendix D, F or J).

4. File the agency report and related materials in the Regional Office surveillance file for the agency and review these issues during the next scheduled survey.

5. Data-enter results of investigation.

D. In “Converting” an Agency Investigated Case to an Area Office Investigated Case, Area Office staff will:

For UCTS: Indicate dates of B18 and DOH investigation initiated in addition to dates of B16 – Date agency report received on Area Office Actions & Outcomes.

For ACTS: Initiate a new complaint survey kit in ACTS.
HOME HEALTH CARE COMPLAINT INVESTIGATION

REGIONAL OFFICE INVESTIGATIVE ACTIVITIES FOR ADMINISTRATIVE OR OTHER COMPLAINTS

A. For complaint allegations categorized as **ADMINISTRATIVE OR OTHER COMPLAINTS**, in UCTS Regional Office staff will:

1. Complete and data-enter intake items into UCTS/ACTS within two business days of complaint receipt.

2. Send an acknowledgment letter to the complainant within three business days of receipt which indicates that the Department:

   – Has reviewed the complaint and has forwarded a summary of the allegations to the home care agency for investigation.

   – Will maintain the confidentiality of the complainant.

   – Will respond directly to the complainant when an acceptable response has been received from the agency with their findings and resolutions.

   – Will issue deficiencies to the agency should there be any form of reprisal against a patient as a result of the complaint.

3. Send a letter (Appendix I), Agency Reporting Form (Appendix I – Enclosure), and, as appropriate, the Complaint Intake Information Summary:

   – Delineates the allegations and issues as presented to the Department by the complainant.

   – Directs an agency investigation and resolution documented on the Agency Reporting Form within 10 days.

   – Indicates that the confidentiality of the complainant is being maintained.

   – Emphasizes that the Department will take appropriate action if there is retaliation against the patient.

   – Indicates that the Department will validate complaint resolutions at the next survey.

B. For **COMPLETED INVESTIGATIONS** in which the agency submits an ACCEPTABLE REPORT in response to Administrative or Other Complaints, Regional Office staff will:

1. Complete and data-enter all appropriate items into UCTS/ACTS within two business days of determining that an agency report is acceptable.

2. Send a response letter to the complainant within seven days of receipt of the agency report indicating the findings and notifying them that the Department considers the matter closed (Appendix J).

3. Send a letter to the agency within seven days of receipt of the agency report, notifying the provider that the report is acceptable.

4. File the agency report in the Regional Office surveillance file for the agency and review these issues during the next scheduled survey.

5. Data-enter results of investigation within two days of its completion.
Attachment 17
Home Health Care Complaint Investigation

C. If an agency FAILS to submit a report within 10 business days or if the agency report submitted to the Department is UNACCEPTABLE for Administrative or Other Complaints, Area Office staff will:

1. Send a response letter to the complainant which indicates that the Department is continuing to investigate the situation and will require additional time for resolution of their complaint (Appendix K).

2. Determine what further steps are necessary to investigate the allegation which may include:
   - A request for further agency documentation of its investigation of the complaint.
   - Telephone interviews with patient, complainant, agency staff, and other concerned persons.
   - Unannounced onsite visits to the agency.
   - Issuance of a statement of deficiencies to the agency for failing to fully investigate the complaint and take appropriate action to resolve the issues.
   - If Regional Office staff have concerns about the agency’s investigation of a complaint designated as Administrative or Other, they should discuss their concerns with the Program Director and “CONVERT” the complaint for further investigation by Regional Office staff.

3. Send a final response letter to the complainant within 2 days from date of the complaint resolution (Appendix D. F or J).

4. File the agency report and related materials in the Regional Office surveillance file for the agency and review these issues during the next scheduled survey.

5. Data-enter results of investigation.
   
   A. In “Converting” Agency Investigated Cases, the Regional Office staff will indicate the appropriate dates in the B18 DOH investigation initiated field in addition to dates of B16 - Date agency report received on Area Office Actions & Outcomes field.
PLANNING FOR REGIONAL OFFICE ONSITE INVESTIGATIONS OF COMPLAINTS

Each complaint investigation, including interviews, the review of documents and observations should be planned in advance. Planning lends structure to the investigation, helps to ensure that all areas of concern are addressed and that all leads and sources of information are evaluated and utilized.

The surveyor/survey team assigned to the investigation may review the agency’s compliance history, OBQI and OBQM reports for CHHAs, and any data or supportive information received from other programs such as advocacy programs. The preparatory process may require additional contact with the complainant.

An investigation plan is a strategy for organizing information gathered from interviews, record reviews and home visits. The plan addresses the areas of concern and includes any additional information that may become available as the investigation proceeds. The original plan may need to be revised to accommodate variables that may arise in the course of the investigation.

SITE VISITS TO HOME CARE AGENCIES

All initial onsite visits are unannounced. The determination of whether a site visit is required for complaints is made by the Home Care Program Director based on the specific nature of the complaint and the work plan developed.

When a site visit is conducted, the investigator announces his/her presence on arrival to the agency administrator or director, states the purpose for the investigation and then proceeds immediately with the investigation. All contacts with the agency during the course of the investigation are documented. Such documentation should include at least the following:

- Name of the agency.
- Name and title of contact(s).
- Date, time and content of any conversation with agency personnel.
- Copies of pertinent documents reviewed.

HOME VISITS

Home visits may be conducted to interview patients and/or complainants in the investigation of patient care complaints. Regional Office staff will arrange for the home visit and obtain the patient’s permission by telephone. At the time of the home visit, the surveyor will obtain a signature on the Consent for Home Visit Form (Appendix M) from the patient or family member (if the patient is unable to sign). As appropriate, an agency staff member may accompany the surveyor on the home visit.
INTERVIEW PROCESS

As a practical guideline for complaint investigations, the following sequence of interviews should be followed:

1. The initial interview is with the complainant since additional information may be needed from the complainant to fully understand the seriousness of the complaint.

2. When a complaint is being investigated and the complainant is not the patient, an attempt should be made to also interview the patient. The patient should be interviewed following the interview with the complainant at a mutually convenient location which, in most instances, will be the patient’s home. If a personal interview is not possible, a telephone interview may be the best alternative.

3. Each individual interviewed may be able to identify additional individuals who have information or knowledge related directly to the subject of the investigation. These individuals should be included in a revised investigation plan and should be interviewed if at all possible.

INTERVIEW TECHNIQUES

All interviews should be planned. The purpose of the face to face interview should be clearly stated and understood. The investigator, who should be wearing his/her Department of Health name tag, should fully and properly identify himself/herself at the beginning of the interview. The investigator should also explain to the subject what the interview is about and what will be occurring during the interview. Generally, the investigator should establish rapport before beginning to take notes. Taking of notes should not interfere with the interview process.

Questions are the principal tools of the interviewer. The quality and quantity of information obtained from the subject will be related to the investigator’s skill in formulating and asking questions. Questions will be valueless if they:

- Are irrelevant.
- Cannot be understood.
- Do not elicit pertinent information.

The questions asked should follow a logical plan. A standard method of efficient questioning involves beginning with a general question and gradually becoming more specific. In this way, questions build on previous answers and specific, accurate information may be obtained.

Open-ended questions which require more than a simple “yes” or “no” for an answer are valuable in obtaining spontaneous information on a wide range of topics. They encourage original responses from subjects and avoid answers that may be prejudiced by the question. For example:

- “Tell me what happened during your visit”
- “What can you tell me about Ms. Smith, the home health aide assigned to this case?”
- “Describe in your own words the events of July 5, 2006.”
Controlled answer questions (leading questions) or statements may be used to stimulate a desired answer or impression. They are often used to stimulate a person to admit that he has knowledge about some matter that he is reluctant to discuss. For example: “I understand you were present when the drug was administered. Would you please describe how it happened?” The fact that the investigator knew that the subject was present when the drug was administered may motivate the subject in a persuasive way to admit knowledge of the incident. If the investigator merely asks, “Were you present when the drug was administered?” it would provide the subject with opportunity to evade a direct answer to the question.

The one rule in the interview process which is applicable to all interviews is: gain control of the interview at the very beginning and maintain that control. If control is lost, take immediate steps to re-establish it in a calm and friendly but positive manner.

As a representative of the Department, the investigator is obligated to treat everyone with courtesy and sensitivity. If the investigator becomes concerned about legal questions, s/he should contact his/her supervisor immediately. If the legal questions cannot be resolved at the Regional Office level, the Home Care Program Director should contact the Bureau of Home Care Services and Quality Management for further consultation. The Bureau will determine if contact with the Division of Legal Affairs is warranted and will make the contact if necessary.

As a general rule, investigators should start the interview by asking the witness to tell (allowing free narrative discussion) what she/he knows about the specific matter being investigated. The open narrative should give a general coverage of the topic under discussion. It may bring out unanticipated areas of knowledge which can be followed up in a later interview. All unknown detail questions on an investigator’s list not satisfactorily covered by the free narrative discussion should be explored by direct questions. Each unknown should be taken up separately before proceeding to the next.

To explore an unknown detail, it is generally necessary to use a sequence of questions. The sequences should proceed from general to specific and the individual questions should be precise and discerning. Failure to ask a key question is often the only reason for not obtaining an unknown fact.

In all cases, the information received from a subject should be reviewed for accuracy before the interview is concluded. The investigator should “leave the door open” for subsequent interviews if necessary.

If there are signs that the subject is becoming unwilling to talk during the questioning, questions and conversation should be immediately shifted to more neutral topics about which the subject has previously talked freely. Then, the questioning may progress slowly toward the desired topic by using a different line of inquiry.

When questioning known or suspected hostile subjects, it may be desirable to have a second investigator present. If two investigators are present, one may be used to vent the hostile feelings of the subject. The other investigator can support the subject’s problem, gain confidence, and eventually the desired information. If the subject is quarrelsome, it may be wise to let him ventilate any grievance. After the subject has ventilated a bit, he will usually calm down and participate in an interview, at least to some extent. However, if the interview becomes uncontrollable, it should be terminated. If the investigation may lead to criminal action, the interviewer should inform the person of their rights (Miranda).
# FINAL DETERMINATION OF FINDINGS BY REGIONAL OFFICE

The Regional Office staff make a final determination on the disposition of each case depending on the outcome of their investigation of serious patient care complaints or the review of the agency’s investigative report of non serious, administrative or other complaints. One of the following seven determinations, four for those investigations completed by Regional Office and three for those investigated by the agency, will be chosen at the conclusion of each case and data-entered. The determinations are as follows:

## REGIONAL OFFICE INVESTIGATIONS

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<thead>
<tr>
<th>REGIONAL OFFICE INVESTIGATIONS</th>
<th>OUTCOME</th>
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<tbody>
<tr>
<td>1. Allegation Substantiated. Statement of Deficiencies Issued</td>
<td>1. Evidence found that substantiated the original allegation(s) and deficiencies were cited.</td>
</tr>
<tr>
<td>2. Allegation substantiated. No deficiencies found.</td>
<td>2. Evidence found that allegation occurred. Agency had taken prompt appropriate action to correct the deficient practice and implement actions to prevent recurrence.</td>
</tr>
<tr>
<td>4. Allegation Unsubstantiated. No Deficiencies Found.</td>
<td>4. Original allegation(s) not Substantiated and deficiencies not found.</td>
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## AGENCY SELF INVESTIGATIONS

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<th>AGENCY SELF INVESTIGATIONS</th>
<th>OUTCOME</th>
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<tbody>
<tr>
<td>5. Allegation Substantiated. Action Taken</td>
<td>5. Agency investigation found evidence to support original allegation(s) and action was taken to resolve the situation and prevent recurrence.</td>
</tr>
<tr>
<td>6. Allegation Unsubstantiated, Other Problem Areas Noted. Action Taken.</td>
<td>6. Original allegation(s) not substantiated yet other problem areas were found and action was taken.</td>
</tr>
<tr>
<td>7. Allegation Unsubstantiated. No Problem Identified.</td>
<td>7. Original allegation(s) not substantiated and no deficiencies were found.</td>
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RELEASE OF RECORDS TO OUTSIDE GROUPS/FREEDOM OF INFORMATION/RECORDS ACCESS

In accordance with the New York State Department of Health Administrative Policy and Procedure Manual (Item Number 100), it is the policy of the Department that access to and release of copies of Department records to outside individuals be provided only through the designated records access officers pursuant to the Freedom of Information Law (FOIL). Fees are charged for all copies of records provided through FOIL to persons outside the Department.

The Department has five days in which to respond to a FOIL request. Lists of documents provided under FOIL are available free of charge. The Department does not routinely notify agencies and/or individuals of FOIL requests related to them.

When the Department receives an inquiry from the news media that involves information pertaining to a specific agency or group of agencies, the Department is obligated to provide information available under FOIL. Such information may include statements of deficiencies, plans of correction upon which the Department has completed its review, responses by the agency, final orders, stipulations, hearing officer reports and survey documents.

The Department does not release any patient specific information because such release is prohibited by law. Similarly, the Department does not release names of individual agency staff members or complainants, regarding them as protected under FOIL, by the provision shielding individuals from unwarranted invasion of personal privacy. Personal identifying information should be edited out of any documents released under FOIL.

Names of professionals who are referred to the Department's Office of Professional Medical Conduct or the State Education Department's Office of Professional Discipline are handled confidentially. However, when the Department receives an inquiry about whether an active case is pending involving a specific physician, the Department’s Office of Professional Medical Conduct does confirm the conduct of the investigation.

For complaint-specific inquiries, the Department does not provide information to the news media while the investigation is in progress, except to acknowledge the existence of an investigation in progress.

The contents of the statement of deficiencies generally are not made public for 48 hours following receipt of the document by the agency. This provides the agency with an opportunity to review the report, respond to the Department and/or prepare a public statement. The Department routinely informs the news media in such cases that the agency in question can challenge the report’s findings and that it has a specific time frame for responding to the deficiencies.
COMPLAINT APPEALS PROCESS

1. Appeals of Complaints Investigated by Home Care Agencies

   Any correspondence or telephone calls that dispute the findings of an agency investigation of a non serious patient care, administrative or other complaint will be followed up by Regional Office staff. Initial action will include discussion with the complainant about alleged unresolved issues and, as appropriate, discussion with agency administration and/or staff.

   Based on the results of the initial action, Regional Office staff, in collaboration with the Home Care Program Director, may determine that the situation has been resolved and the complainant will be so notified. The results of the initial action may, however, require Regional Office staff to do its own investigation and “CONVERT” the case following the procedures described for Regional Office investigations.

2. Appeals of Complaints Investigated by Regional Office Staff

   Appeals of Serious Patient Care Complaints which have been investigated by Regional Office staff may be submitted in writing to the Central Office Appeals Designee. The Appeals Designee will review all aspects of the complaint investigation and, as necessary, may require additional follow-up by Area office staff.

   Receipt of the written appeal in Central Office should be acknowledged in writing within five business days of receipt. Within 60 days of the acknowledgement, the complainant should be notified in writing of the appeal designee’s findings.
Attachment 18

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 18
Home Care Services Agency Quality Activities
Home Care and Hospice Complaint Investigation

Home Health Care Complaint Investigation Policies And Procedures, Complaint Manual Draft is set out in full as Attachment 17 of this RFP.
Attachment 19

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 19**
ICF/MR Quality Activities
ICF/MR Federal Standard Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix J.
Attachment 20

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 20**
ICF/MR Quality Activities
ICF/MR Life Safety Code Review

CMS State Operations Manual

CMS State Operations Manual, Appendix J.
Attachment 21

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 21
ICF/MR Quality Activities
ICF/MR Extended Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix J.
Attachment 22

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 22**
ICF/MR Quality Activities
On-Site Complaint Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix J.
Attachment 23

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 23
ICF/MR Quality Activities
Federal Revisit – Health

CMS State Operations Manual

CMS State Operations Manual, Appendix J.
Attachment 24

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 24
ICF/MR Quality Activities
ICF/MR Complaint Intake and Investigation

CMS State Operations Manual

CMS State Operations Manual, Appendix J
Attachment 25

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 25
ICF/MR Quality Activities
ICF/DD Certification Review

42 CFR Part 483
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr483_04.html

42 CFR Part 442
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr442_04.html
Attachment 26

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 26
Medicaid Waiver Related Quality Activities
Complaint Intake Related to Care At Home Waivers

There is no specific procedure associated with complaint intake for CAH waivers. Contractor staff receiving complaints related to CAH waiver services will use the home care complaint intake procedures described in Attachment 17 above.
Attachment 27

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 27**

Medicaid Waiver Related Quality Activities
Complaint Intake Related to Long Term Home Health Care Waiver Program

Long Term Home Health Care Program Complaint Process
The NYS Department of Health (DOH) operates a Home Health Hotline to investigate complaints concerning home care services to ensure that all patients are offered adequate and safe quality care. All complaints received through the Home Health Hotline regarding the provision of services by Long Term Home Health Care Programs (LTHHCP) are processed according to the complaint Home Health Hotline investigation procedures.

Participants in the LTHHCP waiver, family members or responsible others may contact the Home Health Hotline by means of a toll free number to express concerns or file a complaint regarding the quality of the participant’s care, freedom of choice, service provision or other complaint related to home care services. LTHHCPs are required to provide clients, in writing, the telephone number of the hotline and the hours of operation at the start of care.

All complaints through the Home Health Hotline are investigated and prioritized by DOH to ensure patients are offered adequate and safe quality care. Complaints may be referred to an appropriate DOH office, Local Department of Social Services (LDSS), LTHHCP waiver management staff, Office of the Medicaid Inspector General, Adult Protective or Child Protective Services, or other appropriate State agencies for further investigation and resolution. Any complaint received by the Hotline or brought to the attention of DOH by any means that indicates potential abuse or neglect is a high priority and is investigated immediately.

Participants in the LTHHCP waiver, family members or responsible others may also contact the LDSS in the county where the participant resides when concerns or questions arise regarding their LTHHCP waiver services. The LDSS staff may call the Home Health Hotline when significant concerns arise related to the care and services provided to waiver participants by the LTHHCP.

Filing a complaint through the Home Health Hotline is not a prerequisite to nor a substitute for a LTHHCP participant to request a conference or to request a Fair Hearing when the participant is not in agreement with a decision made regarding participation in the waiver or services denied, reduced or discontinued.
Attachment 28

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 28

Medicaid Waiver Related Quality Activities
Complaint Intake Related to Nursing Home Transition and Diversion Waiver

There is no specific procedure associated with complaint intake for NHTD waivers. Contractor staff receiving complaints related to NHTD waiver services will use the TBI complaint intake procedures described in Attachment 29 below.
Attachment 29

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 29
Medicaid Waiver Related Quality Activities
Complaint Intake Related to Traumatic Brain Injury Waiver

TBI Medicaid Waiver Complaint Line Protocol
The current TBI Waiver Program compliant hotline contractor, the Brain Injury Association of NYS (BIA), uses the following protocol. Staff are working with Becky Gray to develop a coordinated/centralized process for similar MA community based services.

1. BIA receives the complaint.

2. BIA emails the complaint to DOH TBI Waiver Program on a filled out a standard complaint record form.

3. DOH forwards the complaint form to the respective Regional Resource Development Specialists (RRDS).

4. The RRDS contacts the participant immediately to inform the participant that a complaint has been received.

5. Within two working days, the RRDS notifies DOH that contact with the participant has been made, as well as a status update of the investigation process.

6. The RRDS investigates the complaint.

7. The RRDS will email the resolution to DOH within thirty days. If the complaint cannot be resolved within thirty days, please notify DOH that the complaint remains open and the expected resolution timeframe. (The investigation process and resolution is noted on the form itself.)

8. DOH checks the appropriate outcome on the complaint form and emails the form to BIA.
Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 30**
Nursing Home Quality Activities
Federal Standard Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 31

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 31**
Nursing Home Quality Activities
Extended Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 32

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 32
Nursing Home Quality Activities
Staggered Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 33

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 33**
Nursing Home Quality Activities
On-site Complaint Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 34

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 34**
Nursing Home Quality Activities
Partial Extended Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 35

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 35**
Nursing Home Quality Activities
Off-site Complaint Investigation

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 36

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 36
Nursing Home Quality Activities
Federal Initial Survey

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 37

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 37
Nursing Home Quality Activities
Federal Revisit -- Health

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 38

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 38
Nursing Home Quality Activities
Federal Revisit - Complaint

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 39

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 39
Nursing Home Quality Activities
State Monitoring Visit

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 40

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 40
Nursing Home Quality Activities
Federal Revisit -- Life Safety Code

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 41

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 41
Nursing Home Quality Activities
Complaint Intake

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 42

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 42**
Nursing Home Quality Activities
Informal Dispute Resolution

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 43

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 43**
Nursing Home Quality Activities
Random Quality Assurance Audits

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 44

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 44**
Nursing Home Quality Activities
Enforcements

CMS State Operations Manual

CMS State Operations Manual, Appendix P

CMS State Operations Manual, Appendix PP

CMS State Operations Manual, Appendix Q

CMS State Operations Manual, Appendix R.
Attachment 45

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 45
Diagnostic and Treatment Center Quality Activities
D&TC Survey

ASPEN ACO Training Guide
ASPEN CENTRAL OFFICE
TRAINING GUIDE

Prepared for New York State Department of Health
Hospital Program Regional Office Training

QTSO Help Desk (888) 477-7876
Version 3
August 2007
This manual is designed to explain the processing of Federal certification kits, including upload to the OSCAR/ODIE system, as well as processing of State (Article 28) surveys.

The manual provides step by step instructions for processing certification kits and State surveys in ACO. Complaints, whether State complaints or Federal allegations, are to be processed in ACTS, as described in detail in the ACTS training manual.

The most recent versions of the ASPEN Central Office Reference Guide and the ASPEN Certification Procedures Guide provide more detailed presentations of the certification process and should be maintained at each site of the Regional Office, as additional reference tools.
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FACILITY INFORMATION

Locating the Facility

Filters

Be sure an appropriate filter is selected for the type of facility you are trying to locate. There are two major filter categories for Hospital Program facilities: (1) hospitals and (2) diagnostic and treatment centers. Hospital filters are specific to acute care facilities. Diagnostic and treatment center filters include ESRDs, RHCS, ASCs, CORFs, OPTs, and diagnostic and treatment centers certified under Article 28 of the Public Health Law with no federal designation.

There are several pre-defined system filters for hospitals and diagnostic and treatment centers, which include regional filters by these two major categories.

In order to identify the currently selected filter, click the plus sign next to “My Selections.” The selected filter is checked in green. The active filter selection is also noted in the blue bar at the top of the screen (a), as well as in the drop down box under “ACO Selection” (b).

To change the filter, highlight the desired filter, right click for a menu and select “Activate” and press F5 to refresh (c).
You may also change the filter by selecting a new filter from the drop down box under “ACO Selection.”

Creating Personal Filters for Your ACO Access

You may create your own filter by right clicking on “My Selections” and left clicking “New Selection.”

Select the appropriate categories under the “Facility Type” Tab, “Office/Location” Tab, and “Operation Status” Tab. Place a check mark in the “Activate Box” in each tab to enable the selection process.
In the “Facility Type” Tab, check the activate box and highlight the appropriate facility type(s).

In the “Office/Location” Tab, check the activate box and highlight the appropriate office(s).
In the “Operation Status” Tab, check the activate box and highlight:

00 – Pending, 01 – Active, 20 – Conditional OPS:

![Image of the interface with filters highlighted]

**Note:** Be sure to name your filter. This filter selection will be specific to your access in ACO.

As noted on page 1-1, a filter is activated by right clicking on the filter you wish to apply, left clicking “Activate,” and then hitting the F5 button on your keyboard to refresh the screen. You may also change your filter from the drop down box under "ACO Selection."
Selecting the Facility

In the alphabetical tree view (Alpha Tab), locate the facility by expanding (left click once on the plus sign) the appropriate group of letters under which the facility should be located.

When completing a survey for a chronic dialysis unit located in a hospital setting, be sure to select the ESRD unit facility, not the hospital. The correctness of the selection can be verified by ensuring that the facility selected has the Medicare provider number for the ESRD unit, not the hospital.
If the facility is not listed under the name you are referencing, you may search for the facility by clicking on the binoculars at the top of the tree view and searching for the facility by a variety of search criteria, such as provider number, portion of its name or address.

Once you determine by which item to search, be sure to select that criteria in the “Type” category that corresponds to your search (i.e. facility name, Medicare number, address, etc.). Click the “Find Now” button.

You can access the facility by double clicking on the facility in the “Search Results” Box.
Creating a Facility

Facilities will be entered and updated by Central Office staff in the Division of Primary and Acute Care Services.

Existing facilities should be listed in the ACO directory. If you identify an existing facility not listed in ACO, contact the Division of Primary and Acute Care Services, directly (518 402-1004).

New facilities should be listed in the ACO directory prior to the time frame for accomplishing the initial survey. If a facility is not listed prior to the initiation of the initial survey activities, contact the Division of Primary and Acute Care Services directly.

Updating Facility Information

Facility information in the ACO directory will be updated by staff in the Division of Primary and Acute Care Services.

Revisions requiring Certificate of Need approval, or other Department of Health authorization, will be processed by the Division of Primary and Acute Care Services through direct notification from the Project Management Unit.

Area Office staff are responsible for notifying the Division of Primary and Acute Care Services of revisions in facility administrative information by submitting the form entitled “Facility Administrative Information Update.”

(See Form: Facility Administrative Information Update on page 1 - 8)

Each area office should designate specific staff or a specific unit for transmitting updated information forms to the Division of Primary and Acute Care Services.
FACILITY ADMINISTRATIVE INFORMATION UPDATE

FACILITY NAME:


FACILITY ADDRESS:


OPERATING CERTIFICATE NUMBER: ______________________

PROVIDER NUMBER: _____________ PFI NUMBER: ________________

REVISIONS:

REVISED PHONE NUMBERS: Phone ______________ Fax ____________

ADMINISTRATIVE INFORMATION (Administrator, Medical Director, Board Chairman):

<table>
<thead>
<tr>
<th>Title</th>
<th>Previous Person</th>
<th>Revised Person</th>
<th>Effective Date</th>
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<tbody>
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ACO Hospital Training Manual 1 - 8 Version 3 August 2007
Facility Closure

If a facility closes, the Area Office is responsible for submitting the appropriate paperwork to the Division of Project Management for termination of the State Operating Certificate.

If the facility has an assigned federal Medicare provider number, the Area Office is also responsible for submitting to the Division of Primary and Acute Care Services, the following documentation:

- Certification and Transmittal Form 1539 (C&T)
- Copy of the letter accepting the facility closure plan issued by the Director of the Office of Health Systems Management.

Create the 1539 in ACO, even though there is no survey event.

- Right click on the facility name to see a menu. Select “Forms” and then select “CMS C&T 1539.”
This screen will appear.

Select the “Add New” Button.

This screen will appear with four tabs. Complete the information on each tab, following the directions provided in Addendum Eight of this manual.

Screen shots for the remaining three (3) tabs are presented on the following pages.
In the Remarks Section, be sure to make a notation as to the facility closure.
The Division will file this information with CMS to effectuate closure of the provider number in ACO and in the National Data Base.
SURVEY PROCESS

**Federal Certification Kits**

Facility Types:
- End Stage Renal Disease Center (ESRD)
- Rural Health Clinic (RHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Outpatient Physical Therapy/Speech Therapy Service (OPT)

These Survey Kits Require Health Survey Shell Only (No Life Safety Survey Event)

**Step One:** Locate the Facility  (See Section One)

**Step Two:** Initiate the Certification Kit

**Creating the Certification Kit**

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:

<table>
<thead>
<tr>
<th>Create Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Facility...</td>
</tr>
<tr>
<td>Facility Properties...</td>
</tr>
<tr>
<td>Change Facility Type...</td>
</tr>
<tr>
<td>Facility History</td>
</tr>
<tr>
<td>Forms...</td>
</tr>
<tr>
<td>Print Letters...</td>
</tr>
<tr>
<td>Send To</td>
</tr>
<tr>
<td>Facility Login...</td>
</tr>
<tr>
<td>Quick Report</td>
</tr>
</tbody>
</table>

2) Select **Create Certification** from the pop-up menu.

The Certification window appears with the Certification & Surveys page displayed (see example on the following page). The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.

**NOTE:** For existing facilities, the kit will open as a recertification kit. For new facilities, the kit will open as an initial certification kit.
The Certification Kit consists of five (5) sections:

Certifications and Surveys, Tracking, Transmittal (1539), Application, and Upload.

As specified in the Federal Training Manual:

The red check mark on the tabs of the Transmittal (CMS-1539) and Application (CMS 1856/1893E for OPT, CMS 3427 for ESRD, CMS 29/30E for RHC, and CMS 359 for CORF) pages of a new certification kit indicate that these forms are **not** ready for transmittal to ODIE. CMS 1539 edits are being applied as you complete the forms. Once you supply all required information and exit the form, the check marks will change to **green**. ASPEN will advise you of missing information whenever you exit an incomplete form. You can temporarily override these messages while working in the kit. The certification kit cannot be transmitted to ODIE until all required information has been provided and the forms completed.
3) To create and manage certification surveys, scroll to the **Survey List** section in the middle of the Certification & Surveys window by using the scroll bar on the right of the computer screen.

The following descriptions of the survey section buttons is provided from the Federal Training Manual:

*Here is a description of the buttons located in the Survey List section:*
  - **The New button** allows you to create new surveys.
  - **The Update button** allows you to update a survey that already has been defined.
  - **The Remove button** will send the survey you selected to the Recycle Bin.
  - **The Citations Mgr button** takes you to the Citation Manager window for a specified survey.
  - **The Survey Forms button** allows you to print or view the forms for the specified survey.
  - **The Update 670 button** allows you to enter the 670 hours for the survey.
  - **The Create Revisit button** allows you to create a revisit survey for a specified survey.
4) To create the survey shell in either an initial or recertification kit, select the **New** button. For ESRD, OPT, CORF, RHC facility types, for which a separate life safety survey event is not required, the Initial Survey Type window appears with Health Survey selected. (The Life Safety Survey category will be grayed out.) Click the “OK” Button.

5) The **Create Health Survey** window below appears. Enter the expected Start and Exit dates for the survey event. Then enter required information for each of the four (4) sections.

**Regulations:**
Select the appropriate state and federal regulation sets (including state structural regulations).

**Type of Survey:**
For initial survey kits select “E-Initial Certification.”

For recertification survey kits select “I-Recertification” for the Federal aspects of the survey and “K-State Licensure” and “2-ReLicensure” for the State aspects of the survey.
Team Roster:
Select the team members using the “Update” button.

Extent(s):
“A-Routine/Std Survey” will automatically be selected.

6) Select **OK**. The Survey window appears asking if you want to proceed to Citation Manager. Select **No**.

7) Select **Done** on the Certification window. The Certification window closes saving the certification information and returning to the main ACO window.

8) Notify survey team of Event ID.

*If you will be exporting the survey shell to ASE, see the instructions provided as Addendum Five (pages 5-21 through 5-26) of this training manual.*
Step Three: Conduct On-Site Activities.

Process Survey Information through Citation Manager

You are able to access Citation Manager in any of three (3) methods.

(1) Locate your survey through the Certification Kit. Right click to get a menu.

Left click on Certification Kit. Highlight the survey event in the Survey List section, click on the “Citation Manager” Button.
Or locate your survey on the Alpha Tree by (2) right clicking the survey under the certification kit or (3) on the survey under “Surveys” on the facility tree. Left click “Citation Manager.”

Process the citations in Citation Manager. **When selecting a tag reflecting a violation of a state regulation, be sure to select “K State Licensure” and “2-Re-Licensure” (or “K State Licensure” and “1-Initial Licensure” for initial certification kits) on the “Citation Properties” Page. When selecting a tag reflecting a violation of a federal regulation, be sure to select “I-Recertification” (or “E-Initial Certification”) for Federal tags in Citation Properties.**

*The CMS release box is to be checked when condition-level violations are identified during survey.*
**Step Four**: Issue Statement of Deficiencies (2567)  
Record SOD Issuance Date on the Survey Properties Form

You are able to access the Survey Properties Form in any one of the same three (3) methods noted above (Step Three) for accessing Citation Manager.

Record the date the SOD was issued to the facility. Post revisit status.

Revisit Status Options:

- 0 - Not Determined
- 1 - Required
- 2 - Not Required

**Note**: If there are no deficiencies identified, a 2567 is to be issued to the facility stating the facility is complaint with Conditions of Participation. The 2567 issuance date is posted in the “SOD Sent” date field.

**Step Five**: Process the Plan of Correction/Update Plan of Correction Information

- Record POC receipt date and Facility Administrator Signoff (X6) in the Survey Properties Form.

You are able to access the Survey Properties Form in any one of the same three (3) methods noted in Step Three for accessing Citation Manager.

**Note**: If no Plan of Correction is required, the first page of the 2567 is to be signed and dated by the facility administrator and returned to the regional office. The date of the administrator’s sign off is to be posted in “Adm Signoff (X6)” date field.
Record Plan of Correction information for each citation in **Citation Manager**.

You are able to access Citation Manager in any one of the same three (3) methods noted in Step Three.

In Citation Manager, right click on each citation to see a menu.

Left click on “Citation Properties.” Record POC received date, Facility Completion date (X5) and SA Accepted date for each citation.

Note: The SA POC Accepted date is the date of the Department’s written notification to the facility of acceptance of the PoC. It is not the date of the surveyor approval of the material submitted for that tag.
Record the Status Plan of Correction

Access the Status Plan of Correction Form by selecting the POC button next to the appropriate survey event in the Track column in the Survey List Section of the Certifications & Surveys Tab.

This screen will appear. Complete the information for each category and record applicable notes in the “POC Notes” section.

POC Notes should include but not be limited to:

- Documentation of communication with the facility indicating efforts to work with the them to get an acceptable PoC.
- Documentation of communication with CMS.
Step Six: Complete the 670

*Be sure to process the office hours (supervisory and clerical).*

See page 2-3 (description of buttons) to locate the access button for the 670 Form through the Certification Kit.

Note: Appropriate portions of the 670 should be completed by participating surveyors at various stages throughout the survey process.

Step Seven: Complete the Transmittal (CMS 1539)

- In the Certification Kit, select the Transmittal (CMS-1539) tab. Enter data.

You can tab through this screen or use the scroll bar located on the right side of the window to navigate through the form.

Yellow boxed fields are required fields for data entry.

*If a facility is determined to be in compliance, note if a Plan of Correction was required (darken 1 – ACCEPTABLE POC) to meet compliance standards.*

If condition-level non-compliance is identified, select “B Not in Compliance.” This selection is not to be changed if the facility comes into full compliance with Conditions of Participation as a result of revisit survey activities.
Even though the “Remarks” field at the bottom of the form is not yellow, appropriate narrative information is to be recorded. Since Section 10 is not to be revised subsequent to the entry for the initial survey event, revisit notices should be posted in the “Remarks” section.

Once you supply all required information and exit the form, the check marks on the tabs will change to green.

**Step Eight: Enter Information on the Application Tab**

The Application Form will vary by the type of provider.

Once you supply all required information and exit the form, the check marks on the tabs will change to **green**.

Application form information and directions presented on pages 2 - 13 through 2 - 21 are provided from applicable Federal Training Manuals and Certification Guides.
Enter CMS-1856/1893E Data - OPT/SP

Enter application information for Outpatient Physical Therapy/Speech Pathology services on the App/CDE (CMS-1856/1893E) tab of the Certification window.
1. Click the App/CDE (CMS-1856/1893E) tab in the Certification window.

2. In the Request for Certification section (CMS-1856 fields), enter information about the provider.
   
   - Request to Establish Eligibility In (R22) - select the program for which the provider is applying.
   - Services Provided (R18) – Select the appropriate option from the drop-down list.
   - Type of Organization (R9) – Select the option that best characterizes the organization that provides the OPT/SP services. If 01 Hospital, 02 Skilled Nursing Facility, or 03 Home Health Agency, also complete R12.
   - Related Provider Number (R12) - Enabled only if you select 01, 02, or 03 for R9. Either type in the related provider’s Medicare number, or use to locate the related provider and insert the number.
   - Type of Control (R10) – select the type of entity operating the facility.
   - Number of Qualified Personnel (FTE) - enter number of Physical Therapists (R14, R15) and Speech Pathologists (R20, R21) as applicable. ASPEN calculates the totals (R13, R19).

3. In the CDE - 1893E section, indicate if occupational therapy services are offered.
   
   - Does the facility provide outpatient occupational therapy services? (I172) - Yes or No.
   - Total number of qualified occupational therapists (I173) - enter a number if I172 is Yes.

4. Click at the bottom of the window to print the CMS-1856 and 1893E forms. They are printed separately.
Enter CMS-3427 Data ESRD

Enter application information for End Stage Renal Disease facilities on the Application (CMS-3427) tab of the Certification window.
1. Click the Application (CMS-3427) tab in the Certification window.

2. In Part I, enter information about the provider.

   - Authorized Official - enter Name, Address, and Phone No of an individual responsible for the management of the facility.
   - Type of Application/Notification (V1) – select all categories that apply. Add details in the Remarks section at the end of Part I.
   - Ownership (V2) – select the category that best describes the entity that owns the facility.
   - Is this Facility Hospital-Based? (V3) – select the check box if yes, and complete V4.
   - Provider Number (V4) – either type in the hospital’s Medicare provider number, or use to locate the hospital and insert the number.
   - Is this Facility SNF-Based? (V5) - select the check box if yes, and complete V6.
   - Provider Number (V6) – either type in the SNF’s Medicare number, or use to locate the SNF and insert the number.
   - Is this facility owned and/or managed by a Multi-facility Organization? (V7) - select the check box if yes, and complete V8.
   - If Yes, name and address of parent organization (V8) - enter the Name and Address of the multi-facility organization that owns the ESRD.
   - Services Provided (V9) – select all services that the ESRD provides. Add details in the Remarks section at the end of Part I.
   - Is Reuse Practiced? (V10) - select if yes and complete V11 and V12.
   - Reuse system (V11), Germicide (V12) - select all that apply.
   - Number of Dialysis Patients (V13-15), Number of Stations (V16-18) – enter Patients numbers (V14, V15) and Stations numbers (V17, V18) as applicable. ASPEN calculates the totals (V13, V16).
   - Does this facility have Isolation Stations? (V19) – select if yes.
• Patients - enter the number of patients treated by shift.
• Total Patients Followed at Home (V20) - enter the number of home patients.
• Staffing (FTE) – enter the number of personnel for each applicable category (V21-V26).
• Remarks - enter explanatory information as needed for Part I items

3. **Complete the items in Part II.**

• Network Number (V27) – enter the number of the Network to which the ESRD is assigned.
• Type of Survey (V30), Survey Protocol (V31) - select the applicable option(s) for each.

4. Click at the bottom of the window to print the CMS-3427 form.
Enter CMS-29/30E Data - RHC

Enter application information for Rural Health Clinics on the App/CDE (CMS-29/30E) tab of the Certification window.

1. Click the App/CDE (CMS-29/30E) tab in the Certification window.
2. In the Request to Establish Eligibility section (CMS-29 fields), enter information about the provider.
• Medical Direction – enter Name(s) and Address(es) of the physician(s) who provide medical direction for the clinic.

• Clinic Personnel (FTE) – enter the number of personnel for each applicable category (RH6-RH9).

• Type of Control (RH10) – select the type of entity operating the facility.

• If … part of an existing Medicare provider indicate the provider number (RH11) - either type in the provider’s Medicare number, or use to locate the provider and insert the number.

• Is this clinic site receiving support from a Federal program to provide health services in a medically underserved area or in an area with a shortage of primary care health providers? (RH12) - Yes or No. If Yes, complete RH13.

• Title of Federal Program (RH13) - Select the applicable program from the drop-down list.

• Is this clinic participating in the Physician Extender Experiment Program (F14) - Yes or No.

3. In the CDE - 30E section, enter Staff numbers.

If you enter an FTE value for RH7 and/or RH8 in CMS-29, you must also enter a value in the Staff section (30E) for at least one of the fields J43 1-3 and/or at least one of the fields (J44 1-3) respectively.

4. Click at the bottom of the window to print the CMS-29 and 30E forms. They are printed separately.
Enter CMS-359 Data - CORF

Enter application information for Comprehensive Outpatient Rehabilitation Facilities on the Application (CMS-359) tab of the Certification window.

1. Click the Application (CMS-359) tab in the Certification window.

2. Provide Eligibility information.
   - Request to Establish Eligibility In (RD05) - select the program for which the provider is applying from the drop-down.
   - Related Provider Number (RD06) - enter if the facility contains more than one distinct provider. Either type in the related provider’s Medicare number, or use Find Facility to locate the related provider and insert the number.
3. **Enter Control information.**
   - Type of Control (RD07) – select the type of entity operating the facility.
   - Does your organization currently participate in Medicare as a provider of Outpatient Physical Therapy/Speech Pathology (e.g., Rehabilitation Agency)? (RD08) – Yes or No. If Yes, complete RD09.
   - If yes, list Provider Number (RD09) - either type in the provider’s Medicare number, or use [Find Facility](#) to locate the provider and insert the number.

4. **In the Services Provided (RD10) grid, select the check box in the appropriate column(s) to indicate which services are provided and by whom.**

   Click [Print](#) at the bottom of the window to print the CMS-359 form.
Step Nine: Upload the Certification Kit to the National Database

When an acceptable Plan of Correction has been received, with notification issued to the facility, and all information has been provided and forms completed for the certification kit, submit the certification kit to the National (OSCAR/ODIE) system.

Select the Upload tab. The following window appears.

To transmit the current certification kit, select the Prevalidate and Upload button.

A confirmation message appears. Select Yes.
The upload activity will be presented on the screen as noted below.

If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.
Correct the errors and upload the kit again. The upload transaction will be in Pending Status (with a yellow stoplight). This means the kit will be uploaded to the ODIE system overnight.

NOTE:

- **Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.**

- **An upload is to be accomplished following the completion of each survey event (after receipt of an acceptable PoC) and PRIOR to a required revisit.**

If the certification kit is complete (no revisit is indicated):

**PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.**

**FOR INITIAL CERTIFICATION KITS, TRANSMIT APPROPRIATE DOCUMENTATION (C&T 1539 and signed Application Form) TO THE DIVISION OF PRIMARY AND ACUTE CARE SERVICES.**
Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5-33 through 5-36.) When it is verified the Certification Kit has been uploaded and it is determined that no revisit or further activity is indicated, return to the **Certification and Surveys** tab and post the status to “CLOSED.”

On the **Tracking** tab, change the Tracking Status to “10 Processing Complete.”

Select **Done** to save the information and close the Certification window.
RE-VISIT ACTIVITIES

If a condition-level situation was identified during survey, the re-visit survey event is to be created following successful upload of the kit with the first survey event.

- To create a re-visit, access the Certification Kit in the facility tree.
- Scroll to the Survey List section of the Certification & Surveys Tab.
- Highlight the survey and click the “Create Re-visit” Button.

This screen will appear:

Post the dates of the re-visit survey.

SELECT THE “OK” BUTTON WITHOUT REMOVING ANY OF THE SURVEYORS FROM THE ORIGINAL SURVEY TEAM!!! YOU MAY ADD MEMBERS TO THE TEAM BUT DO NOT REMOVE ANY TEAM MEMBERS.
The revisit event ID will be added to the listing of survey events and will carry the same event ID number except it will have a number 2 at the end.

You may also add members to the team at this point (if not done at the time the revisit event ID was created) who will be participating in the re-visit survey, if they did not participate in the original survey. Selecting the “Update” Button will bring you to the Survey Properties Form to make necessary modifications.

**DO NOT REMOVE ANY SURVEYORS FROM THE TEAM, EVEN IF THEY WILL NOT BE PARTICIPATING IN THE RE-VISIT SURVEY. REMOVING THEIR NAMES WILL REMOVE ANY CITATIONS THEY HAVE POSTED IN CITATION MANAGER FOR THE FIRST EVENT.**

**SURVEYORS WHO ARE ON THE LIST BECAUSE OF BEING A MEMBER OF THE TEAM FOR THE FIRST VISIT BUT DO NOT PARTICPATE IN THE RE-VISIT SURVEY ARE TO BE NOTED AS NOT PARTICIPATING IN THE RE-VISIT BY UNCHECKING THEIR NAMES ON THE 670 FORM FOR THE RE-VISIT SURVEY EVENT.**
After returning from the re-visit survey:

1. Create citations, if indicated, through Citation Manager for the revisit survey through the same procedures as for the initial survey. Be sure to process the revisit information in the revisit survey shell event.

2. Post Correction Dates:

Acceptable implementation of the Plan of Correction for one or more of the citations associated with the survey is to be posted as corrected through the revisit survey.

To enter or change citation correction dates:

Access the revisit survey event by expanding the facility in the Alpha Tab, locating the revisit survey event either through the Certification Kit or in the listing of surveys under "Surveys."

From the Facility Tree:
Expand the revisit survey event, right click a citation listed under the revisit survey to see a menu. Select “Correction Dates.”
From Citation Manager in the Certification Kit (Recommended Procedure): Access the revisit survey event in the Certification Kit, by expanding the facility in the Alpha Tab, right clicking on the Kit to see a menu and clicking on “Certification Kit.”

In the Certification & Surveys Tab, scroll to the Surveys section and select the revisit survey event. Click on the “Citation Manager” button.

In “Citation Manager” select the citation, and right click to get a menu. Select “Correction Dates.”

Post the date citations were noted as being corrected through implementation of the Plan of Correction, as follows:

Select Selected Citation to specify the date for the selected citation only, select Selected Reg Set to specify the date for all citations related to the selected regulation set, or select All Citations to specify the correction date for all the citations associated with the survey.
The Correction Date window appears.

![Correction Date Window](image)

Enter or select a Citation Correction Date from the drop down arrow and click OK.

3. Finalize Survey Activities

After entering correction dates as noted above, complete the process for follow-up surveys (revisits) in the same manner as for the first survey, updating the Remarks Section of the 1539.

- If a Statement of Deficiencies is issued, follow the steps for issuing and posting the Statement of Deficiencies and Plan of Correction information. Complete 670 information for the revisit event, update the Remarks Section of the 1539 and complete the final upload.

- If no deficiencies are identified, issue the 2567 noting the facility is fully compliant with Conditions of Participation. Include a copy of the 2567B. Be sure the facility returns the first sheet of the 2567 signed by the administrator. Post the X6 date on the Survey Properties Form, complete 670 information for the revisit event, update the Remarks Section of the 1539 and complete the final upload.
Upload and Close the Certification Kit

When the Administrative Sign Off (X6) has been received or a Plan of Correction accepted (if applicable), with notification issued to the facility, and all information has been provided and forms completed for the certification kit, submit the certification kit to the National (OSCAR/ODIE) system.

Select the Upload tab. The following window appears.

To transmit the current certification kit, select the Prevalidate and Upload button.

A confirmation message appears. Select Yes.
The upload activity will be presented on the screen as noted below.

If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.
Correct the errors and upload the kit again. The upload transaction will be in Pending Status (with a yellow stoplight). This means the kit will be uploaded to the ODIE system overnight.

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- **Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded.** This will save time instead of having to wait overnight to send up another transaction the next day. **Only the person that sent the Pending Transaction can delete the Pending Transaction.**

- **An upload is to be accomplished following the completion of each survey event (after receipt of an acceptable PoC) and PRIOR to an additional revisit, if required.**

PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.

FOR INITIAL CERTIFICATION KITS, TRANSMIT APPROPRIATE DOCUMENTATION (C&T 1539 and signed Application Form) TO THE DIVISION OF PRIMARY AND ACUTE CARE SERVICES.
Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5-33 through 5-36.)

When it is verified the Certification Kit has been uploaded and it is determined that no revisit or further activity is indicated, return to the **Certification and Surveys** tab and post the status to “CLOSED.”

On the **Tracking** tab, change the Tracking Status to “10 Processing Complete.”

Select **Done** to save the information and close the Certification window.
SURVEY PROCESS

Federal Certification Kits

Facility Types: Hospitals and Ambulatory Surgery Centers

Certification kits for hospital and ambulatory surgery center federal survey activities have basically the same format as federal survey kits for other facility types (described in Section Two of this manual). Most of these surveys, however, require a life safety survey event, in addition to the health survey event.

Each kit will have the same five (5) tabs:

Certification & Surveys, Tracking, Transmittal (CMS 1539), Application, and Upload

Consistent with kits for other facility types and as specified in the Federal Training Manual:

The red check mark on the Transmittal (CMS-1539) tab and the Application Worksheet tab of a new certification kit indicate that these forms are not ready for transmittal to ODIE. Once you supply all required information and exit the form, the check marks will change to green. ASPEN will advise you of missing information whenever you exit an incomplete form. You can temporarily override these messages while working in the kit. The certification kit cannot be transmitted to ODIE until all required information has been provided and the forms completed.
Application Form for Ambulatory Surgery Centers

Application information for Ambulatory Surgical Centers (ASC) is to be entered on the Application (CMS-377/378E) tab of the Certification window.

1. Click the Application (CMS-377/378E) tab in the Certification window.

2. Provide Control information.
   - If the provider is not a free-standing facility, enter the related 6-digit Medicare Provider Number (AS2) or use the Find Facility button to locate and insert the number.
   - Type of Control (AS7) – select the type of entity operating the provider.

3. Provide Ancillary Services Information (AS8) – Select the applicable method of providing Laboratory, Radiology, EKG, and Pharmacy services.

4. Surgical Specialties (AS9) – select Yes or No for each specialty that is provided. If you select Yes in box 13 Other, specify the specialty in the next box.

5. Facility Characteristics
   - Number of Operating Rooms (AS10) – enter the number of operating rooms.
   - Date Center Began Providing Services (AS11) – enter the date.
Application Worksheet for Hospitals

For hospitals, the application form is the Worksheet that replaced the CMS 1514. The form looks like this in the kit.

The hard copy of the form is presented on the four (4) following pages and in Addendum Seven of this manual:
HOSPITAL/CAH MEDICARE DATABASE WORKSHEET
Worksheet completed by the SA surveyor to gather data, not to be given to provider to fill out

Medicare Provider Number:___________________ Date Updated: ____________________
Medicaid Provider Number:__________________ (MMDDYYYY) (M1)
Fiscal Year Ending Date (MMDD): _____________
Name and Address of Facility (Include County, City, State):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________ Zip Code:_____
Telephone Number (M2):_____________________
Fax Number (M3): ______________________
Accreditation Status:____ Effective Date of Accreditation: __________________________
  0 Not Accredited (MMDDYYYY) (M4)
  1 JCAHO Accredited Expiration Date of Accreditation:__________________________
  2 AOA Accredited (MMDDYYYY) (M5)
  4 Both
State/County Code (M6):_________   CLIA ID Numbers (M9):_____________________
State Region Code (M7):__________ ________________________________
Request to Establish Eligibility In (M8):_____ _________________________________
  1 Medicare ______________________ 
  2 Medicaid ______________________
  3 Both __________________________
Type of Hospital or a Critical Access Hospital (CAH) (select 1)  (M10):____
  01 Short-term ______________________
  02 Long-term ______________________
  03 Religious Non-medical Health Care Institution ______________________
  04 Psychiatric _____________________
  05 Rehabilitation __________________
  06 Childrens ______________________
  07 Distinct Part Psychiatric Hospital __________________________
  11 CAH ________________________
Affiliation with a Medical School
(M11):_____
01 Major 03 Graduate School
02 Limited 04 No Affiliation
Type of Control (select 1) (M13):_____
01 Church 06 State
02 Private 07 Local
04 Proprietary 08 Hospital District or Authority
05 Federal 03 Other (specify)
Average Daily Census (M14):_____
Type of System Involvement (M16):_____
01 None
02 System Ownership
03 System Management
04 Both System Owned and Managed
Name of System (M17):__________________
Corporate Headquarters City (M18):__________________ State (M19):_____

<table>
<thead>
<tr>
<th>Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalents FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M20 Physicians (Salaried only)</td>
</tr>
<tr>
<td>M21 Physicians - Residents</td>
</tr>
<tr>
<td>M22 Physician Assistants (PA)</td>
</tr>
<tr>
<td>M23 Nurses - CRNA</td>
</tr>
<tr>
<td>M24 Nurses - Practitioners</td>
</tr>
<tr>
<td>M25 Nurses - Registered</td>
</tr>
<tr>
<td>M26 Nurses - LPN</td>
</tr>
<tr>
<td>M27 Dieticians</td>
</tr>
<tr>
<td>M28 Medical Social Workers</td>
</tr>
<tr>
<td>M29 Medical Laboratory Technicians</td>
</tr>
</tbody>
</table>

Type of Reimbursement or Status Categories of a Hospital or a CAH (select all that apply) (M40):_____
01 CAH Psychiatric DPU 07 Hospital PPS Excluded Psych Unit
02 CAH Rehabilitation DPU 08 Hospital PPS Excluded Rehab Unit
03 CAH Swing Beds 09 Hospital Swing Beds
04 Cancer Hospital 10 Medicare Dependent Hospital
05 Hospital in a Hospital - Host 11 Regional Referral Center
06 Hospital in a Hospital - Tenant 12 Sole Community Hospital
**Services Provided by the Facility (M41):**

1. Services provided by facility staff
2. Services provided by arrangement or agreement
3. Services provided through a combination of facility staff and through agreement

Leave blank if the services are not provided

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services (Owned)</td>
<td>01</td>
</tr>
<tr>
<td>Alcohol and/or Drug Services</td>
<td>02</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>03</td>
</tr>
<tr>
<td>Audiology</td>
<td>04</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>05</td>
</tr>
<tr>
<td>Burn Care Unit</td>
<td>06</td>
</tr>
<tr>
<td>Cardiac Catheterization Laboratory</td>
<td>07</td>
</tr>
<tr>
<td>Cardiac-Thoracic Surgery</td>
<td>08</td>
</tr>
<tr>
<td>Chemotherapy Service</td>
<td>09</td>
</tr>
<tr>
<td>Chiropractic Service</td>
<td>10</td>
</tr>
<tr>
<td>CT Scanner</td>
<td>11</td>
</tr>
<tr>
<td>Dental Service</td>
<td>12</td>
</tr>
<tr>
<td>Dietetic Service</td>
<td>13</td>
</tr>
<tr>
<td>Emergency Department (Dedicated)</td>
<td>14</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>15</td>
</tr>
<tr>
<td>Extracorporeal Shock Wave Lithotripter</td>
<td>16</td>
</tr>
<tr>
<td>Gerontological Specialty Services</td>
<td>17</td>
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<tr>
<td>Home Health Services</td>
<td>18</td>
</tr>
<tr>
<td>Hospice</td>
<td>19</td>
</tr>
<tr>
<td>ICU - Cardiac (non-surgical)</td>
<td>20</td>
</tr>
<tr>
<td>ICU - Medical/Surgical</td>
<td>21</td>
</tr>
<tr>
<td>ICU - Neonatal</td>
<td>22</td>
</tr>
<tr>
<td>ICU - Pediatric</td>
<td>23</td>
</tr>
<tr>
<td>ICU - Surgical</td>
<td>24</td>
</tr>
<tr>
<td>Laboratory - Anatomical</td>
<td>25</td>
</tr>
<tr>
<td>Laboratory - Clinical</td>
<td>26</td>
</tr>
<tr>
<td>Long Term Care (swing-beds)</td>
<td>27</td>
</tr>
<tr>
<td>Magnetic Resonance Imagining (MRI)</td>
<td>28</td>
</tr>
<tr>
<td>Neonatal Nursery</td>
<td>29</td>
</tr>
<tr>
<td>Neurosurgical Services</td>
<td>30</td>
</tr>
<tr>
<td>Nuclear Medicine Services</td>
<td>31</td>
</tr>
<tr>
<td>Obstetric Service</td>
<td>32</td>
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<tr>
<td>Occupational Therapy Services</td>
<td>33</td>
</tr>
<tr>
<td>Operating Rooms</td>
<td>34</td>
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<tr>
<td>Ophthalmic Surgery</td>
<td>35</td>
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<tr>
<td>Optometric Services</td>
<td>36</td>
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<tr>
<td>Organ Bank</td>
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<tr>
<td>Organ Transplant Services</td>
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<tr>
<td>Orthopedic Surgery</td>
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<tr>
<td>Opthalmic Surgery</td>
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<tr>
<td>Optometric Services</td>
<td>41</td>
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<tr>
<td>Pharmacy</td>
<td>42</td>
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<tr>
<td>Physical Therapy Services</td>
<td>43</td>
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<tr>
<td>Positron Emission Tomography Scan</td>
<td>44</td>
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<tr>
<td>Post-Operative Recovery Rooms</td>
<td>45</td>
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<tr>
<td>Psychiatric Services - Emergency</td>
<td>46</td>
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<tr>
<td>Psychiatric - Child/Adolescent</td>
<td>47</td>
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<tr>
<td>Psychiatric - Forensic</td>
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<tr>
<td>Psychiatric - Geriatric</td>
<td>49</td>
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<tr>
<td>Psychiatric - Inpatient</td>
<td>50</td>
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<tr>
<td>Psychiatric - Outpatient</td>
<td>51</td>
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<tr>
<td>Radiology Services - Diagnostic</td>
<td>52</td>
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<tr>
<td>Radiology Services - Therapeutic</td>
<td>53</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>54</td>
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<tr>
<td>Respiratory Care Services</td>
<td>55</td>
</tr>
<tr>
<td>Rehab - Inpatient (CARF Acc)</td>
<td>56</td>
</tr>
<tr>
<td>Rehab - Inpatient (Not CARF Acc)</td>
<td>57</td>
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<tr>
<td>Rehab - Outpatient</td>
<td>58</td>
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<tr>
<td>Renal Dialysis (Acute Inpatient)</td>
<td>59</td>
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<tr>
<td>Social Services</td>
<td>60</td>
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<tr>
<td>Speech Pathology Services</td>
<td>61</td>
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<tr>
<td>Surgical Services - Inpatient</td>
<td>62</td>
</tr>
<tr>
<td>Surgical Services - Outpatient</td>
<td>63</td>
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<tr>
<td>Trauma Center (Certified)</td>
<td>64</td>
</tr>
<tr>
<td>Transplant Center, Medicare Certified</td>
<td>65</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>66</td>
</tr>
</tbody>
</table>

**Sprinkler Status, Primary Location (select 1) (M42):**

01 Totally sprinklered: All required areas are sprinklered
02 Partially sprinklered: Some but not all required areas are sprinklered
03 Sprinklers: None
Number of off-site locations with the same provider number (M43):

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Remote Locations</th>
<th></th>
<th>Satellites of a PPS Excluded Psych Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td></td>
<td>07</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Offsite Freestanding Outpatient Surgery</td>
<td>08</td>
<td>Satellites of a Long Term Care Hospital</td>
</tr>
<tr>
<td>03</td>
<td>Urgent Care Center (Freestanding)</td>
<td>09</td>
<td>Satellites of a cancer hospital</td>
</tr>
<tr>
<td>04</td>
<td>Satellites of a Rehabilitation Hospital</td>
<td>10</td>
<td>Satellites of a Childrens’ Hospital</td>
</tr>
<tr>
<td>05</td>
<td>Satellites of a Psychiatric Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Satellites of a PPS Excluded Rehab Unit</td>
<td>11</td>
<td>Other Provider-Based Locations</td>
</tr>
</tbody>
</table>

Identification Number of Off-site Location (from table) (M44): ______

Name of Off-site Location M45): ____________________________________________

Off-site Street Address (M46): ____________________________________________

County (M47) ____________________________

City (M48): ____________________________ State (M49): ______ Zip Code (M50): ______

Sprinkler Status of Off-site Location (select 1) (M51) ______

01 Totally sprinklered: All required areas are sprinklered
02 Partially sprinklered: Some but not all required areas sprinklered
03 Sprinklers: None
04 Sprinklers are not required but the location is sprinklered

Attach a List of Additional Locations:

Number of related or affiliated provider numbers (M52): ______

<table>
<thead>
<tr>
<th></th>
<th>ASC</th>
<th></th>
<th>Home Health Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td></td>
<td>06</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Co-located Hospitals</td>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>03</td>
<td>Co-located Satellites of Another Hospital</td>
<td>08</td>
<td>PRTF</td>
</tr>
<tr>
<td>04</td>
<td>ESRD</td>
<td>09</td>
<td>RHC</td>
</tr>
<tr>
<td>05</td>
<td>FQHC</td>
<td>10</td>
<td>SNF</td>
</tr>
</tbody>
</table>

Identification Number of related or affiliated provider numbers (M53): ______________

Provider Number (M54): ______________

Attach a List:

Signature of Authorized Individual: ____________________________________________

Name of Authorized Individual: ________________________________ Date: __________
The following Field/Button Descriptions for the fields on the Worksheet are provided from the ASPEN 8.5 Procedures Guide (pages 194-198):

<table>
<thead>
<tr>
<th>Field/Button</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Updated (M1)</td>
<td>Date the agency updated the worksheet with current information. For accredited providers, the Worksheet may be periodically refreshed with new information provided by the Hospital.</td>
</tr>
<tr>
<td>Effective Date of Accreditation (M4)</td>
<td>The effective date of the current accreditation period by the CMS-approved accrediting organization. Cannot be entered when Accreditation Status (L10) on the 1539 is 0 Unaccredited.</td>
</tr>
<tr>
<td>Expiration Date of Accreditation (M5)</td>
<td>The expiration date of the current period of accreditation by the CMS-approved accrediting organization. Must be entered when accreditation effective date (M4) is entered. Cannot be entered when Accreditation Status (L10) is 0 Unaccredited.</td>
</tr>
<tr>
<td>Type of Validation Survey</td>
<td>Options are: 1 Concurrent, 2 Focused, 3 Traditional. Must be entered if Type of Action (L8) on the 1539 is 5 Validation.</td>
</tr>
<tr>
<td>Request to Establish Eligibility in (M8)</td>
<td>Indicate whether the provider participates in: 1 Medicare Only, or 3 Medicare and Medicaid.</td>
</tr>
<tr>
<td>CLIA ID Numbers (M9)</td>
<td>If the Hospital laboratory (ies) participate(s) in CLIA, list all the CLIA ID numbers for each lab. Numbers must correspond to an active CLIA to upload to OSCAR, but once the kit is accepted, inactive numbers will not cause errors.</td>
</tr>
<tr>
<td>Type of Hospital or Critical Access Hospital (M10)</td>
<td>OSCAR subtype indicator code and description for the Hospital. Brought forward by ASPEN from Facility Properties.</td>
</tr>
<tr>
<td>Affiliation with a Medical School (M11)</td>
<td>The type of affiliation the Hospital has with a medical school. Options are 1 Major, 2 Limited, 3 Graduate, 4 No affiliation.</td>
</tr>
<tr>
<td>Resident Programs (M13)</td>
<td>Select Yes or No to indicate if the resident program at the Hospital is approved by the named associations: 01 AMA, 02 ADA, 03 AOA, 04 Other.</td>
</tr>
<tr>
<td>Type of Control (M13)</td>
<td>Select the type of organization that operates the Hospital. Must be 01 Voluntary Nonprofit Church when Type of Hospital (M10) is Religious Non-medical Healthcare Institution.</td>
</tr>
<tr>
<td>Average Daily Census (M14)</td>
<td>The Hospital’s Average Daily Census.</td>
</tr>
<tr>
<td>Number of Staffed Beds (M15)</td>
<td>Number of staffed beds. Cannot be greater than Total Beds (L18) on the 1539.</td>
</tr>
<tr>
<td>Type of System Involvement (M16)</td>
<td>Options are: 01 None, 02 System Ownership, 03 System Management, 04 Both System Owned and Managed.</td>
</tr>
<tr>
<td>Name of System (M17)</td>
<td>Enter the name of the system.</td>
</tr>
<tr>
<td>Corporate Headquarters City (M18)</td>
<td>Enter the name of the city where corporate headquarters is located.</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>State (M19)</td>
<td>Select the corporate headquarters state from the drop-down list.</td>
</tr>
<tr>
<td>Number of Employees Salaried by Hospital/CAH (M20-M39)</td>
<td>In the box next to each classification, enter the number of full-time equivalents (to the nearest quarter-hour) of that type employed by the provider. Under All Others (M39) include all other regularly employed personnel (medical and non-medical) that are not included in the other classifications. M23, M27, M28, M30, M31, M32, M34, M36, M37 and M38 have cross-checks with Services Provided (M41).</td>
</tr>
<tr>
<td>Type of Reimbursement or Status Categories (M40)</td>
<td>Select all that apply. At this time, the PPS fields in this section have no cross-checks with the PPS fields in the Hospital Special Fields section on the Certifications &amp; Surveys tab.</td>
</tr>
<tr>
<td>Services Provided by the Facility (M41)</td>
<td>For each type of service (01-66), indicate how it is provided. Options are: 0 Not Provided, 1 Provided by Staff, 2 Provided by Staff and Through Agreement. If the service is provided directly by the facility (includes hourly or per visit contracts), select 1. If a service is provided under arrangement with an outside resource, select 2. If a service is provided by a combination of both, select 3.</td>
</tr>
<tr>
<td>Sprinkler Status, Primary Location (M42)</td>
<td>Select the appropriate sprinkler status for the Hospital's primary location. At this time, there is no cross-check between this field and Sprinkler Status (K180) in the building record. Both this field and K180 for each building are uploaded to the national systems.</td>
</tr>
<tr>
<td>Off-site Locations</td>
<td>Services provided in a separate location that are certified under the parent provider's Medicare ID.</td>
</tr>
<tr>
<td>Number of off-site locations with the same provider number (M43)</td>
<td>Generated by ASPEN based on the number of records entered in the Off-site locations grid.</td>
</tr>
<tr>
<td>Add</td>
<td>Opens the Facility Relationship Manager, where you can add an off-site record (see &quot;Facility Relationship Manager - Off-site&quot; on page 197 of 8.5 Procedures Guide).</td>
</tr>
<tr>
<td>Modify</td>
<td>Opens the Facility Relationship Manager for the selected record, so you can make changes.</td>
</tr>
<tr>
<td>Remove</td>
<td>Removes the selected off-site location record.</td>
</tr>
<tr>
<td>Merge Existing</td>
<td>Click to open the Merge Aspen Affiliations window, where you can select from records added to the Affiliations node of the provider prior to the ASPEN 8.5 release, and merge them into the Off-site locations section.</td>
</tr>
<tr>
<td>Affiliated Providers</td>
<td>Services provided by the parent Hospital that are certified under a separate Medicare ID, e.g., an ESRD center operating within or affiliated with the Hospital.</td>
</tr>
<tr>
<td>Number of related or affiliated provider numbers (M52)</td>
<td>Generated by ASPEN based on the number of affiliations entered in the Affiliated providers grid.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><img src="image" alt="Add" /> Add</td>
<td>Opens the Facility Relationship Manager, where you can add an affiliated provider record (see &quot;Facility Relationship Manager - Affiliations&quot; on page 198 of the 8.5 Procedures Guide).</td>
</tr>
<tr>
<td><img src="image" alt="Modify" /> Modify</td>
<td>Opens the Facility Relationship Manager for the selected record, so you can make changes. However, affiliated provider records are read-only.</td>
</tr>
<tr>
<td><img src="image" alt="Remove" /> Remove</td>
<td>Removes the selected affiliated provider record.</td>
</tr>
<tr>
<td><img src="image" alt="Merge Existing" /> Merge Existing</td>
<td>Click to open the Merge Aspen Affiliations window, where you can select from records added to the Affiliations node of the provider prior to the ASPEN 8.5 release, and merge them into the Affiliated providers sections.</td>
</tr>
</tbody>
</table>

### Facility Relationship Manager - Off-site

<table>
<thead>
<tr>
<th>Relationship Type</th>
<th>For off-site locations, the only option is 01 Branch/Extension/Offsite.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/Branch ID</td>
<td>Supplied by the system.</td>
</tr>
<tr>
<td>Licensed Only?</td>
<td>Select this check box if the off-site location is subject only to state regulations.</td>
</tr>
<tr>
<td></td>
<td>▲ If you select this option, the off-site location will not be added to the Off-site locations grid on the Worksheet and it won't be uploaded. However, it will be added to the provider's Affiliations node in Tree views.</td>
</tr>
<tr>
<td>Type</td>
<td>Select the appropriate off-site location type from the drop-down list.</td>
</tr>
<tr>
<td>Name (M45)</td>
<td>Name of the off-site locations.</td>
</tr>
<tr>
<td>Location Code (M44)</td>
<td>Off-site location number. The first two positions indicate the specified Type of off-site location, the second two identify the location itself. For example, 0302 identifies the second off-site location of Type 03 added to the Provider.</td>
</tr>
<tr>
<td>Zip Code (M50)</td>
<td>Zip code of off-site location.</td>
</tr>
<tr>
<td>City (M48)</td>
<td>Off-site location city.</td>
</tr>
<tr>
<td>State (M49)</td>
<td>Postal abbreviation of off-site location state.</td>
</tr>
<tr>
<td>County (M47)</td>
<td>SSA county code of off-site location.</td>
</tr>
<tr>
<td>RO Approved</td>
<td>Not required for Hospitals.</td>
</tr>
<tr>
<td>Total Beds</td>
<td>Not required for Hospitals.</td>
</tr>
<tr>
<td>Operating Beds</td>
<td>Not required for Hospitals.</td>
</tr>
<tr>
<td>Branch Terminated</td>
<td>Effective termination date of the off-site location. This field becomes active when Termination Code (L30) on the 1539 is other than 00 Active.</td>
</tr>
<tr>
<td>Termination Code</td>
<td>If the off-site location is terminated, select the appropriate termination code.</td>
</tr>
<tr>
<td>Contact Information</td>
<td>Supply contact information for the off-site location.</td>
</tr>
</tbody>
</table>
Facility Relationship Manager - Affiliations

When you complete the fields below, ASPEN provides the rest of the information about the affiliate from its provider record. The affiliation record is read-only, so you cannot make any changes to it.

<table>
<thead>
<tr>
<th>Relationship Type</th>
<th>Options are: 02 Affiliate (Sibling Hospital) and 03 Affiliate (Child of Non-Hospital Type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility/Branch ID</td>
<td>Supplied by the system.</td>
</tr>
<tr>
<td>Licensed Only?</td>
<td>Not enabled. You can add an affiliate from the provider's Affiliations node in the Tree view; right click the Affiliations node, select New Relation/Branch.</td>
</tr>
<tr>
<td>Type</td>
<td>Select the appropriate affiliation type from the drop-down list. The available options depend on the provider type of the selected affiliated entity.</td>
</tr>
</tbody>
</table>

Use this button to locate the affiliated provider. If the affiliated entity is out-of-state, you must search by Out-of-State Provider Number. When you find the provider, ASPEN pulls in other information about it, except affiliation Type (see just below), from the provider record.

“Off-site locations” and “Affiliated providers”

Information posted in the “Off-site locations” section and the “Affiliated providers” section is carried forward from the previous kits.

Access to these sections is limited to staff in the Division of Primary and Acute Care Services. Therefore, required modifications to these sections must be directed to the Division for updating prior to upload.

**Definitions:**

**Off-site location:** Services provided under the hospital's provider number, such services being offered at a location, separate and distinct from the hospital site. These sites will NOT have a separate and distinct provider number.

**Options:** There is only one selection category for off-site location - Branch/Extension/Off-site

*The only off-site locations to be added into ASPEN for New York State will be off-site locations which provide acute care inpatient services, which share the hospital provider number with the parent organization.*
When conducting Federal surveys at hospitals other than complaints, (Validation and Full Surveys at hospitals with deemed status and Recertification of hospitals without deemed status), it is required that provider-based off-site locations be included in the survey. These off-site locations are to be identified by the survey team from the HFIS file (the facility operating certificate).

The policy determination not to post other than inpatient acute care off-site locations in ASPEN is based on the fact that the non-acute off-site locations are added, deleted or modified in some way on numerous occasions during the three (3) year recertification time cycle. This information is accurately maintained on the facility operating certificate through the Department’s Certificate of Need and operating certificate issuance processes.

Maintaining an accurate and updated listing of the numerous off-site locations of any given hospital would be duplicative of the HFIS process and may not be accurate since ASPEN does not have a “gate-keeping” process like HFIS which has the Certificate of Need Program.

The Area Office will be responsible for identifying the hospital’s off-site locations from the facility’s operating certificate. Determination of the off-site locations to be included in the survey is to be accomplished as part of the pre-survey activities in accordance with CMS requirements.

**Affiliated provider:** Services provided by the hospital under a provider number different from the hospital provider number or facilities with a separate and distinct provider number that are an affiliate of the hospital.

Options: Sibling Hospital and Child of Non-Hospital Type

Examples of “Sibling Hospital” would be two hospitals, each having their own provider number, but operated by the same operating entity.

Examples of “Child of Non-Hospital Type” would be an ESRD or nursing home that is run by the hospital or operating entity, which runs the hospital.
The Worksheet may be revised to update information or to add or remove off-site locations and affiliations (example: addition of an ESRD facility) at times other than the three-year recertification process. To make these modifications, **OPEN THE MOST RECENT RECERTIFICATION KIT** and update the worksheet as indicated. **DO NOT CREATE A NEW CERTIFICATION KIT.**

Post the date the changes are made in the "Date Updated" M1 Field on the Worksheet. The L34 date on the 1539 must not be revised, since this is the date which queues accomplishment of the next (three-year) recertification.

Re-upload the kit with the Worksheet revisions.
Unique Features of Hospital Certification Kits

Certification and Surveys Tab

The Certification and Surveys Tab includes a new section at the bottom of the form for Hospital Special Fields.

![Hospital Special Fields Section](image)

Information posted in the Hospital Special Fields Section from previous survey kits is carried forward to newly created kits for any given hospital.

Review the information carried forward, update accordingly and complete all applicable fields for the given facility.

The following Field/Button Descriptions for the fields in the Hospital Special Fields Section are provided from the ASPEN 8.5 Procedures Guide (pages 186-187):

<table>
<thead>
<tr>
<th>Hospital Special Fields</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Field/Button</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Nurse – Bed Override (SF13)</td>
<td>Select this check box to OK a record that is flagged for review due to the ratio of nurse (M25 &amp; M26) to certified beds (L17) being less than 1 to 10.</td>
</tr>
<tr>
<td>Validation Survey Date (SF32)</td>
<td>Exit date of the validation survey. This date is supplied by ASPEN when certification Type of Action is 5-Validation (L8 on the 1539) and a validation survey is scheduled.</td>
</tr>
<tr>
<td>Provides Swing Beds (SF44)</td>
<td>Indicates if a hospital has swing bed services. Required. To change swing bed status, create a new certification kit. Not applicable for Psychiatric, Children’s or RNHCI Hospitals.</td>
</tr>
<tr>
<td>Size Code (SF28)</td>
<td>Indicates the size of the hospital providing swing bed services. Required when SF44 is Yes.</td>
</tr>
<tr>
<td>Psychiatric – Has a PPS Exempt Unit? (SF45)</td>
<td>Select this box when a hospital has a PPS exempt psychiatric unit.</td>
</tr>
<tr>
<td><strong>Psychiatric – Effective Date (SF49)</strong></td>
<td>The date a psychiatric unit became exempt from the prospective payment system.</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Psychiatric – Number of Beds (SF46)</strong></td>
<td>The number of beds in a PPS exempt psychiatric unit of a hospital.</td>
</tr>
<tr>
<td><strong>Psychiatric – Termination Code (SF51)</strong></td>
<td>When the PPS exemption is terminated, select the reason the psychiatric unit is no longer exempt from PPS.</td>
</tr>
<tr>
<td><strong>Psychiatric – Termination Date (SF52)</strong></td>
<td>The date the psychiatric unit is no longer exempt from the prospective payment system.</td>
</tr>
<tr>
<td><strong>Rehabilitation – Has a PPS Exempt Unit? (SF47)</strong></td>
<td>Select this box if the hospital has a PPS exempt rehabilitation unit.</td>
</tr>
<tr>
<td><strong>Rehabilitation – Effective Date (SF49)</strong></td>
<td>The date the rehabilitation unit became exempt from the prospective payment system.</td>
</tr>
<tr>
<td><strong>Rehabilitation – Number of Beds (SF48)</strong></td>
<td>The number of beds in the PPS exempt rehabilitation unit of the hospital.</td>
</tr>
<tr>
<td><strong>Rehabilitation – Termination Code (SF53)</strong></td>
<td>When the PPS rehab exemption is terminated, select the reasons for the hospital’s rehabilitation unit termination from under the prospective payment system.</td>
</tr>
<tr>
<td><strong>Rehabilitation – Termination Date (SF54)</strong></td>
<td>The date the hospital’s rehabilitation unit is no longer excluded from the prospective payment system.</td>
</tr>
</tbody>
</table>

**NOTES**

Use the “Notes” Button at the bottom of the certification kit to provide additional information or explanations for issues related to the “Hospital Special Fields” section. For example, if the “Nurse-Bed Override (SF 13) is checked to certify it is acceptable that the nurse bed ratio is less than 1 to 10, provide an explanation for accepting the variance, such as the certified beds is greater than the operational and staffed beds.
FACILITY TYPES: HOSPITALS WITH DEEMED STATUS

AMBULATORY SURGERY CENTERS WITH DEEMED STATUS

Survey Types Based on Facility Type:

**Hospitals with Deemed Status**

- Recertifications
- Validation Surveys
- Full Survey After Complaint

**Ambulatory Surgery Centers with Deemed Status**

- Validation Surveys

Recertification Kits (Hospitals with Deemed Status)

Hospitals accredited by either JCAHO or AOA automatically receive deemed status by CMS.

Certification kits for facilities with deemed status will be displayed in the Alphabetical Tree in *blue italics.*
Hospitals with Deemed Status without Certified Swing Beds:

Recertification kits for hospitals with deemed status with no certified swing beds, do not require completion of an on-site survey. The process does involve an on-site visit, but the on-site activity is a not survey, precluding the creation of a survey event and the preparation of a 2567 or completion of the 670 form.

Recertifications at hospitals with deemed status are to be accomplished on a three-year cycle. (These recertifications are often referenced as “triennials” by staff of the New York State Department of Health.)

To create and process the certification kit:

**Step One:** Locate the Facility (See Section One)

**Step Two:** Initiate the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:
2) Select **Create Certification** from the pop-up menu.

The certification kit appears with the **Certification & Surveys** page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.

**NOTE:** Since on-site surveys are not allowed for recertifications of hospitals with deemed status (with no certified swing beds), the “New” button, used to create a survey event, is de-activated.
Step Three: Certification and Surveys Tab

Review the information in the “Hospital Special Fields” section and update accordingly. Refer to pages 3 – 14 through 3 – 15 for information on updating the “Hospital Special Fields” section.

Step Four: Complete the 1539 Form

As previously indicated, facilities accredited by JCAHO or AOA automatically receive deemed status by CMS. Therefore, when an accrediting organization is specified in the “Accreditation Status (L10)” field, the “Deemed?” indicator will be set to “Yes” and locked.

Generally, ASPEN automatically generates the 1539 Survey Date (L34) field from the exit date of the health or life safety survey event (whichever is the latter.) Since recertification kits for hospitals with deemed status (and no swing bed certification) do not require a survey event, ASPEN allows this field to be updated on the CMS 1539 Form by the surveyor. The date to be entered in the L34 field is the date the surveyor went to the facility to collect the worksheet information.

Verify and complete required fields on the 1539 Form. Information for completing the 1539 Form is provided in Addendum Eight of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to green.
**Step Five:** Complete the Application Worksheet Form

Update the information on the Application Worksheet as indicated, referring to pages 3 – 3 through 3 – 13 of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to **green**.

**Step Six:** Upload the Kit to the National Data Base

Select the **Upload** tab. The following window appears.

To transmit the current certification kit, select the **Prevalidate and Upload** button.

A confirmation message appears. Select **Yes**.
The upload activity will be presented on the screen as noted below.

If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.

Correct the errors and upload the kit again.
A successful upload will be reflected in the “Prior Certification Kit Uploads” window with a yellow stop light, indicating the upload is in pending status and will be uploaded overnight.

**NOTE:**

*Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.*

PRINT A HARD COPY OF THE COMPLETE KIT (Worksheet and 1539) FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.

Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5 – 33 through 5 – 36.)

When it is verified the certification kit has been uploaded, return to the Certification and Surveys tab and post the status to “CLOSED.”

On the Tracking tab, change the Tracking Status to “10 Processing Complete.”

Select **Done** to save the information and close the Certification window.
Hospitals with Deemed Status with Certified Swing Beds:

Recertification kits for hospitals with deemed status with certified swing beds, require completion of an on-site survey for the swing bed component ONLY. Recertifications at hospitals with deemed status are to be accomplished on a three-year cycle.

To create and process the certification kit:

**Step One:** Locate the Facility (See Section One)

**Step Two:** Initiate the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:
2) Select **Create Certification** from the pop-up menu.

The Certification window appears with the **Certification & Surveys** page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.

**NOTE:** Since a survey event is required for the swing-bed component of the hospital recertification process for hospitals with deemed status (with certified swing beds), the “New” button, used to create a survey event, is activated.
**Step Three:** Certification and Surveys Tab

Review the information in the “Hospital Special Fields” section and update accordingly. Verify the Swing Bed indicator is posted as “Yes.”

Refer to pages 3 – 14 through 3 – 15 for information on updating the “Hospital Special Fields” section.

- **Create a survey shell**
  
  In the “Survey List” section, select the **New** button.

  On the “Initial Survey Type” screen, “Health Survey” will be selected.

  A Life Safety Survey is not required for swing bed surveys. Therefore, the option for creating a Life Safety Survey is de-activated.

  Click the “OK” Button.
The Create Health Survey window below appears. Fill out the appropriate information for each of the four (4) sections.

**Regulations:**
Select the appropriate state and federal regulation sets (including state structural regulations).

Note: In the health survey event, select the applicable state structural regulation sets. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Type of Survey:**
For recertification survey kits select “I-Recertification” for the Federal aspects of the survey and “K-State Licensure” and “2-ReLicensure” for the State aspects of the survey.

**Team Roster:**
Select the team members using the “Update” button.

Note: Be sure to include the sanitarian on the health survey event. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

Select OK.
The Survey window appears asking if you want to proceed to Citation Manager. Select No.

The screen will return to the Certification and Surveys tab of the certification kit.

- Process Survey Information through Citation Manager

NOTE: This survey event is allowed only because the facility has certified swing beds. Therefore, only the swing bed tags (A1500-1599) are to be cited from the Federal Acute Care Regulation Set (A Tags) and only the swing bed tags will be uploaded to the National Database. This does not preclude, however, the citation of State tags, if indicated.

Process the citations in Citation Manager. Be sure to select “K State Licensure” and “2 Re-Licensure” for State tags and “Recertification” for Federal tags in Citation Properties.
• Issue the 2567. Record SOD Issuance Date and Revisit Status on the Survey Properties Form. (Shown below with the red arrows.)

If there are no deficiencies identified, a 2567 is to be issued to the facility stating the facility is compliant with Conditions of Participation. The 2567 issuance date is posted in the “SOD Sent” date field.

If no Plan of Correction is required, the first page of the 2567 is to be signed and dated by the facility administrator and returned to the regional office. The date of the administrator’s sign off is to be posted in “Adm Signoff (X6)” date field.

• Process the Plan of Correction/Update Plan of Correction Information

1) Record date of receipt of the POC and Facility Administrator Signoff (X6) on the Survey Properties Form. (Shown above with the blue arrows.)

2) Record Plan of Correction information for each citation in Citation Manager.

On the “Citation Properties” screen for each citation, record POC received date, Facility Completion date (X5) and SA Accepted date for each citation.

Note: The SA POC Accepted date is the date of the Department’s written notification to the facility of acceptance of the POC. It is not the date of the surveyor approval of the material submitted for that tag.
• **Record the Status Plan of Correction**

Access the Status Plan of Correction Form by selecting the **POC** button next to the appropriate survey event in the **Track** column in the **Survey List** Section of the **Certifications & Surveys** Tab.

This screen will appear. Complete the information for each category and record applicable notes in the “POC Notes” section.

• **Complete the 670**

  *Be sure to process the office hours (supervisory and clerical).*

  See page 2-3 (description of buttons) to locate the access button for the 670 Form through the certification kit.

  **Note:** Appropriate portions of the 670 should be completed by participating surveyors at various stages throughout the survey process.
**Step Four: Complete the 1539 Form**

As previously indicated, facilities accredited by JCAHO or AOA automatically receive deemed status by CMS. Therefore, when an accrediting organization is specified in the “Accreditation Status (L10)” field, the “Deemed?” indicator will be set to “Yes” and locked.

Verify and complete required fields on the 1539 Form. Information for completing the 1539 Form is provided in Addendum Eight of this manual.

**Yellow boxed fields are required fields for data entry.**

*If a facility is determined to be in compliance, note if a Plan of Correction was required (darken 1 – ACCEPTABLE POC) to meet compliance standards.*

Even though the “Remarks” field at the bottom of the form is not yellow, appropriate narrative information is to be recorded. Since Section 10 is not to be revised subsequent to the entry for the initial survey event, revisit notices should be posted in the “Remarks” section.

Once all required information is supplied and you exit the form, the check marks on the tab will change to green.
**Step Five: Complete the Application Worksheet Form**

Update the information on the Application Worksheet as indicated, referring to pages 3 – 3 through 3 – 13 of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to **green**.

**Step Six: Upload the Kit to the National Data Base**

Select the **Upload** tab. The following window appears.

To transmit the current certification kit, select the **Prevalidate and Upload** button.

A confirmation message appears.

Select **Yes**.

The upload activity will be presented on the screen as noted below.
If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.

Correct the errors and upload the kit again.

A successful upload will be reflected in the “Prior Certification Kit Uploads” window with a yellow stop light, indicating the upload is in pending status and will be uploaded overnight.

**NOTE:**

*Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.***

PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.
Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5 – 33 through 5 – 36.)

When it is verified the certification kit has been uploaded, return to the Certification and Surveys tab and post the status to “CLOSED.”

On the Tracking tab, change the Tracking Status to “10 Processing Complete.”

Select Done to save the information and close the Certification window.
**Validation Surveys**

Validation surveys are performed at hospitals with deemed status and at ambulatory surgery centers with deemed status, as directed by CMS. These surveys are conducted to validate the findings of the accrediting agency.

**Step One:** Locate the Facility (See Section One)

**Step Two:** Initiate the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:
2) Select **Create Certification** from the pop-up menu.

The certification kit appears with the **Certification & Surveys** page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.
GO DIRECTLY TO THE TRANSMITTAL TAB (CMS-1539) TO SET THE TYPE OF ACTION

For **Validation Surveys**, go to the drop down box “4. Type of Action (L8)” and select “5 VALIDATION.”

Validation Surveys are accomplished at hospitals or ambulatory surgery centers with deemed status. Recertification kits at hospitals with deemed status or ambulatory surgery centers with deemed status do not allow the creation of survey events. However, changing the “Type of Action” to Validation allows for the creation of survey events on the **Certification and Surveys** Tab.

Once created, Validation certification kits are reflected on the facility tree with a “V” designation.

**Step Three:**  
**Certification and Surveys Tab**

**For Hospital Validation Kits**, return to the “Certification and Surveys” Tab and review the information in the “Hospital Special Fields” section and update accordingly.

Refer to pages 3 – 14 through 3 – 15 for information on updating the “Hospital Special Fields” section.
• **Create the survey events**

Validation surveys at hospitals and ambulatory surgery centers require both a health survey and a life safety survey.

In the “Survey List” section, select the **New** button.

On the “Initial Survey Type” screen, “Health Survey” will be selected.

Click the “OK” Button.
The **Create Health Survey** window below appears. Fill out the appropriate information for each of the four (4) sections.

**Regulations:**
Select the appropriate state and federal regulation sets (including state structural regulations).

Note: In the health survey event, select the applicable state structural regulation sets. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Type of Survey:**
For Validation survey kits select “I-Recertification” and “G-Validation” for the Federal aspects of the survey and “K-State Licensure” and “2-ReLicensure” for the State aspects of the survey.

**Team Roster:**
Select the team members using the “Update” button.

Note: Be sure to include the sanitarian on the health survey event. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

Select OK.
The Survey window appears asking if you want to proceed to Citation Manager. Select **No**.

The screen will return to the **Certification and Surveys** tab of the certification kit and the health survey event will be listed.

Select the “New” Button again to create the Life Safety Survey event.
The “Initial Survey Type” screen will appear with “Health Survey” grayed out and “LSC Survey” selected. Click on the **OK** Button.

This screen will appear. Enter required information for each of the four (4) sections.

**Regulations:**
When the survey dates are entered, the appropriate life safety regulation set will appear in the “Regulations” section. Select the regulation set.

**Team Roster:**
Post the sanitarian in the “Team Roster” section.

**Type of Survey:**
“1-Recertification” and “H-Life Safety Code” will automatically be selected.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

**Note:** Since environmental and structural State deficiencies are cited in the Health Survey, only the Federal categories of “1-Recertification” and “H-Life Safety Code” should be selected for “Type of Survey.” There should be no state licensure categories selected. This will allow all the state deficiencies to be printed on one form from the health survey event.
• **Process Survey Information through Citation Manager**

Process the citations in Citation Manager for the Health Survey Event. **Be sure to select “K State Licensure” and “2 Re-Licensure” for State tags and “I-Recertification” and “G-Validation” for Federal tags in Citation Properties.**

Post life safety citations through Citation Manager in the Life Safety Survey Event, selecting **“I-Recertification” and “H-Life Safety Code”** as the categories for the life safety tags in Citation Properties. Only the Federal Life Safety Code violations will be cited in the life safety survey event. State structural violations are to be recorded in the health survey event with the appropriate state regulation tag.
Complete the Life Safety Form.

In the **Survey List** Section of the **Certification & Surveys** Tab, select the LSC 2786 tab (K9).

![Image of the Certification & Surveys Tab with LSC 2786 selected]

This form will appear. Enter the “Comp Status” from the drop down listing and complete the remaining sections of the form.

![Image of the Survey List with LSC 2786 selected]
• Issuance of the Statement of Deficiencies

For Hospital Validation Kits, CMS Region II issues the 2567.
Check the “Release for CMS Review” box when the 2567 is ready for review and transmit an electronic notification to CMS that the 2567 is ready for review.

The electronic notification is to be issued to the identified CMS hospital contact person (Annette Tucker-Osborne).

Retain, in the hard copy certification kit file, a copy of the electronic notification to CMS that the 2567 is ready for review and any further communications from CMS requesting revisions to the deficiency statements.

Maintain communication with CMS for copies of the issued 2567 and receipt of the Plan of Correction.

For Ambulatory Surgery Centers, the State Agency issues the 2567.

Check the “Release for CMS Review” box ONLY if a condition-level violation has been identified during survey and send an electronic notification to the identified CMS contact person (Gwendolyn Taylor).
When the 2567 is issued (Ambulatory Surgery Centers) or CMS provides the copy of the issued 2567 (Hospitals), post the SOD issuance date on the Survey Properties Form and the revisit status. (Shown below with the red arrows.)

- Process the Plan of Correction/Update Plan of Correction Information

1) Record date of receipt of the POC and Facility Administrator Signoff (X6) on the Survey Properties Form. (Shown above with the blue arrows.)

NOTE: When a hospital validation survey identifies deficiencies with no condition-level violations, CMS does not require submission of a Plan of Correction. The facility has the option of submitting or not submitting a POC. If the facility opts not to submit the POC, they must still return the first page of the 2567 signed and dated by the Administrator to confirm receipt of the 2567. The date of the signed 2567 by the hospital administrator is to be posted as the X6 date on the Survey Properties Form, as note above.
2) Record Plan of Correction information for each citation in Citation Manager.

On the "Citation Properties" screen for each citation, record POC received date, Facility Completion date (X5) and POC Accepted date for each citation.

Note: The POC Accepted date is the date of written notification from CMS to the facility of acceptance of the POC.

Retain hard copy documentation of all requests to CMS for POC information.

- Record the Status Plan of Correction

Access the Status Plan of Correction Form by selecting the POC button next to the appropriate survey event in the Track column in the Survey List Section of the Certifications & Surveys Tab.
This screen will appear. Complete the information for each category and record applicable notes in the “POC Notes” section.

- **Complete the 670 for the Health and Life Safety Survey Events**

  *Be sure to process the office hours (supervisory and clerical).*

  See page 2-3 (description of buttons) to locate the access button for the 670 Form through the certification kit.

  **Note:** Appropriate portions of the 670 should be completed by participating surveyors at various stages throughout the survey process.

**Step Four: Complete the 1539 Form**

The top section of the 1539 Form was completed during Step Two of this process.
Verify and complete required fields on the 1539 Form. Information for completing the 1539 Form is provided in Addendum Eight of this manual.

Yellow boxed fields are required fields for data entry.

If a facility is determined to be in compliance, note if a Plan of Correction was required (darken 1 – ACCEPTABLE POC) to meet compliance standards.

Even though the “Remarks” field at the bottom of the form is not yellow, surveyors are to document narrative information. Since Section 10 is NOT to be revised after posting the selection after the initial survey event for the kit, revisit activities are to be posted as additional comments in the “Remarks” section.

Once all required information is supplied and you exit the form, the check marks on the tab will change to green.

**Step Five: Complete the Application Form for the Ambulatory Surgery Center or the Application Worksheet for the Hospital**

Complete the Ambulatory Surgery Form or update the information on the Hospital Application Worksheet as indicated, referring to pages 3 – 2 through 3 – 13 of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to green.
Step Six: Upload the Kit to the National Data Base

Select the **Upload** tab. The following window appears.

![Upload Navigation](image)

To transmit the current certification kit, select the **Prevalidate and Upload** button. A confirmation message appears.

Select **Yes**.

The upload activity will be presented on the screen as noted below.

![Upload Confirmation](image)

If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.
Correct the errors and upload the kit again.

A successful upload will be reflected in the “Prior Certification Kit Uploads” window with a yellow stop light, indicating the upload is in pending status and will be uploaded overnight.

**NOTE:**

*Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.*

**REVISIT ACTIVITIES**

If a re-visit is indicated (a condition-level situation was identified during survey), process the re-visit as outlined on pages 3 – 80 through 3 – 84 of this manual.

The first survey activity will have been uploaded before re-visit activities are initiated. Complete the re-visit process, including the upload process, for each re-visit survey conducted.

When no further activity is required (CMS directs there will be no further re-visits to the facility and the Plans of Correction are acceptable), proceed to preparing a hard copy of the certification kit for the Area Office file and close the kit as noted below.
PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.

Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5 – 33 through 5 – 36.)

When it is verified the certification kit has been uploaded and no further survey activity is required, return to the Certification and Surveys tab and post the status to “CLOSED.”

On the Tracking tab, change the Tracking Status to “10 Processing Complete.”

Select Done to save the information and close the Certification window.
Full Survey After Complaint (Hospitals with Deemed Status)

Full Survey Following Complaint is accomplished at the direction of CMS following an allegation survey at a hospital where condition-level non-compliance has been identified.

**Step One:** Locate the Facility (See Section One)

**Step Two:** Initiate the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:
2) Select **Create Certification** from the pop-up menu.

The certification kit appears with the **Certification & Surveys** page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.
GO DIRECTLY TO THE TRANSMITTAL TAB (CMS-1539) TO SET THE TYPE OF ACTION

For **Full Survey After Complaint**, go to the drop down box “4. Type of Action (L8)” and select “8 Full Survey After Complaint.”

A Full Survey After Complaint is accomplished at hospitals with deemed status. Recertification kits at hospitals with deemed status do not allow the creation of survey events. However, changing the “Type of Action” to Full Survey After Complaint allows for the creation of survey events on the **Certification and Surveys Tab**.

**Step Three:** Certification and Surveys Tab

Review the information in the “Hospital Special Fields” section and update accordingly.

Refer to pages 3 – 14 through 3 – 15 for information on updating the “Hospital Special Fields” section.
• **Create the survey events**

The Full Survey Following Complaint Recertification requires both a health survey and a life safety survey.

In the “Survey List” section, select the **New** button.

On the “Initial Survey Type” screen, “Health Survey” will be selected.

Click the “OK” Button.
The **Create Health Survey** window below appears. Fill out the appropriate information for each of the four (4) sections.

**Regulations:**
Select the appropriate state and federal regulation sets (including state structural regulations).

Note: In the health survey event, select the applicable state structural regulation sets. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Type of Survey:**
For Full Survey After Complaint kits select "I-Recertification" for the Federal aspects of the survey and "K-State Licensure" and "2-ReLicensure" for the State aspects of the survey.

**Team Roster:**
Select the team members using the “Update” button.

Note: Be sure to include the sanitarian on the health survey event. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Extent(s):**
"A-Routine/Std Survey" will automatically be selected.

Select OK.
The Survey window appears asking if you want to proceed to Citation Manager. Select No.

The screen will return to the **Certification and Surveys** tab of the certification kit and the health survey event will be listed.

Select the “New” Button again to create the Life Safety Survey event.
The “Initial Survey Type” screen will appear with “Health Survey” grayed out and “LSC Survey” selected. Click on the OK Button.

This screen will appear. Enter required information for each of the four (4) sections.

**Regulations:**
When the survey dates are entered, the appropriate life safety regulation set will appear in the “Regulations” section. Select the regulation set.

**Team Roster:**
Post the sanitarian in the “Team Roster” section.

**Type of Survey:**
“I-Recertification” and “H-Life Safety Code” will automatically be selected.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

**Note:** Since environmental and structural State deficiencies are cited in the Health Survey, only I-Recertification and “H-Life Safety Code” should be selected for “Type of Survey.” There should be no state licensure categories. This will allow all the state deficiencies to be printed on one form from the health survey event.
• **Process Survey Information through Citation Manager**

Process the citations in Citation Manager. **Be sure to select “K State Licensure” and “2 Re-Licensure” for State tags and “I-Recertification” for Federal tags in Citation Properties.**

Post life safety citations through Citation Manager in the Life Safety Survey Event, selecting “I-Recertification” and “H-Life Safety Code” as the categories for the life safety tags in Citation Properties. Only the Federal Life Safety Code violations will be cited in the life safety survey event. State structural violations are to be recorded in the health survey event with the appropriate state regulation tag.

• **Complete the Life Safety Form**

In the **Survey List** Section of the **Certification & Surveys** Tab, select the LSC 2786 tab (K9).

This form will appear. Enter the “Comp Status” from the drop down listing and complete the remaining sections of the form.
• **Issuance of the Statement of Deficiencies**

*CMS Region II issues the 2567 for Full Surveys.*

Check the “Release for CMS Review” box when the 2567 is ready for review and transmit an electronic notification to CMS that the 2567 is ready for review.

The electronic notification is to be issued to the identified CMS hospital contact person (Annette Tucker-Osborne).

Retain, in the hard copy certification kit file, a copy of the electronic notification to CMS that the 2567 is ready for review and any further communications from CMS requesting revisions to the deficiency statements.

Maintain communication with CMS for copies of the issued 2567 and receipt of the Plan of Correction.

**When CMS provides the copy of the issued 2567, post the SOD issuance date on the Survey Properties Form and the revisit status.**
• **Process the Plan of Correction/Update Plan of Correction Information**

1) Record date of receipt of the POC and Facility Administrator Signoff (X6) on the **Survey Properties Form**. (Shown on the previous page with the blue arrows.)

**NOTE:** When a full survey after complaint identifies deficiencies with no condition-level violations, CMS does not require submission of a Plan of Correction. The facility has the option of submitting or not submitting a POC. If the facility opts not to submit the POC, they must still return the first page of the 2567 signed and dated by the Administrator to confirm receipt of the 2567. The date of the signed 2567 by the hospital administrator is to be posted as the X6 date on the **Survey Properties Form**, as noted above.

2) Record Plan of Correction information for each citation in **Citation Manager**.

On the “Citation Properties” screen for each citation, record POC received date, Facility Completion date (X5) and POC Accepted date for each citation.

Note: The POC Accepted date is the date of written notification from CMS to the facility of acceptance of the POC.

Retain hard copy documentation of all requests to CMS for POC information.

• **Record the Status Plan of Correction**

Access the Status Plan of Correction Form by selecting the **POC** button next to the appropriate survey event in the **Track** column in the **Survey List** Section of the **Certifications & Surveys** Tab.

![Status Plan of Correction Form](image)
This screen will appear. Complete the information for each category and record applicable notes in the “POC Notes” section.

- **Complete the 670 for the Health and Life Safety Survey Events**

  *Be sure to process the office hours (supervisory and clerical).*

  See page 2-3 (description of buttons) to locate the access button for the 670 Form through the certification kit.

  **Note:** Appropriate portions of the 670 should be completed by participating surveyors at various stages throughout the survey process.

**Step Four: Complete the 1539 Form**

The top section of the 1539 Form was completed during Step Two of this process.

Verify and complete required fields on the 1539 Form. Information for completing the 1539 Form is provided in Addendum Eight of this manual.
Yellow boxed fields are required fields for data entry.

If a facility is determined to be in compliance, note if a Plan of Correction was required (darken 1 – ACCEPTABLE POC) to meet compliance standards.

Even though the “Remarks” field at the bottom of the form is not yellow, surveyors are to document narrative information. Since Section 10 is NOT to be revised after posting the selection after the initial survey event for the kit, revisit activities are to be posted as additional comments in the “Remarks” section.

Once all required information is supplied and you exit the form, the check marks on the tab will change to **green**.

**Step Five: Complete the Application Worksheet Form**

Update the information on the Application Worksheet as indicated, referring to pages 3 – 3 through 3 – 13 of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to **green**.
**Step Six: Upload the Kit to the National Data Base**

Select the **Upload** tab. The following window appears.

To transmit the current certification kit, select the **Prevalidate and Upload** button.

A confirmation message appears.

Select **Yes**.

The upload activity will be presented on the screen as noted below.

Select **OK** on the “Sending Certificate to ODIE” screen.
If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.

Correct the errors and upload the kit again.

A successful upload will be reflected in the “Prior Certification Kit Uploads” window with a yellow stop light, indicating the upload is in pending status and will be uploaded overnight.

**NOTE:**

*Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.*
REVISIT ACTIVITIES

If a re-visit is indicated (a condition-level situation was identified during survey), process the re-visit as outlined on pages 3 – 80 through 3 – 84 of this manual.

The first survey activity will have been uploaded before re-visit activities are initiated. Complete the re-visit process, including the upload process, for each re-visit survey conducted.

When no further activity is required (CMS directs there will be no further re-visits to the facility and the Plans of Correction are acceptable), proceed to preparing a hard copy of the certification kit for the Area Office file and close the kit as noted below.

PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.

Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5 – 33 through 5 – 36.)

When it is verified the certification kit has been uploaded and no further survey activity is required, return to the Certification and Surveys tab and post the status to “CLOSED.”

On the Tracking tab, change the Tracking Status to “10 Processing Complete.”

Select Done to save the information and close the Certification window.
FACILITY TYPE:  HOSPITALS WITHOUT DEEMED STATUS
AMBULATORY SURGERY CENTERS WITHOUT DEEMED STATUS

Survey Type:  Recertification Surveys

Recertification Surveys

Recertification surveys are performed at hospitals without deemed status on a three (3) -year cycle. If the facility is certified for swing beds, the recertification is to include review of the swing bed service (Tags A1500-1599).

Recertification surveys are performed at ambulatory surgery centers without deemed status on a six (6)-year cycle.

Recertification surveys at hospital without deemed status or ambulatory surgery centers without deemed status require a health survey and a life safety survey.

Step One:  Locate the Facility  (See Section One)

Step Two:  Initiate the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:
2) Select **Create Certification** from the pop-up menu.

The certification kit appears with the **Certification & Surveys** page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.
Step Three: Certification and Surveys Tab

For Hospital Recertification Kits, on the “Certification and Surveys” Tab, review the information in the “Hospital Special Fields” section and update accordingly.

Refer to pages 3 – 14 through 3 – 15 for information on updating the “Hospital Special Fields” section.

- Create the survey events

In the “Survey List” section, select the New button.

On the “Initial Survey Type” screen, “Health Survey” will be selected.

Click the “OK” Button.
The Create Health Survey window below appears. Fill out the appropriate information for each of the four (4) sections.

**Regulations:**
Select the appropriate state and federal regulation sets (including state structural regulations).

Note: In the health survey event, select the applicable state structural regulation sets. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Type of Survey:**
Select “I-Recertification” for the Federal aspects of the survey and “K-State Licensure” and “2-ReLicensure” for the State aspects of the survey.

**Team Roster:**
Select the team members using the “Update” button.

Note: Be sure to include the sanitarian on the health survey event. The sanitarian is required to post the state structural deficiencies in the health survey event, so that the facility will receive one 2567 document for all state deficiencies.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

Select OK.
The Survey window appears asking if you want to proceed to Citation Manager. Select No.

The screen will return to the **Certification and Surveys** tab of the certification kit and the health survey event will be listed.

Select the “New” Button again to create the Life Safety Survey event.
The “Initial Survey Type” screen will appear with “Health Survey” grayed out and “LSC Survey” selected. Click on the OK Button.

This screen will appear. Enter required information for each of the four (4) sections.

**Regulations:**
When the survey dates are entered, the appropriate life safety regulation set will appear in the “Regulations” section. Select the regulation set.

**Team Roster:**
Post the sanitarian in the “Team Roster” section.

**Type of Survey:**
“l-Recertification” and “H-Life Safety Code” will automatically be selected.

**Extent(s):**
“A-Routine/Std Survey” will automatically be selected.

**Note:** Since environmental and structural State deficiencies are cited in the Health Survey, only I-Recertification and “H-Life Safety Code” should be selected for “Type of Survey.” There should be no state licensure categories. This will allow all the state deficiencies to be printed on one form from the health survey event.
Process Survey Information through Citation Manager

Process the citations in Citation Manager for the Health Survey Event. Be sure to select “K State Licensure” and “2 Re-Licensure” for State tags and “I-Recertification” for Federal tags in Citation Properties.

Post life safety citations through Citation Manager in the Life Safety Survey Event, selecting "I-Recertification" and "H-Life Safety Code" as the categories for the life safety tags in Citation Properties. Only the Federal Life Safety Code violations will be cited in the life safety survey event. State structural violations are to be recorded in the health survey event with the appropriate state regulation tag.
Complete the Life Safety Form.

In the **Survey List** Section of the **Certification & Surveys** Tab, select the LSC 2786 tab (K9).

This form will appear. Enter the “Comp Status” from the drop down listing and complete the remaining sections of the form.
• Issuance of the Statement of Deficiencies

If a condition-level situation has been identified, check the “Release for CMS Review” box.

Post the SOD issuance date and the revisit status on the Survey Properties Form. (Shown below with the red arrows.)

If there are no deficiencies identified, a 2567 is to be issued to the facility stating the facility is complaint with Conditions of Participation. The 2567 issuance date is posted in the “SOD Sent” date field.

If no Plan of Correction is required, the first page of the 2567 is to be signed and dated by the facility administrator and returned to the regional office. The date of the administrator’s sign off is to be posted in “Adm Signoff (X6)” date field.

• Process the Plan of Correction/Update Plan of Correction Information

1) Record date of receipt of the POC and Facility Administrator Signoff (X6) on the Survey Properties Form. (Shown above with the blue arrows.)
2) Record Plan of Correction information for each citation in **Citation Manager**.

On the “Citation Properties” screen for each citation, record POC received date, Facility Completion date (X5) and POC Accepted date for each citation.

Note: The SA POC Accepted date is the date of the Department’s written notification to the facility of acceptance of the POC. It is not the date of the surveyor approval of the material submitted for that tag.

- **Record the Status Plan of Correction**

Access the Status Plan of Correction Form by selecting the **POC** button next to the appropriate survey event in the **Track** column in the **Survey List** Section of the **Certifications & Surveys** Tab.

This screen will appear. Complete the information for each category and record applicable notes in the “POC Notes” section.
• Complete the 670 for both the Health and Life Safety Survey Events.

  Be sure to process the office hours (supervisory and clerical).

See page 2-3 (description of buttons) to locate the access button for the 670 Form through the certification kit.

Note: Appropriate portions of the 670 should be completed by participating surveyors at various stages throughout the survey process.

**Step Four: Complete the 1539 Form**

On the Transmittal Tab (CMS 1539, “Type of Action” will have automatically been set to “2 RECERTIFICATION” when the kit was created.

Verify and complete required fields on the 1539 Form. Information for completing the 1539 Form is provided in Addendum Eight of this manual.

Yellow boxed fields are required fields for data entry.

*If a facility is determined to be in compliance, note if a Plan of Correction was required (darken 1 – ACCEPTABLE POC) to meet compliance standards.*

Even though the “Remarks” field at the bottom of the form is not yellow, surveyors are to document narrative information. Since Section 10 is NOT to be revised after posting the selection after the initial survey event for the kit, revisit activities are to be posted as additional comments in the “Remarks” section.

Once all required information is supplied and you exit the form, the check marks on the tab will change to green.
**Step Five:** Complete the Application Worksheet Form

Complete the information on the Application Form for Ambulatory Surgery Centers (referring to page 3-2) or update the information on the Application Worksheet for Hospitals (referring to pages 3 – 3 through 3 – 13) of this manual.

Once all required information is supplied and you exit the form, the check marks on the tab will change to **green**.

**Step Six:** Upload the Kit to the National Data Base

Select the **Upload** tab. The following window appears.

![Upload Window]

To transmit the current certification kit, select the **Prevalidate and Upload** button.

A confirmation message appears.

Select **Yes**.

The upload activity will be presented on the screen as noted below.

![Upload Confirmation]

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If all required information is submitted, a notation of successful transmission will be posted.

If errors occur, the errors or missing information can be identified. The upload transactions for the certification kit are listed. Select the transaction that had errors and the errors will be listed in the “Upload Transaction Errors” section.

Correct the errors and upload the kit again.

A successful upload will be reflected in the “Prior Certification Kit Uploads” window with a yellow stop light, indicating the upload is in pending status and will be uploaded overnight.

**NOTE:**

*Use the Delete Pending button if you know the kit has incorrect information that will need to be re-uploaded. This will save time instead of having to wait overnight to send up another transaction the next day. Only the person that sent the Pending Transaction can delete the Pending Transaction.*
REVISIT ACTIVITIES

If a re-visit is indicated (a condition-level situation was identified during survey), process the re-visit as outlined on pages 3 – 80 through 3 – 84 of this manual.

The first survey activity will have been uploaded before re-visit activities are initiated. Complete the re-visit process, including the upload process, for each re-visit survey conducted.

When no further activity is required (CMS directs there will be no further re-visits to the facility and the Plans of Correction are acceptable), proceed to preparing a hard copy of the certification kit for the Area Office file and close the kit as noted below.

PRINT A HARD COPY OF THE COMPLETE KIT FOR YOUR FILES. ORIGINAL FORMS ARE TO BE RETAINED WITH THE REGIONAL OFFICE FILES.

Check to make sure the kit was uploaded successfully the following day. (See Addendum Five, pages 5 – 33 through 5 – 36.)

When it is verified the certification kit has been uploaded and no further survey activity is required, return to the Certification and Surveys tab and post the status to “CLOSED.”

On the Tracking tab, change the Tracking Status to “10 Processing Complete.”

Select Done to save the information and close the Certification window.
- To create a re-visit survey event, access the Certification Kit through the facility tree.
- Scroll to the Survey List section of the Certification & Surveys Tab.
- Highlight the survey and click the “Create Re-visit” Button.

This screen will appear:

Post the dates of the re-visit survey.

**SELECT THE “OK” BUTTON WITHOUT REMOVING ANY OF THE SURVEYORS FROM THE ORIGINAL SURVEY TEAM!!! YOU MAY ADD MEMBERS TO THE TEAM BUT DO NOT REMOVE ANY TEAM MEMBERS.**
You may also add members to the team at this point (if not done at the time the revisit event ID was created) who will be participating in the re-visit survey, if they did not participate in the original survey. Selecting the “Update” Button will bring you to the Survey Properties Form to make necessary modifications.

**DO NOT REMOVE ANY SURVEYORS FROM THE TEAM, EVEN IF THEY WILL NOT BE PARTICIPATING IN THE RE-VISIT SURVEY. REMOVING THEIR NAMES WILL REMOVE ANY CITATIONS THEY HAVE POSTED IN CITATION MANAGER FOR THE FIRST EVENT.**

**SURVEYORS WHO ARE ON THE LIST BECAUSE OF BEING A MEMBER OF THE TEAM FOR THE FIRST VISIT BUT DO NOT PARTICIPATE IN THE RE-VISIT SURVEY ARE TO BE NOTED AS NOT PARTICIPATING IN THE RE-VISIT BY UNCHECKING THEIR NAMES ON THE 670 FORM FOR THE RE-VISIT SURVEY EVENT.**

After returning from the survey:

1. Create citations, if indicated, through Citation Manager for the revisit survey through the same procedures as for the initial survey. Be sure to process the revisit information in the revisit survey shell event.

2. **Post Correction Dates:**

   Acceptable implementation of the Plan of Correction for one or more of the citations associated with the survey is to be posted as corrected through the revisit survey.

**To enter or change citation correction dates:**
Access the revisit survey event by expanding the facility in the Alpha Tab, locating the revisit survey event either through the Certification Kit or in the listing of surveys under “Surveys.”

From the Facility Tree:
Expand the revisit survey event, right click a citation listed under the revisit survey to see a menu. Select “Correction Dates.”

OR

From Citation Manager in the Certification Kit (Recommended Procedure):

Access the revisit survey event in the Certification Kit, by expanding the facility in the Alpha Tab, right clicking on the Kit to see a menu and clicking on “Certification Kit.”

In the Certification & Surveys Tab, scroll to the Surveys section and select the revisit survey event. Click on the “Citation Manager” button.

In “Citation Manager” select the citation, and right click to get a menu. Select “Correction Dates.”
Post the date citations were noted as being corrected through implementation of the Plan of Correction, as follows:

Select **Selected Citation** to specify the date for the selected citation only, select **Selected Reg Set** to specify the date for all citations related to the selected regulation set, or select **All Citations** to specify the correction date for all the citations associated with the survey.

The Correction Date window appears.

Enter or select a Citation Correction Date from the drop down arrow and click OK.
3. Finalize Survey Activities

After entering correction dates as noted above, complete the process for follow-up surveys (revisits) in the same manner as for the first survey, updating the Remarks Section of the 1539.

- If a Statement of Deficiencies is issued, follow the steps for issuing and posting the Statement of Deficiencies and Plan of Correction information. Complete 670 information for the revisit event, update the Remarks Section of the 1539 and complete the final upload.

- If no deficiencies are issued, complete 670 information for the revisit event, update the Remarks Section of the 1539 and complete the final upload.

4. Upload and Close the Certification Kit

If the certification kit is complete (no further revisits indicated):

Proceed to the activities for accomplishing the upload and closing the kit (Step Six):

- Hospitals with Deemed Status:
  - Validation Surveys Page 3 – 48 through 3 - 50
  - Full Surveys Page 3 – 63 through 3 - 65

- Hospitals and Ambulatory Surgery Centers without Deemed Status:
  - Recertification Surveys Page 3 – 77 through 3 – 79

SPECIAL TRANSACTIONS FOR HOSPITALS

FACILITY TYPES: HOSPITALS WITH DEEMED STATUS and HOSPITALS WITHOUT DEEMED STATUS

- Actions: Changing Deemed Status
  - PPS Excluded Units
  - PPS Attestations
CHANGING DEEMED STATUS

Hospital with Deemed Status (Accredited) Changing Status to a Hospital without Deemed Status (Unaccredited)

If a hospital no longer has accreditation from an authorizing agency, the accreditation status is to be revised in ASPEN. In order to do this a new certification kit must be created.

**Step One:** Locate the Facility (See Section One)

**Step Two:** Create the Certification Kit

1) Locate the facility (be sure you have the correct filter to locate the facility) and right click on the facility name. The following pop-up menu appears:

2) Select **Create Certification** from the pop-up menu.
The certification kit appears with the Certification & Surveys page displayed. The Track ID and Category fields are automatically assigned to the certification kit. In the Status field, 01 Open is selected by default.

**GO DIRECTLY TO THE 1539 TAB AND CHANGE THE ACCREDITATION STATUS (L10) TO “UNACCREDITED.”**

Process the kit consistent with steps three through six for Recertification Surveys for facilities without deemed status, pages 3 – 68 through 3 – 79.

**PPS EXCLUDED UNITS**

**Survey of PPS Excluded Units at Hospitals**
ASPEN does not accommodate kits for PPS excluded units. Therefore, these surveys must continue to be processed in ACO, without a kit, by creating a survey event.

**Step One:** Locate the Facility (See Section One)

**Step Two:** Create the Survey Shell

1. Expand the facility tree by left clicking the plus sign next to the facility name.

2. Right click on the word “Survey” for a menu.

Complete the Survey Properties Form, using the following directions:

Regulations:
Select the Fed Acute Care Regulation Set for Federal deficiencies. Select Acute Care Hospital – State for State regulatory deficiencies identified.

Type of Survey
For Federal tags, select “A - Complaint Investig” for “Type of Survey.”

Since PPS surveys are not fully supported in ACO, the choices for Federal purposes is limited. There is only one selection, “A - Complaint Investig.” In order to select a Federal category in Citation Properties in Citation Manager when selecting the 0000 tag or selecting a tag noting a Federal deficiency, it is necessary to select the only Federal category under “Type of Survey,” even though it does not accurately reflect the type of survey activities.

For State tags, select “K-State Licensure” and “2-Re-Licensure” for “Type of Survey.”

Extent(s)
Select “D – Other Survey” for “Extent.” Be sure to de-select “A-Routine/Std Survey” under “Extent(s).” Only one category is to be selected under “Extent(s).”

Click the “OK” Button when the form is completely updated. ASPEN creates the survey event and returns to the main screen in the Tree View.
Step Three: Process the Survey Findings

- Process Survey Information through Citation Manager

NOTE: To access Citation Manager, locate the survey event listed under the “Surveys” category under the facility name. Right click the survey event to see a menu and select “Citation Manager.”

Process the citations in Citation Manager. Be sure to select “K State Licensure” and “2 Re-Licensure” for State tags and “A-Complaint Investig” for Federal tags in Citation Properties.
Issue Statement of Deficiencies. Record SOD Issuance Date and revisit status on the Survey Properties Form. (Shown below with the red arrow.)

If there are no deficiencies identified, a 2567 is to be issued to the facility stating the facility is complaint with Conditions of Participation. The 2567 issuance date is posted in the “SOD Sent” date field.

If no Plan of Correction is required, the first page of the 2567 is to be signed and dated by the facility administrator and returned to the regional office. The date of the administrator’s sign off is to be posted in “Adm Signoff (X6)” date field.

- Process the Plan of Correction/Update Plan of Correction Information

1) Record date of receipt of the POC and Facility Administrator Signoff (X6) on the Survey Properties Form. (Shown above with the blue arrows.)

2) Record Plan of Correction information for each citation in Citation Manager.

On the “Citation Properties” screen for each citation, record POC received date, Facility Completion date (X5) and SA Accepted date for each citation.

Note: The SA POC Accepted date is the date of the Department’s written notification to the facility of acceptance of the POC. It is not the date of the surveyor approval of the material submitted for that tag.
Step Four: Prepare the 670 and 1539 Forms

When there is an acceptable Plan of Correction (if indicated) and no further revisits or action is required, process the required federal forms.

From the Tree View, right click on the survey event to present a menu.

Select “Print Forms.” From here you are able to prepare the 670 and 1539 Forms for the survey event.
**Step Five: Print Hard Copy Documentation**

From the Tree View, right click on the survey event to present a menu.

Again select “Print Forms.”

From this form, print the 2567, 670 and 1539 Forms.

Submit the following to the Division of Primary and Acute Care Services:

- PPS Survey Booklet
- 2567 Form
- Plan of Correction (if indicated)
- 670 Form
- 1539 Form (with the correct PPS bed capacity)

The Division will forward the documentation to CMS.

Retain a copy for the Area Office files.
Step Six: Close the Survey Event

Go to “Survey Properties” Form from the facility tree by right clicking the survey listed under the Surveys category for a menu, and then selecting “Survey Properties.”

The “Survey Properties” screen will appear. Change the survey status to “CLOSED.”
**PPS Attestations**

ASPEN does not accommodate the annual PPS unit attestation process.

The regional offices should continue to submit on an annual basis the following documentation to the Division of Primary and Acute Care Services:

- The facility completed PPS Survey Booklet
- The facility completed Attestation Form
- 1539 Form (with the correct PPS bed capacity)

Create the 1539 in ACO, even though there is no survey event.

- Right click on the facility name to see a menu. Select “Forms” and then select “CMS C&T 1539.”
This screen will appear.

Select the “Add New” Button.

This screen will appear with four tabs. Complete the information on each tab, following directions as provided in Addendum Eight of this manual.

Screen shots for the remaining three (3) tabs are presented on the following pages.
In the Remarks Section, be sure to document this is a PPS attestation.
The Division will forward the documentation to CMS.

Retain a copy for the Area Office files.
**STATE SURVEYS**

This section of the manual describes the processes for accomplishing state surveys (except for complaints) at health care facilities under the jurisdiction of the Division of Primary and Acute Care Services, when there is not a concurrent Federal survey being accomplished.

**Types:**
- Incident Investigations
- Article 28 Focused Surveys
- Stipulation Monitoring (Process as a re-visit to original event)
- Article 28 Surveys at Diagnostic and Treatment Centers

**STATE COMPLAINTS AND FEDERAL ALLEGATIONS ARE PROCESSED IN ACTS.**

The applicable State regulations are posted in ACO as follows:

- **Section 405:** Acute Care Hospital – State St S – 2.0
- **Section 750:** Diagnostic And Treatment Ctrs – St T – 1.20
- **Sections 702 and 711:** Health Fac Env / Construction – St U – 1.2
- **Section 400:** Health Facility Requirements St Y – 1.2
- **Section 720:** Perinatal Regionalization System – St X – 1.0
- **Section 407:** Primary Care Hospitals – St V – 1.1
- **Section 406:** Rural Hospital Swing Bed – State St W – 1.0
- **Sections 712, 715, 716:** Standards of New Construction – St Z – 1.1
**Step One:** Locate the Facility  (See Section One)

**Step Two:** Create the Survey Shell

1. Expand the facility tree by left clicking the plus sign next to the facility name.

2. Right click on the word “Survey” for a menu.
3. Left click (or double click) on “New Survey.” The Survey Properties Form will appear.

Complete the Survey Properties Form. Use the following selections for Survey Type:

**Incident:**
A survey event will be created for those incidents where the New York State Department of Health conducts an independent investigation of the event (whether or not deficiencies are identified) or if deficiencies are to be sighted for non-compliance with NYPORTS requirements.

K State Licensure **ONLY**

*Note:* The “Extent” category to be selected for incident investigations is “D-Other Survey.”

**Focused Survey or other general Article 28 Survey:**
K State Licensure and 2-Re-Licensure

**Stipulation Monitoring:**
Survey events for Stipulation Monitoring visits will be created as a revisit to the event that caused the enforcement action, and will, therefore, have the Survey Type selected automatically.
Step Three: Process Survey Information through Citation Manager

Expand the facility tree in the Alpha Tab. Expand the listing under “Surveys” by clicking on the plus sign. Locate the survey, right click for a menu and left click on “Citation Manager.”

Every State Survey Statement of Deficiencies is to begin with standard language as presented in the Interpretive Guidelines section of the 0000 Initial Comments Tag.

Standard language for initial comments is retained as a template in the “Interpretive Guidelines” section of the 0000 Initial Comments Tag for each regulation set.

Standard text is inserted into the Statement of Deficiencies by copying and pasting the appropriate statement from the Interpretive Guidelines section into the evidentiary text section of the tag.

Once the standard text is in the evidentiary text section of the tag, the language may be modified to include the PFI number, operating certificate number, complaint or incident number, or the type of Article 28 survey, if indicated.
Introductory language is provided for a complaint investigation, incident investigation or a general Article 28 survey, as well as language for not requiring submission of a Plan of Correction if a Plan of Correction is not required for the Statement of Deficiencies in total. The language provided in the Interpretive Guidelines section of the Initial Comments Tag for each regulation set is presented below. (Complaint survey language is not presented below since these surveys are processed in ACTS.)

**INCIDENTS**

PFI #
OPERATING CERTIFICATE #

NOTE: THE NEW YORK OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS (10NYCRR) DEFICIENCIES BELOW ARE CITED AS A RESULT OF INCIDENT #_____________. THE PLAN OF CORRECTION, HOWEVER, MUST RELATE TO THE CARE OF ALL PATIENTS AND PREVENT SUCH OCCURRENCES IN THE FUTURE. INTENDED COMPLETION DATES AND THE MECHANISM(S) ESTABLISHED TO ASSURE ONGOING COMPLIANCE MUST BE INCLUDED.

**ARTICLE 28 SURVEYS**

PFI #
OPERATING CERTIFICATE #

NOTE: THE NEW YORK OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS (10NYCRR) DEFICIENCIES BELOW ARE CITED AS A RESULT OF A SURVEY CONDUCTED IN ACCORDANCE WITH ARTICLE 28 OF THE NEW YORK STATE PUBLIC HEALTH LAW. THE PLAN OF CORRECTION, HOWEVER, MUST RELATE TO THE CARE OF ALL PATIENTS AND PREVENT SUCH OCCURRENCES IN THE FUTURE. INTENDED COMPLETION DATES AND THE MECHANISM(S) ESTABLISHED TO ASSURE ONGOING COMPLIANCE MUST BE INCLUDED.

**NO DEFICIENCIES**

NOTE: THIS LANGUAGE SHOULD BE POSTED AFTER THE INTRODUCTORY LANGUAGE ADVISING REPORTING THE TYPE OF SURVEY WHICH WAS ACCOMPLISHED. DELETE THE PFI# AND OPERATING CERTIFICATE # SINCE THAT INFORMATION WILL HAVE BEEN POSTED IN THE INTRODUCTORY LANGUAGE.

PFI #
OPERATING CERTIFICATE #
THERE WERE NO DEFICIENCIES IDENTIFIED FOR THIS INVESTIGATION.
SUBMISSION OF A PLAN OF CORRECTION NOT REQUIRED

NO PLAN OF CORRECTION IS REQUIRED FOR THIS STATEMENT OF DEFICIENCIES AS THE FACILITY HAS INITIATED CORRECTIVE ACTION.

LANGUAGE NOT AVAILABLE IN TEMPLATE FORMAT

Due to the numerous inadvertent modifications made to pre-defined text language in ASPEN Survey Explorer on the local servers, the Hospital Program will not use pre-defined text. Therefore, specific language with regard to not requiring a plan of correction for any given citation or any component of a given citation will not be available on the ACO server and is to be typed into the evidentiary text of the specific tag by the surveyor, as applicable.

Examples of language for specific citations is as follows:

NO PLAN OF CORRECTION IS REQUIRED FOR THIS CITATION.

NO PLAN OF CORRECTION IS REQUIRED FOR THIS CITATION SINCE THE FACILITY HAS IMPLEMENTED CORRECTIVE MEASURES.

NO PLAN OF CORRECTION IS REQUIRED FOR THIS CITATION SINCE THE FACILITY HAS IDENTIFIED THE PROBLEM AND IMPLEMENTED CORRECTIVE ACTION.

Examples of language for specific components within citations is as follows:

NO PLAN OF CORRECTION IS REQUIRED FOR THE ABOVE NOTED FAILURE(S).

NO PLAN OF CORRECTION IS REQUIRED FOR THE ABOVE NOTED FAILURE(S) SINCE THE FACILITY HAS IMPLEMENTED CORRECTIVE MEASURES.

NO PLAN OF CORRECTION IS REQUIRED FOR THE ABOVE NOTED FAILURE(S) SINCE THE FACILITY HAS IDENTIFIED THE PROBLEM AND IMPLEMENTED CORRECTIVE ACTION.

You may find it helpful to prepare a word document with the wording noted above for individual citations. Save the document on your hard drive, so that you may refer to it and copy and paste the language into evidentiary text of a citation, as needed.
NYPORTS CITATION LANGUAGE

The following language will be available as a template in the “Interpretive Guidelines” section of specific tags as noted below. The language will be available to be copied and pasted into the evidentiary text area of the tag. Once pasted into that area, modifications may be made as indicated.

Non-Reporting (single case): 405.8 (a) Incident Reporting

This RULE is not met as evidenced by:

Based on an administrative review of the New York Patient Occurrence Reporting and Tracking System (NYPORTS) on date, verified with title of staff member on date, the hospital failed to report the ___code occurrence (If identified through retrospective review, add “as identified through the retrospective review process” to the end of this sentence).

Enter brief description of scenario and reason it is reportable- e.g. In this case an elderly patient underwent a total hip replacement. On hospital day #3, the patient suffered an unexpected stroke. The patient remained impaired two weeks later; this impairment represented a 919 occurrence.)

(See Attachment for Case Identifiers)

Non-Reporting (multiple cases): 405.8 (a) Incident Reporting

This RULE is not met as evidenced by:

Based on an administrative review of the New York Patient Occurrence Reporting and Tracking System (NYPORTS) on date, verified with title of staff member on date, the hospital failed to report the following occurrences associated with cases #1-6 respectively. (If identified through retrospective review, add “as identified through the retrospective review process” to the end of this sentence). Specifically:

• Case #1 Enter brief description of scenario and reason it is reportable
• Case #2, etc.

(See Attachment for Case Identifiers)

Late Reporting (multiple cases): 405.8 (a) Incident Reporting

This RULE is not met as evidenced by:

Based on an administrative review of the New York Patient Occurrence Reporting and Tracking System (NYPORTS) on date, and verified with title of staff member on date, the hospital failed to submit the following occurrence(s) within the required regulatory timeframe. Specifically,
• Case # 1
  The facility became aware of this incident on _______, however, the occurrence was not reported into NYPORTS until _______, more than (24 hours, 30 days) timeframe.

(See Attachment for Case Identifiers)

Late RCA without an Extension (for multiple cases): 405.8 (d) Incident Reporting

This RULE is not met as evidenced by:

Based on an administrative review of the New York Patient Occurrence Reporting and Tracking System (NYPORTS) on date, and verified with title of staff member on date, the hospital failed to submit the Root Cause Analysis (RCA) within 30 days in accordance with §PHL 2805-l. Specifically:

• Case # 1
  The RCA was due to be submitted on _____, and was not submitted until ______.

(See Attachment for Case Identifiers)

Late RCA with an Extension (for multiple cases): 405.8 (d) Incident Reporting

This RULE is not met as evidenced by:

Based on an administrative review of the New York Patient Occurrence Reporting and Tracking System (NYPORTS) on date, and verified with title of staff member on date, the hospital failed to submit the RCA following the issuance of the requested extension in accordance with the §PHL 2805-l. Specifically,

• Case #1
  The RCA was due on ______, but was not submitted until __________.

(See Attachment for Case Identifiers)

Attachment

The attachment for case identifiers will contain columns of consecutively numbered occurrences and correlating NYPORTS Occurrence ID Numbers.

Case #1      NYPORTS Occurrence ID#____________          MR#_____
Case #2      NYPORTS Occurrence ID#____________          MR#_____

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When selecting tags from the State Code, be sure that appropriate category(ies) are selected for that tag on the **Citation Properties** Screen.
**Step Four:** Issue Statement of Deficiencies/Record Date SOD is Issued to the Facility on Survey Properties Form.

Expand the facility tree in the Alpha Tab. Expand the listing under **Surveys** by clicking on the plus sign. Locate the survey, right click for a menu and left click on “Survey Properties.”

Record date SOD was issued to the facility and revisit status.

Revisit status Options:  
0 – Not Determined  
1 – Required  
2 – Not Required  

If there are no deficiencies identified, a statement noting there were no deficiencies identified for this survey should be posted in the 0000 tag for initial comments.
**Step Five:** Process the Plan of Correction/ Update Plan of Correction Information

- Record date of receipt of the POC and Facility Administrator Signoff (X6) in Survey Properties Form.

Expand the facility tree in the Alpha Tab. Expand the listing under “Surveys” by clicking on the plus sign. Locate the survey, right click for a menu and left click on Survey Properties.

Post the date the PoC was received and the Adm Signoff (X6) date.
Record Plan of Correction information for each citation in **Citation Manager**.

Expand the facility tree in the Alpha Tab. Expand the listing under **Surveys** by clicking on the plus sign. Locate the survey, right click for a menu and left click on “Citation Manager.”

In Citation Manager, right click on each citation to see a menu.

![Image 1](https://via.placeholder.com/150)

**Left click on “Citation Properties.”** Record POC received date, Facility Completion date (X5) and SA Accepted date for each citation.

![Image 2](https://via.placeholder.com/150)

The dates posted in Citation Properties for each tag should be taken from the PoC Review Sheet. The “SA POC Accepted” date is the date of the Department’s written notification to the facility of acceptance of the PoC. It is **not** the date of the surveyor approval of the material submitted for that tag.
Step Six: Create Re-visit if Indicated. If no revisit is indicated, go to Step Seven.

- Expand the facility tree in the Alpha Tab.
- Expand the listing under “Surveys” by clicking on the plus sign.
- Locate the survey, right click for a menu and left click on Create Follow-up Survey.
  
  DO NOT REMOVE ANY OF THE SURVEYORS ON THE ORIGINAL SURVEY TEAM!!!

- Complete the Survey Properties Form.

  NOTE: Stipulation and Order Monitoring visits are to be created as a revisit survey shell of the original event and processed to completion, with or without citations. (If there are no deficiencies identified, a statement noting no deficiencies were identified for this survey should be posted in initial comments.)

Step Seven: Once the Plan of Correction is Accepted, Record Survey as Closed
Go to “Survey Properties” Form from the facility tree by right clicking the survey listed under the **Surveys** category for a menu, and then left clicking “Survey Properties.”

The “Survey Properties” screen will appear. Change the survey status to “CLOSED.”
ADDENDUM
ADDENDUM ONE: QUICK REFERENCES

F5 button on keyboard refreshes the screen.

Left clicking on a plus sign expands the options.

Left clicking on the negative sign collapses the options.

Right clicking on an object provides a menu of options.

Left clicking on an object initiates an action.
## ADDENDUM TWO: GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspen Suite:</strong></td>
<td>Surveillance Computerized Data System developed by Alpine Technologies for CMS. The system is comprised of several components, including ACO, ASE, ACTS, and the soon to be rolled out components for Enforcement and Survey and Tracking.</td>
</tr>
<tr>
<td><strong>ACO</strong></td>
<td><em>Aspen Central Office</em> – the main data repository of surveillance activity.</td>
</tr>
<tr>
<td><strong>ACTS</strong></td>
<td><em>Aspen Complaint Tracking System</em> – The complaint tracking system currently used by the Hospital Program for Federal Allegations against Hospitals (including EMTALAs), ESRDs, OPTs, RHCs, and CORFs.</td>
</tr>
<tr>
<td><strong>ASE</strong></td>
<td><em>Aspen Survey Explorer</em> – The surveillance component located on local servers and laptops used in conjunction with ACO to drop down survey shells to enable surveyors to work on the shell while out in the field.</td>
</tr>
<tr>
<td><strong>OSCAR/ODIE</strong></td>
<td>Federal National Database for Surveillance Activities</td>
</tr>
<tr>
<td><strong>CMS</strong></td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td><strong>New York State RO</strong></td>
<td>New York State Department of Health Regional Offices:</td>
</tr>
<tr>
<td></td>
<td>Western Regional Office (WRO)</td>
</tr>
<tr>
<td></td>
<td>Central New York Regional Office (CRO)</td>
</tr>
<tr>
<td></td>
<td>Capital District Regional Office</td>
</tr>
<tr>
<td></td>
<td>Metropolitan Area Regional Office (MARO)</td>
</tr>
<tr>
<td><strong>RO</strong></td>
<td>Federal reference to the CMS Regional Office</td>
</tr>
<tr>
<td><strong>SA</strong></td>
<td>Federal reference to the State Agency</td>
</tr>
<tr>
<td>Event ID</td>
<td>The number assigned to a survey by the Aspen System at the time the survey shell is created.</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Track ID</td>
<td>The number assigned to a certification kit by the Aspen System at the time the kit is created.</td>
</tr>
<tr>
<td>Transaction Number</td>
<td>The number assigned to a transaction event by the Aspen System when a certification kit is uploaded to the national database.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASC</th>
<th>Ambulatory Surgery Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESRD</td>
<td>End Stage Renal Disease</td>
</tr>
<tr>
<td>CORF</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>OPT/SP</td>
<td>Outpatient Physical Therapy/Speech Pathology</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachments</th>
<th>Documents, such as investigative or survey narrative reports or patient/employee identifiers, which are saved in an “rtf” format and are electronically attached to the corresponding survey EventID.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>CMS forms for specific facility types</td>
</tr>
<tr>
<td>Accrediting Agency</td>
<td>An agency approved by CMS to accredit facilities. Approval by CMS indicates the agency’s accreditation requirements are consistent with CMS requirements.</td>
</tr>
<tr>
<td>Certification Kit</td>
<td>Compilation of documents to be submitted to CMS for the initial or recertification survey process.</td>
</tr>
<tr>
<td>Deemed Status</td>
<td>Health care facility accredited by an agency approved by CMS</td>
</tr>
<tr>
<td><strong>Evidentiary Text</strong></td>
<td>Survey documentation (i.e. who, what, when, where) provided to support the deficiency citation.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>F5 – Refresh</strong></td>
<td>Keyboard stroke that will refresh the screen in an ASPEN product and save work accomplished.</td>
</tr>
<tr>
<td><strong>Filters</strong></td>
<td>Mechanism to limit the amount of facilities on the ACO screen to assist in locating a given facility.</td>
</tr>
<tr>
<td><strong>FTE</strong></td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td><strong>Identifier Sheet</strong></td>
<td>Document attached to the Statement of Deficiencies that, through a coding system, identifies specific confidential information, such as staff names, medical record numbers, etc.</td>
</tr>
</tbody>
</table>
| **Interpretive Guidelines** | Information provided to surveyors to assist in defining the basis for a violation.  
In State Regulations, Interpretive Guidelines for TAG 0000 (Initial Comments) provide the standard language to be used for the introductory statement of the Statement of Deficiencies. |
| **“rtf” Format**          | File type in which a document is saved in MS Word in order to attach the document to a particular survey. |
| **Survey Shell**          | The product in the ASPEN suite with a unique identifier, in which survey citations are recorded.  |
| **Unaccredited Facility** | A facility NOT accredited by an accrediting agency recognized by CMS (i.e. JCAHO, AOA).          |
| **Upload to National**    | The transaction which submits certification kit information to the national database (OSCAR/ODIE). |
| **X5**                    | Data field in Citation Properties to record the date the facility reported implementation of corrective action for that specific citation has been, or will be, implemented. |
| **X6**                    | Data field in Survey Properties to record the date the Facility Administrator signed the Plan of Correction. |
ADDENDUM THREE  ATTACHMENTS

Attachments may be added to any survey or any certification kit.

1. Create the document in MS Word.

2. Save the document. Documents to be attached are to be saved as Word Documents or Rich Text Format (rtf). It should be noted that only documents saved in the rtf format can be modified from the View Form once attached.

Save the document with facility name, Event ID, a reference (such as Identifier Coding or Narrative) and the survey date. (Note, do not use the slash sign / when referencing the date.)

Record the name used to save the document. You will need to use the name later in the attachment process.

Be sure you know the location to which you save the document.
3. The “Attach” button is available in the “Certification Kit” or in Citation Manager."
Attachments in Certification Kits

Information is to be attached through the “Attach” Button in Citation Manager for the specific survey event to which the material relates. For example, medical record numbers, staff identifiers and surveyor reports are to be attached to Citation Manager for the survey event at which those medical records were reviewed or the staff interviewed. Medical record and staff identifiers reviewed during a revisit are to be attached through the “Attach” Button in Citation Manager for the revisit event.

Documents attached to a survey event within a Certification Kit are viewable through the “Attach” Button of the Kit.

Documents that relate generally to the Certification Kit and are not specific to a survey event within the Certification Kit may be attached through the “Attach” Button at the bottom of the Certification Kit record. These attachments are viewable only through the Kit and cannot be seen in the attachment screen in any of the Kit’s survey events.

Attachments for State Survey or Survey Not Accomplished within a Certification Kit

Information for surveys not included within a Certification Kit is to be attached through the “Attach” Button of Citation Manager for the specific survey event.

4. Click the “Attach” button in either the Certification Kit or Citation Manager of the survey event. The screen below will appear.
5. In the yellow description box, type the description in the same format as the saved document. That is: facility name, Event ID, a reference (such as Identifier Coding or Narrative) and the survey date. As in other segments of ACO, the yellow box must be completed before the system will allow you to proceed with the attachment process.

6. Click “Attach/View” and navigate to the saved document. The first screen to appear is presented below. Note, you will be looking at the ACO machine.
From this point, you will need to navigate to the Drive where the document is stored on the user's PC.

If this screen appears:

Select “Full Access” in the first box and “Never ask again for any application” in the second box.
OR

If the “C $ on Client (C:)” appears empty as noted below:

Right click on the ACO Citrix ICA Client Task Bar to see a menu and click on “Client Security Status.”
The “Client File Security” box will appear.

Select “Full Access” in the first box and “Never ask again for any application” in the second box.

Navigate to where the document is stored on your PC.

If the document was not originally saved as a Word Document, select “All Files” in the “Files of type.”
NOTE: Only Word Documents and documents saved in “rtf” format (Rich Text Format) are attachable in the ASPEN Suite.

7. Locate the document, double click on the document or click on “Open.” This step accomplishes the attachment process.

8. View the document and make any formatting revisions. Word documents cannot be modified once attached to a survey event or a Certification Kit. Documents saved in Rich Text Format (rft) can be modified in the View Mode.

DOCUMENT DELETION

If you need to delete the document, it must be deleted from the attachment screen.

- Identify the survey in the facility tree, go to Citation Manager or to the Certification Kit, click the “Attach” button.

- Select the attachment to be deleted and click the delete button on the attachment screen.
ADDENDUM FOUR: SELECTIONS IN CITATION PROPERTIES

Citations are posted through CITATION MANAGER and generated through issuance of the 2567 Form.

When selecting tags, be sure to post the correct category on the “Citation Properties” screen. Category selections are derived from the “Type of Survey” categories selected on the SURVEY PROPERTIES Form when establishing the event ID.

Federal categories are as follows:

I - Recertification
A - Complaint Investig
E - Initial Certification
H - Life Safety Code
G - Validation

State categories involve those selections which include the word “Licensure,” as follows:

K – State Licensure
1 – Initial Licensure
2 – Re-Licensure
3 – Complaint Licensure
For the Federal survey categories, select either “I-Recertification” or “E-Initial Certification” when doing surveys other than a complaint. For Validation Surveys at hospitals with deemed status, select both “I-Recertification” and “G-Validation” for the Federal aspects of the survey. Select “A-Complaint Investig” for Federal allegation surveys.

For the State survey categories, select “K-State Licensure” and the appropriate subcategory:

1 – Initial Licensure should be selected for initial survey activities.

3 – Complaint Licensure should be selected for investigations of complaints.

2 – Re-Licensure should be selected for all other types of survey activities, EXCEPT investigation of incidents which result in issuance of a Statement of Deficiencies.

Categories 1, 2 and 3 are subcategories of “K – State Licensure” and therefore two selections must be made when selecting “K – State Licensure.”

The only time only “K – State Licensure” should be selected without a sub-category is for incident investigations resulting in a Statement of Deficiencies. For these survey events, the “D-Other Survey” should be selected as the category under “Extent(s)” and should be the only category selected.

Be sure to select the appropriate categories in “Type of Survey” on the SURVEY PROPERTIES Form.
When selecting tags in **Citation Manager**, select the appropriate Citation Category on the “Citation Properties” Screen.

Federal tags have the following selection options:

- I - Recertification
- A - Complaint Investig
- E - Initial Certification
- G - Validation

When a complaint allegation is processed at the same time as another survey (such as a recertification survey), be sure to identify if the selected tag is related to the recertification, the complaint or both.

If the findings which resulted in the tag selected is related to both the Recertification and the Complaint, then both “I – Recertification” and “A - Complaint” should be darkened.
State Tags involve those selections which include the word “Licensure:”

K – State Licensure
1 – Initial Licensure
2 – Re-Licensure
3 – Complaint Licensure

As previously indicated, categories 1, 2 and 3 are subcategories of “K – State Licensure” and therefore two selections must be made when selecting a tag, “K – State Licensure” and a numbered category.

The only time only “K – State Licensure” should be selected without a sub-category is for incident investigations resulting in a Statement of Deficiencies.

Be sure to select the appropriate categories on the Citation Properties screen for each tag in CITATION MANAGER.
ADDENDUM FIVE: EXCERPTS FROM THE FEDERAL TRAINING MANUAL

EXPORTING A SURVEY SHELL TO ASE FOR PROCESSING

Place a diskette in your A: drive, and then locate the surveys you want to export to ASE. Left click on the surveys and drag and drop them one at a time to the Export icon. See screen shot below.

The following screen appears.

ACO, Chapter 6: Survey Teams and Survey Transfer, “Exporting Surveys and Facilities”

ACO Hospital Training Manual 5 - 21 Version 3 August 2007
Select OK. The surveys are transferred onto the diskette. The following message will appear when the transfer has been successful.

To enter information in ASE, consult the ASPEN Survey Explorer Training Guide for Certification Entry. Start at Chapter 3 Importing a Survey.

Since we have cited tag(s) on our surveys using ASE, we will import the surveys into ACO. From the main ACO toolbar, select the Import button (see below).

The following Import window appears. Notice the Import window defaults to Import Type of Surveys and Import from your A: drive. Select OK to import the survey from a diskette.
ACO, Chapter 6: Survey Teams and Survey Transfer, “Importing Surveys and Facilities “

The **Select Surveys to Import** window appears (see below).
Highlight the survey(s) you want to import if it is not already highlighted and select OK. The system will flash messages as it is going through the import process. The following window appears. Since we entered the 1539 information in ASE and there is already a survey shell in ACO, it is asking if we want to use the CMS 1539 (C&T) information we entered into ASE.

Select Yes. The following message box will appear when the transfer is complete.
Select OK. You can now expand the tree view out to show the surveys you just imported (see below).

Right-click on the Initial Certification. The popup menu below is displayed.
Select **Certification Kit**. The Certification window below appears. Notice the certification information from the survey you imported is now displayed. (See the information pointed out by arrows below)

**Note:** Don’t forget to add the Administrator Signoff (X6) date in the Survey List section and the Office Hours on the CMS 670 form.
Merging ODIE History

You may choose to merge a survey previously created in ASPEN with the associated OSCAR/ODIE historical kit.

Right-click the certification in the tree view. The following popup menu appears.
Select **Merge Survey**. The following Surveys window appears.

ACO, Chapter 4: Certification, “Merging Surveys into Certification Kits”

Highlight the appropriate survey and select **OK**. The following Confirmation message appears.

Select **Yes**. The system will flash messages as it is going through the merging process. A message will appear stating the system needs to be refreshed. Select **OK**. If ASPEN has questions regarding information that is different on the survey events, it will prompt you to choose whether to use the Source or Destination. The Source is the survey created outside of the certification shell. The Destination is the survey within the certification shell. The Source survey will be merged into the Destination survey.
Tracking Certification Kits

You can view a list of certification kits with some details about each. You can tailor the list by status and date.

To view a list of certification kits:

From the main ACO toolbar, select the Tracking menu (see below).
Select **Certifications**. The Certification Kits window appears (see below). Initial certifications appear in **red** and recertifications appear in **blue**. In the ODIE column, if the column is blank the certification kit has not had an attempted upload. If the column has an envelope icon, the kit was uploaded however the kit has not been accepted by the OSCAR/ODIE system. If the column has a green checkmark, the kit has been accepted by the OSCAR/ODIE system.

![Certification Kits Window](image)

ACO, Chapter 4: Certification, “Tracking Certification Kits“

You can use the Status and Dates fields to filter the list of certification kits. To do this:

In the Filters section, select the desired **Status** from the drop-down list. Enter or select the start and end **Dates** of the time range for which you desire. Select **Set**.

The list of certification kits is refreshed to reflect the specified criteria.
To print a Certification Kit report, which includes all listed certification kits, select the Print Tracking Report button. The following Sort Order window appears. You can sort by Facility Name, Provider ID or Exit (Survey) Date. Also, select Ascending or Descending order. The default is Facility Name in Ascending order.

Select OK. The report preview window appears. You can maximize the preview window. The following report is displayed. You may print the report if you desire.

ACO, Chapter 9: CMS Forms and Reports, “The Report Preview Window”
Click the x icon in the upper right corner to close the preview window. You are returned to the Certification Kits window.

To open a certification kit from the Certification Kits window, highlight the kit and select the **View Highlighted Certification** button. The Certification window appears with the Certification & Surveys tab selected (see below).

**Note:** You may also double click on the certification kit to view the certification kit.

```
```

Select **Done** to exit the Certification window. You are returned to the Certification Kits window.

Select **Close** to close the Certification Kits window.
Tracking ODIE Upload Transactions

You can view a master list of upload transactions (attempted and accepted) for a specified time period. This list shows the certification kits that were attempted or successfully uploaded to ODIE and provides some details about each transaction.

To view ODIE upload transactions select the Tracking menu.
From the **Tracking** menu, select **Transactions**. The following window appears. This Date Qualification Dialog window allows you to specify the dates of the transactions you want to view. In the Date Qualification Dialog, enter or select the Start Date and End Date, and select **OK**.

![Date Qualification Dialog](image)

The Transactions window below appears with a list of upload transactions for the specified time range. All attempted and successful upload transactions are shown. Initial certifications are displayed **red**; recertifications are displayed **blue**. The Action column shows the action assigned by ASPEN for processing each upload transaction. The Status column indicated whether the transaction was successful or non-successful.

![Transactions window](image)

ACO, Chapter 4: Certification, “Tracking Upload Transactions“
To view text of error messages (if any) associated with a transaction, highlight the transaction. The Upload Transaction Errors section appears at the bottom of the window. Only the transactions with a Status of -1-Failed will display error messages in the Upload Transaction Errors section. See screen below.
To view the certification kit related to a transaction, from the Transactions window highlight the transaction and select **View Related Certification Kit**. The certification screen below appears.

**Note:** You may also double click on the transaction to view the certification kit.

Select **Done** to close the Certification window. You are returned to the Transactions window.

Select **OK**. The Transactions window closes.
ADDENDUM SIX: DELETING CERTIFICATION KITS

Certification Kits which were created in error or are to be deleted for some other reason can only be deleted by central office staff in the Division of Primary and Acute Care Services.

Contact Central Office staff directly for assistance in deleting certification kits.
ADDENDUM SEVEN:

HOSPITAL/CAH MEDICARE DATABASE WORKSHEET
HOSPITAL/CAH MEDICARE DATABASE WORKSHEET
Worksheet completed by the SA surveyor to gather data, not to be given to provider to fill out

Medicare Provider Number:_______________ Date Updated: _________________

Medicaid Provider Number:_______________ (MMDDYYYY) (M1)

Fiscal Year Ending Date (MMDD): _______

Name and Address of Facility (Include County, City, State):
_________________________________________________
_________________________________________________
_________________________________________________ Zip Code:____

Telephone Number (M2):_______________

Fax Number (M3): _________________

Accreditation Status:_____ Effective Date of Accreditation: _________________
0 Not Accredited (MMDDYYYY) (M4)
1 JCAHO Accredited Expiration Date of Accreditation:_______________
2 AOA Accredited (MMDDYYYY) (M5)
4 Both

State/County Code (M6):_______ CLIA ID Numbers (M9):
State Region Code (M7):_______

Request to Establish Eligibility In (M8):_____
1 Medicare
2 Medicaid
3 Both

Type of Hospital or a Critical Access Hospital (CAH) (select 1) (M10):____
01 Short-term
02 Long-term
03 Religious Non-medical Health Care Institution
04 Psychiatric
05 Rehabilitation
06 Childrens
07 Distinct Part Psychiatric Hospital
11 CAH
Affiliation with a Medical School (M11):____
  01 Major
  02 Limited

Type of Control (select 1) (M13):____
  01 Church
  02 Private
  04 Proprietary
  05 Federal

Average Daily Census (M14):____

Number of Staffed Beds (M15):____

Type of System Involvement (M16):____
  01 None
  02 System Ownership
  03 System Management
  04 Both System Owned and Managed

Name of System (M17):__________________

Corporate Headquarters City (M18):_________________________________ State (M19):____

| Number of Employees Salaried by Hospital/CAH (Use Full Time Equivalents FTE) |
|-------------------------------|-------------------|-------------------|---------------|
| M20 Physicians (Salaried only) | M21 Physicians - Residents | M22 Physician Assistants (PA) | M23 Nurses - CRNA |
| M24 Nurses - Practitioners | M25 Nurses - Registered | M26 Nurses - LPN | M27 Dieticians |
| M28 Medical Social Workers | M29 Medical Laboratory Technicians | M30 Medical Technologists (Lab) | M31 Nuclear Medicine Technicians |
| M32 Occupational Therapists | M33 Pharmacists (Registered) | M34 Physical Therapists | M35 Psychologists |
| M36 Radiology Technicians (Diagnostic) | M37 Respiratory Therapists | M38 Speech Therapists | M39 All Others |

Type of Reimbursement or Status Categories of a Hospital or a CAH (select all that apply) (M40):____

<table>
<thead>
<tr>
<th>01 CAH Psychiatric DPU</th>
<th>02 CAH Rehabilitation DPU</th>
<th>03 Call Swing Beds</th>
<th>04 Cancer Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 Hospital in a Hospital - Host</td>
<td>06 Hospital in a Hospital - Tenant</td>
<td>07 Hospital PPS Excluded Psych Unit</td>
<td>08 Hospital PPS Excluded Rehab Unit</td>
</tr>
<tr>
<td>09 Hospital Swing Beds</td>
<td>10 Medicare Dependent Hospital</td>
<td>11 Regional Referral Center</td>
<td>12 Sole Community Hospital</td>
</tr>
</tbody>
</table>
Services Provided by the Facility (M41):_____

1 Services provided by facility staff
2 Services provided by arrangement or agreement
3 Services provided through a combination of facility staff and through agreement

Leave blank if the services are not provided

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services (Owned)</td>
<td>01</td>
</tr>
<tr>
<td>Alcohol and/or Drug Services</td>
<td>02</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>03</td>
</tr>
<tr>
<td>Audiology</td>
<td>04</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>05</td>
</tr>
<tr>
<td>Burn Care Unit</td>
<td>06</td>
</tr>
<tr>
<td>Cardiac Catheterization Laboratory</td>
<td>07</td>
</tr>
<tr>
<td>Cardiac-Thoracic Surgery</td>
<td>08</td>
</tr>
<tr>
<td>Chemotherapy Service</td>
<td>09</td>
</tr>
<tr>
<td>Chiropractic Service</td>
<td>10</td>
</tr>
<tr>
<td>CT Scanner</td>
<td>11</td>
</tr>
<tr>
<td>Dental Service</td>
<td>12</td>
</tr>
<tr>
<td>Dietetic Service</td>
<td>13</td>
</tr>
<tr>
<td>Emergency Department (Dedicated)</td>
<td>14</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>15</td>
</tr>
<tr>
<td>Extracorporeal Shock Wave Lithotripter</td>
<td>16</td>
</tr>
<tr>
<td>Gerontological Specialty Services</td>
<td>17</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>18</td>
</tr>
<tr>
<td>Hospice</td>
<td>19</td>
</tr>
<tr>
<td>ICU - Cardiac (non-surgical)</td>
<td>20</td>
</tr>
<tr>
<td>ICU - Medical/Surgical</td>
<td>21</td>
</tr>
<tr>
<td>ICU - Neonatal</td>
<td>22</td>
</tr>
<tr>
<td>ICU - Pediatric</td>
<td>23</td>
</tr>
<tr>
<td>ICU - Surgical</td>
<td>24</td>
</tr>
<tr>
<td>Laboratory - Anatomical</td>
<td>25</td>
</tr>
<tr>
<td>Laboratory - Clinical</td>
<td>26</td>
</tr>
<tr>
<td>Long Term Care (swing-beds)</td>
<td>27</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28</td>
</tr>
<tr>
<td>Neonatal Nursery</td>
<td>29</td>
</tr>
<tr>
<td>Neurosurgical Services</td>
<td>30</td>
</tr>
<tr>
<td>Nuclear Medicine Services</td>
<td>31</td>
</tr>
<tr>
<td>Obstetric Service</td>
<td>32</td>
</tr>
<tr>
<td>Occupational Therapy Services</td>
<td>33</td>
</tr>
<tr>
<td>Operating Rooms</td>
<td>34</td>
</tr>
<tr>
<td>Ophthalmic Surgery</td>
<td>35</td>
</tr>
<tr>
<td>Optometric Services</td>
<td>36</td>
</tr>
<tr>
<td>Organ Bank</td>
<td>37</td>
</tr>
<tr>
<td>Organ Transplant Services</td>
<td>38</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>39</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>40</td>
</tr>
<tr>
<td>Pediatric Services</td>
<td>41</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>42</td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>43</td>
</tr>
<tr>
<td>Positron Emission Tomography Scan</td>
<td>44</td>
</tr>
<tr>
<td>Post-Operative Recovery Rooms</td>
<td>45</td>
</tr>
<tr>
<td>Psychiatric Services - Emergency</td>
<td>46</td>
</tr>
<tr>
<td>Psychiatric - Child/Adolescent</td>
<td>47</td>
</tr>
<tr>
<td>Psychiatric - Forensic</td>
<td>48</td>
</tr>
<tr>
<td>Psychiatric - Geriatric</td>
<td>49</td>
</tr>
<tr>
<td>Psychiatric - Inpatient</td>
<td>50</td>
</tr>
<tr>
<td>Psychiatric - Outpatient</td>
<td>51</td>
</tr>
<tr>
<td>Radiology Services - Diagnostic</td>
<td>52</td>
</tr>
<tr>
<td>Radiology Services - Therapeutic</td>
<td>53</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>54</td>
</tr>
<tr>
<td>Respiratory Care Services</td>
<td>55</td>
</tr>
<tr>
<td>Rehab - Inpatient (CARF Acc)</td>
<td>56</td>
</tr>
<tr>
<td>Rehab - Inpatient (Not CARF Acc)</td>
<td>57</td>
</tr>
<tr>
<td>Rehab - Outpatient</td>
<td>58</td>
</tr>
<tr>
<td>Renal Dialysis (Acute Inpatient)</td>
<td>59</td>
</tr>
<tr>
<td>Social Services</td>
<td>60</td>
</tr>
<tr>
<td>Speech Pathology Services</td>
<td>61</td>
</tr>
<tr>
<td>Surgical Services - Inpatient</td>
<td>62</td>
</tr>
<tr>
<td>Surgical Services - Outpatient</td>
<td>63</td>
</tr>
<tr>
<td>Trauma Center (Certified)</td>
<td>64</td>
</tr>
<tr>
<td>Transplant Center, Medicare Certified</td>
<td>65</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>66</td>
</tr>
</tbody>
</table>

Sprinkler Status, Primary Location (select 1) (M42):_____

01 Totally sprinklered: All required areas are sprinklered
02 Partially sprinklered: Some but not all required areas are sprinklered
03 Sprinklers: None
Number of off-site locations with the same provider number (M43):

| 01 | Inpatient Remote Locations | 07 | Satellites of a PPS Excluded Psych Unit |
| 02 | Offsite Freestanding Outpatient Surgery | 08 | Satellites of a Long Term Care Hospital |
| 03 | Urgent Care Center (Freestanding) | 09 | Satellites of a cancer hospital |
| 04 | Satellites of a Rehabilitation Hospital | 10 | Satellites of a Childrens’ Hospital |
| 05 | Satellites of a Psychiatric Hospital | 11 | Other Provider-Based Locations |

Identification Number of Off-site Location (from table) (M44):_______

Name of Off-site Location M45):_____________________________________________________

Off-site Street Address (M46):_________________________________________________________________

County (M47)_____________________________

City (M48):____________________________State (M49):_______ Zip Code (M50):_______

Sprinkler Status of Off-site Location (select 1) (M51)________

01 Totally sprinklered: All required areas are sprinklered
02 Partially sprinklered: Some but not all required areas sprinklered
03 Sprinklers: None
04 Sprinklers are not required but the location is sprinklered

Attach a List of Additional Locations:

Number of related or affiliated provider numbers (M52):_______

| 01 | ASC | 06 | Home Health Agency |
| 02 | Co-located Hospitals | 07 | Hospice |
| 03 | Co-located Satellites of Another Hospital | 08 | PRTF |
| 04 | ESRD | 09 | RHC |
| 05 | FQHC | 10 | SNF |

Identification Number of related or affiliated provider numbers (M53):_____________________

Provider Number (M54):______________

Attach a List:

Signature of Authorized Individual:_____________________________________________________

Name of Authorized Individual:____________________________________Date:_____________
ADDENDUM EIGHT:

DIRECTIONS FOR COMPLETION OF THE TRANSMITTAL

CMS 1539 FORM

As presented in the ASPEN 8.5 Certification Procedures Guide

Pages 188 - 194
### Certification Kit Fields

**Transmittal (CMS-1 539)**

**CMS-1539 Part I**
To be completed by the State Survey Agency

<table>
<thead>
<tr>
<th>Field/Button</th>
<th>Fac Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date: Change of Ownership (L9)</td>
<td>All</td>
<td>Enabled only in ARO for Medicare providers. Enabled in ACO and ARO for NF Only, Medicaid HHA, and ICF/MR providers. Not enabled for initial certifications that have not been accepted by OSCAR. If there has been a Change of Ownership since the last survey prior to the current certification, enter the date the change was made. This date must be later than current participation date (L24) and current CHOW date, if any. It cannot be later than one year from today’s date. The CHOW date is kept in synch if there is more than one current kit. It is carried forward from prior recertifications.</td>
</tr>
</tbody>
</table>

188 7/7/05 ASPEN 8.5 certification
| **Date of Survey (L34)** | All | Appears on the screen for accredited/deemed Hospital or deemed HHA, ASC, and Hospice recertifications only (as Survey Date). See “Date of Survey for Deemed Kits without Surveys” on page 15 for details. Otherwise, it is on the printed 1539, but not on the screen. Is displayed on the certification kit’s title bar as the Cert Exit date. It is the latest exit date of the standard surveys linked to a certification kit. For NHs and ICF/MRs, and non-deemed Hospitals, ASCs, and Hospices, it is the later of the exit dates of the Health standard and LSC standard surveys. For other provider types, it is the exit date of the Health standard survey. |
| **Type of Action (L8)** | All | Can be Initial, Recertification, or Termination. Enabled only for recertification kits that have not been accepted by OSCAR. If there are no prior kits for the provider, Type of Action is designated as Initial by OSCAR and cannot be changed. For Hospitals, HHAs, ASC5, or Hospices, if you choose an accrediting agency, i.e., any value other than 0 UNACCREDITED, for Accreditation Status (L10), then an additional value, 5 VALIDATION, is available as an option for Type of Action. |
| **Accreditation Status (L10)** | Hospital HHA ASC HOSPICE PRTF | You can select an accrediting agency from the drop-down list. The system administrator can maintain this list via the System menu (Lookup Values | Dictionary | SURV1539). Note: This value is not tied to the accreditation value(s) selected on the Associations tab of the Facility Definition window. |
### Certification Kit Fields

<table>
<thead>
<tr>
<th>Field</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deemed?</td>
<td>Hospital</td>
<td>This indicator is enabled only if an accepted accrediting agency is selected in the Accreditation Status (L10) field. This field is not enabled for PRTFs, which can be accredited, but not deemed. Hospitals are automatically deemed if they are accredited, so when an accrediting organization is specified for a Hospital in the L10 field, the Deemed? indicator is set to Yes and locked. HHA, ASC, and Hospice providers can be accredited but not necessarily deemed, so for these provider types, the L10 field and the Deemed? indicator operate independently. Once a certification is successfully uploaded, Accreditation Status and the Deemed? indicator cannot be changed. If a provider changes its accredited or deemed status, a new certification kit should be created.</td>
</tr>
<tr>
<td>Fiscal Year Ending Date (L35)</td>
<td>All</td>
<td>MM/DD format. ACO supplies the /. Optional for facility/provider type 024 (NF Only). Kept in synch if there is more than one current kit. Carried forward from prior kits.</td>
</tr>
<tr>
<td>LTC Certification Period From/To</td>
<td>N/A</td>
<td>These fields are not used, so they are always disabled.</td>
</tr>
<tr>
<td>Certified As (L12)</td>
<td>All</td>
<td>Indicate whether the provider is certified as A - In Compliance or B - Not in Compliance. If you select A, you may also select what the compliance is Based On from options in the list box. The list varies according to facility/provider type. You can select more than one item. This field is set to B - Not in Compliance and disabled when Type of Action (L8) is Termination.</td>
</tr>
<tr>
<td>Total Facility Beds (L18)</td>
<td>Hospital</td>
<td>The total number of beds in the facility, including those in non-participating and non-licensed areas. This number is kept in synch if there is more than one current kit. It is carried forward from prior certifications. The number must be between 1 and 9999 inclusive. For NHs, you cannot have fewer beds (L18) than residents (F78 on Form 672) prior to the first upload of a certification kit. Once the kit has been successfully uploaded, you can change the number, and that change will be sent to OSCAR implicitly (without uploading the kit). In this case there will be no comparison of L18 to the number of residents on CMS-672.</td>
</tr>
<tr>
<td>Certification Kit Fields</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Total Certified Beds (L17)</strong></td>
<td>Hospital NH ICF/ MR</td>
<td>This field is calculated by ASPEN for NHs and ICF/MRs. For NHs, it is the total of the numbers entered in L37, L38 and L39. For ICF/MRs, it is the same as L43. For Hospitals, there is no beds breakdown, so L37, L38, L39, and L43 are not enabled and L17 is not automatically calculated. L17 must be greater than zero except for an involuntary termination, i.e., Termination Code (L30) is 05 or 06.</td>
</tr>
<tr>
<td><strong>LTC Certified Beds Breakdown (L37, L38, L39, L43)</strong></td>
<td>NH ICF/MR</td>
<td>Enter the number of beds in the applicable field(s): 18 SNF (L37), 18/19 SNF (L38), 19 NF (L39). Fields are enabled as appropriate for the current NH provider type. IMR Beds (L43) is enabled for any ICF/MR. The bed fields may be left blank in the case of an involuntary termination, i.e., Termination Code (L30) is 05 or 06. The Type drop-down list appears for NH Medicare providers (021, 022, 023) if at least one kit for the provider (not necessarily the current kit) has been uploaded and accepted by OSCAR. To change the Medicare provider type, select the desired type from the Type drop-down, which enables the applicable bed fields. Update bed numbers as needed. You cannot change Type for a Medicaid provider (024); the drop-down list is not displayed. ACO/ARO sends a bed number update to OSCAR as an implicit transaction, i.e., without another upload of the entire kit. Note: For Hospitals; there is no beds breakdown—only totals—so L18 and L17 are enabled, but this section is disabled.</td>
</tr>
<tr>
<td><strong>Aspen Beds</strong></td>
<td>NH ICF/MR</td>
<td>If your office maintains ASPEN bed summary information, this button provides a link to that data. You can create new bed summaries, or modify/delete existing summaries from here. The information is for reference only; bed summary numbers do not automatically transfer to the CMS-1539 beds fields.</td>
</tr>
<tr>
<td><strong>Facility Meets (e)(1) or 1861 (j)(1)</strong></td>
<td>NH</td>
<td>Y/N. Does the facility/provider meet the provisions of the specified sections of the Social Security Act?</td>
</tr>
<tr>
<td><strong>See Below for 16. State Remarks</strong></td>
<td>All</td>
<td>Brief remarks entered in 30 Remarks (at the bottom of the tab) will print under 16. State Remarks when you print the form. Longer remarks will print on additional pages to be attached to the form.</td>
</tr>
</tbody>
</table>
**Certification Kit Fields**

<table>
<thead>
<tr>
<th>Field/Button</th>
<th>Fac Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyor Sign Date (L19)</td>
<td>All</td>
<td>Required. Date the surveyor signed the CMS-i539. Must be equal to or later than the survey date, but not later than today’s date. You will not be able to change this date once the kit is uploaded successfully.</td>
</tr>
<tr>
<td>State Agency Approval (L20)</td>
<td>All</td>
<td>Required. Date the State Agency approved the certification. This date must be equal to or later than the surveyor signature date, but not later than today’s date. You will not be able to change this date once the kit is uploaded successfully.</td>
</tr>
</tbody>
</table>

**CMS-1539 Part II**
To be completed by CMS Regional Office or Single State Agency

<table>
<thead>
<tr>
<th>Field/Button</th>
<th>Fac Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination of Eligibility (L21)</td>
<td>All</td>
<td>Required. Select Yes or No. If No, a Termination Code (L30) is required. Termination Code is enabled in ARO; it’s enabled only for NF Medicaid FIHA, and ICF/MR providers in ACO. Not enabled for initial certification kits that have not been accepted by OSCAR or for providers terminated due to a change of status.</td>
</tr>
<tr>
<td>Compliance with Civil Rights</td>
<td>N/A</td>
<td>Not applicable for NH or HHA.</td>
</tr>
<tr>
<td>Statement of Financial Solvency</td>
<td>N/A</td>
<td>Not applicable for NH or HHA.</td>
</tr>
<tr>
<td>Ownership/Ctrl Disclosure Stmt (CMS-1513)</td>
<td>N/A</td>
<td>Not applicable for NH or HHA.</td>
</tr>
<tr>
<td>Original Date of Participation (L24)</td>
<td>All</td>
<td>Required. Enabled in ARO, and in ACO for NFs (024) Medicaid HHA5 (052) and ICF/MR5. For initial certifications with no deficiencies (for NH, no deficiencies with SS greater than D), this date should be equal to or later than the survey date. If deficiencies exist on an initial certification, this date should be equal to or later than the CMS-2567 provider signoff date (X6). For recertifications, the only qualifier is that L24 should be earlier than the termination date, if there is one. L24 is kept in synch if there is more than one current kit, and is carried forward from prior kit(s).</td>
</tr>
<tr>
<td>LTC Agreement Beginning (L41)</td>
<td>ICF/MR</td>
<td>Visible only in ICF/MR certification kits. When clicked, this button will open the LTC Agreement History window, containing the dates of the prior LTC Agreement. Enter the starting date of a certified long term care facility’s time limited agreement. Cannot be entered or changed after a kit has been successfully uploaded.</td>
</tr>
<tr>
<td>Field Name</td>
<td>Required</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LTC Agreement Ending (L25)</td>
<td>ICF/MR</td>
<td>Enter the ending date of a certified long term care facility’s time limited agreement. Cannot be entered or changed after a kit has been successfully uploaded.</td>
</tr>
</tbody>
</table>
| Termination Code (L30)                 | All      | Required. Enabled in ARO. In ACO, this field is enabled only for NF (024), Medicaid HHA, and ICF/MR providers, and non-participating (NP) Hospitals. It is not enabled for initial certification kits that have not been accepted by OSCAR. It also is disabled for a provider terminated as the result of a change of status.  
  If you select anything but 00 Active here, you must also supply a Termination Date (US). If you select Merger or Provider Status Change, you need to enter a Cross-Reference Provider # (SF03 on the Certification & Surveys tab). |
| LTC Extension Date (L27)               | ICF/MR   | The date of an extension of a certified long term care facility’s time limited agreement.                                                                                                              |
| Alternative Sanction (L44, L45)        | ICF/MR   | Enter the date that payments for new admissions in a long term care facility will be denied if an intermediate sanction is taken against the facility, and the date that this action is rescinded.               |
| Termination Date (L28)                 | All      | Must be entered when Termination Code is anything but 00 Active.                                                                                                                                          |
| Intermediary/Carrier No. (L31)         | All      | Must be a valid and active intermediary. Disabled for NF Only (024), Medicaid HHA, and ICF/MR providers. Kept in synch if there is more than one current kit, and carried forward from prior certifications.  
  If you change the intermediary here, the prior intermediary’s number is stored in SF01 on the Certifications & Surveys tab. |
| RO Receipt Date (L32)                  | All      | Enabled in ARO only. Required for validation surveys.                                                                                                                                                  |
  If nothing is entered, ASPEN will insert the date and time of the first upload attempt except for validation certifications, NF Only (024), Medicaid HHAS (052), ICF/MRs, or unflagged recertifications.  
  If the RO chooses to review, this date must be equal to or earlier than the Determination Approval date (L33), except in the case of unflagged recertifications, when it is equal to or later than L33. |
<p>| RO Analyst                             | All      | ARO only. 3 characters. Enter the initials of the RO reviewer.                                                                                                                                       |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>ARO</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination Approval (L33)</td>
<td>All</td>
<td>Required. Enabled in ARO, and in ACO for NF Only (024), Medicaid HHA5 (052), and ICF/MRs. Must be equal to or later than RO Receipt date (L32). When you upload an unflagged recertification, ASPEN attempts to insert the date of the upload if this field is blank. It can also be entered manually. This date must be entered manually for initial certifications, flagged recertifications, and terminations.</td>
</tr>
<tr>
<td>RO Final Rev Date # (SF15)</td>
<td>NH</td>
<td>Regional Office final review date. Available to RO5 only for NF Only (024), Medicaid HHA5, and ICF/MRs. If L32 is entered, Final Review Date (SF15) is enabled and must be provided. It must be greater than or equal to L32. Cannot be entered if 02 is blank.</td>
</tr>
<tr>
<td>Remarks</td>
<td>All</td>
<td>Used to enter notes and instructions (up to 32 K characters) relevant to the certification. Brief remarks entered will print under 16. State Remarks when you print the form. Longer remarks will print on additional pages to be attached to the form.</td>
</tr>
<tr>
<td>FACILITY INFORMATION</td>
<td>CERTIFICATION KITS</td>
<td>CERTIFICATION KITS</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>ESRD, OPT, CORF, RHC</td>
<td>HOSPITALS AND ASC</td>
</tr>
</tbody>
</table>
Attachment 46

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 46
Hospital Quality Activities
Hospital and D&TC Complaint Intake

Centralized Hospital Complaint Intake Unit (CHIP) Complaint Manual.
ACTS TRAINING MANUAL

New York State Department of Health
Hospital Program

June 2004
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June 2004 iii
INTRODUCTION

The ASPEN Complaint Tracking System (ACTS), one of the modules of the ASPEN Suite, provides a date-certain complaint tracking system for the processing of complaints. The module is designed to allow for creation of the complaint at the time of receipt, either by telephone or written communication.

Immediately upon opening the intake, a complaint record is established and a tracking number assigned. Basic information may be posted when the record is created and subsequently modified and updated at any point after creation.

In the Hospital Program, the method of processing the complaint varies significantly based on triage of the complaint and the facility type against which the complaint is filed. A complaint may be triaged and the processing type identified either before or after the intake has been initiated into ACTS and the complaint record established.

This manual presents the three ways to process a complaint within the Hospital Program. As noted above, the processing type will be determined after the complaint has been triaged and may be modified at anytime during the investigative process.
CREATING THE COMPLAINT RECORD

1. Locate the facility against which the complaint has been filed, using the tree list or the find button.

   Note: Filters in ACTS are consistent with the filters established in ACO.

2. Right click on the facility for a menu and select “New Intake.”
3. This screen will appear:

![Complaint Record Screen]

This is the record of the complaint. A complaint number is automatically assigned and recorded in the blue bar at the top of the complaint record.

There are several tabs for each record. The record automatically opens to the “Intake” tab.
STATE COMPLAINTS

INTAKE AND TRIAGE

This section specifically applies to the processing of State complaints.

For those complaints where it is determined, either at triage or at any point during the investigative process, that CMS authorization should be requested to proceed with a Federal allegation survey, it is required a State complaint record be established to process the Article 28 activities. A separate Federal complaint record is to be established to process the request to proceed with a Federal allegation survey and, if approved, the Federal survey activities.

Two separate records are required due to the time frames involved in processing the two separate surveys.

1. Complaint Intake

There are several sections for recording information on the Intake Tab.

It should be noted that there is a “Notes” Section at the very bottom of the Intake Tab, which will be addressed in detail in Section 6 (page 15). This section is specifically designed to collect information during the intake of complaints filed verbally. Prompt questions are available to the right of the Notes Section to assist in collecting information necessary to triage the complaint. However, a summarization of the complaint issues identified in written complaints should also be recorded in the Notes Section of the Intake Tab when the complaint record is created.

- Section One: Intake Staff

The intake staff automatically defaults to the person logged into ACTS. This can be modified by clicking on the “Change Staff” button if the staff intake person is different from the person entering the data on the intake page. Clicking the “Change Staff” button activates the staff selection box and the drop down selection option becomes functional.

The “Status” Box is automatically populated based on activities posted in the record.
Section Two: Assignment

Intake Type: The options for “Intake Type” are “01 Complaint” or “02 Entity Reported Incident.” Always select “01 Complaint.”

When a complaint is being investigated that has also been reported as an incident, “01 Complaint” is to be selected with the NYPORTS incident number posted in the “State Complaint ID” field.

(Note: Incidents investigated by the Department, for which there is no related complaint, and for which deficiencies are identified should continue to be processed in ACO. The survey shell is to reflect “K-State Licensure” and “F-Inspection of Care” as the selections in “Type of Survey.”)

Reference Numbers

The reference numbers located on the right hand side in the Assignment Box should be used as follows:

State Complaint ID: As noted above, the NYPORTS number should be posted here if the complaint involves an event for which an incident has been reported.

CIS number: This is a Federal field and is not to be used.

External Control #: This field should be used for OPMC tracking numbers.
**Intake Subtype:** There are three (3) options available. For a State Complaint, select item B.

**Note:** The Hospital Program will not be using category C – *No State or Federal Provider Compliance Issue Involved.*

ACTS allows for data entry of records for which there are no applicable state or Federal requirements. Since we do not record events which are not within our regulatory jurisdiction, the Hospital Program will not be using this field.

**Received By:** Identify the complaint receipt mechanism from the drop down list provided.

**Location Received:** Select the location the complaint was received using a numbered category for Regional Offices. You may have to scroll up to locate the numbered categories.

(Regional offices with the prefix “The” are reserved for Long Term Care complaints. The Hospital Program is to select Regional Offices with a number prefix.)

June 2004
Responsible Parties: The lower half of the Assignment Section relates to “Responsible Parties.”

Click on the “Add S.A.” Button with the green plus sign. (S.A. = State Agency)
This box will appear:

The person identified for the State Agency is to be the assigned surveyor. Individual area offices may choose to post additional staff, such as the complaint clinical coordinator or the team leader.

Scroll down on the drop down box to locate the State Agency responsible person. You may begin to type the last name to bring you closer to the person’s location in the drop down box.
Click OK to add the person to the “Responsible Parties” listing.

Since this is a State Complaint, do not enter names for R.O. (R.O. = CMS Regional Office.)

Names can be deleted from the “Responsible Parties” listing by highlighting the name and clicking on the “Delete” Button with the red negative sign in the Assignment Section.

**Responsible Team:** Select the responsible team from the drop down box. Again be sure to select the team with a number. (Regional offices with a numbered prefix are to be selected for the Hospital Program.) You may need to scroll up to locate the team with a number prefix.
Section Three: Complainant/Patient Information

The next sections of the Intake Tab relate to Complainant and Patient Information.

Complainant Information

The Intake Tab defaults to the Complainant Tab when opened. To record complainant information, type in the complainant last name, and first name (if known) and click the “Find/Add” Button with the green plus sign.
A listing of complainant’s with similar names will appear.

If the complainant is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The complainant will be added to the record complainant listing.

If the complainant is new to the system, it will be necessary to create a record for that person.

Clicking on the “New” Button will allow creation of a new record for this complainant.
Filling in the appropriate information and clicking the “OK” Button will create the record in the ASPEN database and post the complainant in the listing of complainants for the active record.

There is not a specified limit of the number of complainants per intake.

The system automatically defaults to recording the complainant as anonymous. This is meant to reflect the complainant wishes to remain anonymous to the facility. If the complainant requests anonymity from all aspects of the complaint process, including the New York State Department of Health, do not use the “Add Anonymous” Button to record the complainant. Rather, type ANON in the last name of the Search Section, click the “Find/Add” Button, and select ANONYMOUS HP from the listing and click the “OK” Button. The ANONYMOUS HP record has the identification number 03JOM3.
Patient Information

Patient identification and information is added in the same format as the complainant information. Click on the Patient Tab, enter the name or part of the name in the search area, and click the “Find/Add” Button with the green plus sign.

If the patient is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The patient will be added to the listing. Again, if the patient is new to the ASPEN system, it will be necessary to create a record for that person.

NOTE: The Residents/Patients Tab includes information on the date and time of the alleged event. These fields are optional for purposes of data entry. If the complaint is specific to an event, you may want to record the actual date and possibly the time. If the complaint involves care generally during a specific hospitalization or time period, you may want to record the admission date.

Alleged Perpetrators

The final tab in this section is for the posting of “Alleged Perpetrators.” Allegations of abuse by facility staff, visitors or other patients may be recorded in this section in the same format as done for identifying the complainant and the patient.
• **Section Four: Source**

Specify the source of the complaint.

Select up to three options which best describe the source of the complaint. If the complainant is anonymous and wishes to remain anonymous, click the 05 Box.

• **Section Five: Received Date/Association**

*Received Start and End Dates:*

The date/time of the start and end dates for the complaint receipt defaults to the date and time the Intake Tab was first opened. This may be changed as indicated, if the intake was at a time other than when the intake tab was opened (i.e. date letter received).

For most complaints, the received start and end dates will be the same. There is an option to post a different date for the “End Date.” This is to allow the submission of additional information in order to appropriately triage the complaint. The system allows fourteen (14) working days for the submission of additional information. Different received start and end dates should be utilized only if the initial information provided is so vague the issues of the complaint cannot be identified and additional information is formally requested from the complainant.

Complaints for which additional information is not received within the fourteen-day time frame, are to be closed. It is expected less than five percent (5%) of complaints received will have different received start and end dates.
**Association:**

Just below the Received Start and End Date Fields is the Association Section.

The Association function will be utilized only to associate State complaint records with a Federal record requesting CMS authorization to proceed with an allegation survey. This is addressed in detail in Section Two of this manual.

- **Section Six: Notes**

As noted earlier, the final section of the Intake Tab is the Notes Section.

ACTS is designed to record intake at the time the complaint is being filed either verbally or written. The Notes section provides an area for the intake person to record the major issues of the complaint. The actual allegations will be developed based on the intake notes, written material and surveyor communication with the complainant.

Available to the intake person are questions or prompts to the right of the Notes Section, which may be of assistance in gathering critical information.

It also should be noted there is a spell check feature in the Notes Section, which should always be utilized.
2. Complaint Triage

The remaining section of the Intake Tab has to do with the complaint triage process. The section is labeled “Response Information.”

![Image](image_url)

This section is located just before the “Notes” Section of the Intake Page.

**Priority:**

Based on the information provided, the complaint clinical coordinator is to assign a priority to the complaint. Triage priority definitions are provided in Attachment Six and in the Hospital Program Complaint Manual. These definitions are consistent with the Federal priority designations as presented in CMS Memorandum Ref: S&C-04-09 (Attachment Five of this manual).

Establishing the complaint priority will define the processing type and time frames (See State Complaint Manual). Post the number of days in which the investigation should be initiated in the “Investigate within _______ days.” This is the number of working days in which complaint review activities are to be initiated by the surveyor.

Next post the actual date corresponding to the triage time frame (which is 10 days in the case noted above) by which the surveyor should initiate complaint review activities.

At this point, if the complaint is determined to be a potential EMTALA allegation, an allegation of Patient Death with Restraints or another Federal allegation for which CMS authorization is required to proceed with a Federal survey, finish creation of the State complaint record and proceed to Section Two to create the Federal complaint record to request authorization to proceed with a Federal allegation survey.
3. **Acknowledgment Letter to Complainant**

The acknowledgment letter to the complainant is to be posted through the “Notices” Button.

Click the “Notices” Button at the bottom of the screen.

This window will appear:

In the “Notification History” section, select the “New” Button.
This screen will appear:

![Notification Type](image)

Fill out the fields by selecting items from the drop down boxes:

- The selection for "Type" should be 01:

  ![Type Selection](image)

  - 01 Acknowledgement to Complainant
  - 02 Field Office
  - 03 Final Response to Complainant
  - 04 Findings Sent to Complainant
  - 05 Complaint to Field Office (Acknowledged)
  - 06 Complaint to Field Office (Sent)
  - 07 Memo to Field Office to Unsustain
  - 08 Unsustain to Accused
  - 09 Sustain to Accused

The date the complaint was acknowledged will automatically post in the "Acknowledged" field in the "Acknowlegdement and Parties Notified" Section of the Investigations Properties Page.
At this point a hard copy of the Investigation Report should be printed and provided to the investigating surveyor or investigating survey team.

Select the “Print” Button at the bottom of the complaint record.

This screen will appear. Select “Investigation Report” and click on the “OK” Button. The form will appear on your screen for printing.
ALLEGATIONS

Allegations are entered by the surveyor on the Allegations Tab.

1. Click on the Allegations Tab

This screen will open:
2. In the Allegations Section, click the “Add” Button with the green plus sign.

The “Allegation Input” window will appear:
3. Specify the Category, Subcategory and Seriousness of each allegation.

When selecting subcategories, be sure to select only those categories preceded by a number or the letter “D” or “E.” (Subcategories with an “A” prefix are specific to long term care complaints.)

A listing of allegation categories and the corresponding subcategories for each allegation category is identified in Attachment Seven.

Click the “OK” button. The allegation will be added to the list of allegations for the complaint.
4. To add details about the allegation, click the “Details” Button to the left of the noted allegation.

Write the details of the allegation in the space provided.

You may use the “Insert Notes” button to insert the text posted in the Notes Section of the Intake. The full Notes text will be inserted. Text may be added or deleted once posted from the Notes Section into the Allegation “Details” section.

Be sure to bracket ([ ]) confidential information reported in the “Details” section to preclude public release.

Note: Generally only one allegation per category should be selected.
INVESTIGATION

Once the complaint record has been established and the allegations posted, proceed with the Investigation Phase of the processing.

1. Schedule the survey activity.

Click on the Investigations Tab at the top of the complaint record. This will bring you to the Investigations Page.

Listed in the “Investigation and Survey” Section are surveys posted in ACO for this facility. If there is a survey at the facility that has not yet occurred, you may link the investigation of this complaint to that survey. This allows for the investigation of several complaints during one on-site event, or the investigation of a complaint during another type of survey (i.e. re-certification survey).

To link the complaint to an already scheduled survey, click on the “selected” box for that survey. Click “Yes” to the prompt to verify the complaint should be linked to the selected survey.
A check mark will be reflected in the box to the left of the selected survey to denote the complaint has been linked to the survey.

If there is not a survey to which the complaint may be linked, create a new survey shell by clicking on the “New” Button with the green plus sign and completing the Survey Properties information. Respond “Yes” to the prompt to link the complaint to the newly created survey shell.

A check mark will be reflected in the box to the left of the newly created survey to denote the complaint has been linked to the survey.

When linking the complaint to an existing investigation or when creating a new shell in ACTS, the system will automatically select Category “A – Complaint” for the “Type of Survey.” For State complaints also select “K - State Licensure” and “3 - Licensure Complaint.”

The extent will automatically default to “D-Other Survey.” Use this for complaint investigations unless the review will be done as an “F-Offsite/Paper” review. For desk reviews, deselect “D-Other Survey” and select “F-Offsite/Paper.” Only one selection should be checked for “Extent(s).”
To unlink a complaint from a given survey shell, click the “Selected” box to remove the check mark, and respond “Yes” to the message confirming the unlinking action.

**NOTE:** When creating a survey shell for a complaint investigation, the survey dates are to be the actual dates of the on-site visit. If the complaint review is being accomplished through an off-site desk review, the survey dates are to be the dates of the surveyor review of the medical record and other facility provided information. The time frame for requesting the medical record and facility information is not to be included in the survey date time frame.

2. **Activities**

ACTS includes an “Activities” Tab for each complaint record. This is designed to assign specific activities to program staff. The Hospital Program will be using the Activities Section to record actions taken with regard to the specific complaint.

The activities available in the system are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Activities</th>
<th></th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Electronic Contact</td>
<td></td>
<td>Mail/File</td>
</tr>
<tr>
<td>01</td>
<td>Letter to Complainant</td>
<td></td>
<td>Administrative Review/Offsite</td>
</tr>
<tr>
<td>02</td>
<td>Letter to Provider/Supplier</td>
<td></td>
<td>Investigation</td>
</tr>
<tr>
<td>03</td>
<td>Telephone Contact – Complainant</td>
<td></td>
<td>CRB Forward to RO for Onsite</td>
</tr>
<tr>
<td>04</td>
<td>Telephone Contact – Field Office</td>
<td></td>
<td>Investig</td>
</tr>
<tr>
<td>05</td>
<td>Telephone Contact – Other</td>
<td></td>
<td>Investigation Report Completion</td>
</tr>
<tr>
<td>06</td>
<td>Hold for Written Report</td>
<td></td>
<td>Supervisory Review and Sign Off</td>
</tr>
<tr>
<td>07</td>
<td>Schedule Onsite Visit</td>
<td></td>
<td>Forbearance for AG Investigation</td>
</tr>
<tr>
<td>08</td>
<td>File Review</td>
<td></td>
<td>Expungement Required</td>
</tr>
<tr>
<td>09</td>
<td>Medical Records Requested</td>
<td></td>
<td>Expungement Stopped by</td>
</tr>
<tr>
<td>10</td>
<td>Additional Information Requested</td>
<td></td>
<td>Complainant Appeal</td>
</tr>
<tr>
<td>11</td>
<td>State to Rewrite Deficiencies</td>
<td></td>
<td>Administrative Closure</td>
</tr>
<tr>
<td>12</td>
<td>Received for Final Processing</td>
<td></td>
<td>Facility Closure Letter Issued</td>
</tr>
<tr>
<td>13</td>
<td>Proofread</td>
<td></td>
<td>Complainant Closure Letter Issued</td>
</tr>
</tbody>
</table>

The Hospital Program will be using **ONLY those activities listed in green.** Do not select any of the categories listed in black.
Once one of the noted activities occurs, select the “Activities” Tab and click on the “Add” Button with the green plus sign to define an activity.

The Define Activity Window will appear:

Select the type of activity from the drop down box. Use only those items noted in green on page 26. Fill in the completed date.
NOTE: The 08 Schedule an Onsite Visit will automatically be posted in the Activities Tab when the complaint is linked to either an existing survey or a newly created survey. Therefore, it is not necessary to ever define this activity independent of the survey linkage process.

Communication with the complainant may also be recorded in the Activities Listing. However, it should be noted that the complainant acknowledgement letter is to be posted on the Investigation Properties Page through the “Notices” Button as defined on pages 17 - 18.
3. Findings

Conduct the on-site or off-site complaint review activities.

If during the investigation at a hospital, the surveyor identifies a potential EMTALA situation or a Death with Restraints, create a Federal complaint record to request CMS authorization to proceed with a Federal survey, consistent with procedures defined in Section Two of this manual.

If condition level non compliance with federal regulations is identified during the survey at a facility with Deemed Status, create a Federal complaint record to request CMS authorization to proceed with a Federal survey, consistent with procedures defined in Section Two of this manual.

- Prepare Survey Report

The narrative report can be prepared in one of two ways:

1. Prepare the narrative report in memorandum form in Word and attach the document to the complaint record through the ASPEN attachment process.

2. Use the “View Investigation Notes” option on the “Investigations Tab” or the “Investigations Properties Page” to record the narrative report. When the “Investigation Notes” button is selected a blank word processing document appears for writing of the narrative report.

It is recommended the narrative report be prepared through Investigation Notes. The Investigation Report can then be reprinted and a full report (including the allegation details and findings) will be incorporated into one summary document.
• **Post Citations in Citation Manager**

Post deficiencies in the Citation Manager Section from the “Investigation” Tab or the “Investigation Properties” Page.

**Investigation Tab**

![Investigation Tab Image]

**Investigation Properties Page**

![Investigation Properties Page Image]

**Notes:** When posting deficiencies, be sure to select appropriate categories on the “Citation Properties” screen for each tag: “K – State Licensure” and “3 – Licensure Complaint” for State tags.

If there are no deficiencies, select the 0000 tag and post appropriate facility and complaint identifiers and select the statement saying there were no deficiencies identified. It is not required the 2567 be issued.
- **Post Allegation Findings**

For each allegation, the investigation findings are to be recorded.

Go to the “Allegations” Tab or to the Allegation Section of the “Investigations Properties” Page.

**Allegations Tab:**

![Image of Allegations Tab]

**Investigations Properties Page**

![Image of Investigations Properties Page]

Select the allegation by darkening it from the left-hand side. Click on the “Modify” Button.
In the Findings Section of the Allegation Input Screen, select either “Substantiated” or “Unsubstantiated.”

Definitions for “Substantiated” and “Unsubstantiated” are provided in the CMS Memorandum Ref: S&C 04-09 included in Attachment Five.

Select the appropriate Findings Qualifier in the list box. The selections will vary based on the Findings determination.

The qualifiers for “Substantiated” Findings are as follows:

The qualifiers for “Unsubstantiated” Findings are as follows:
You may add allegation details or non-confidential notes about findings by clicking on the “Find Text” box in the Allegations Listing.

This screen will appear. Only the bottom section is active. The top section is the “Details” Section where specific information about the allegation would have been added when the allegation was posted. See page 23.

Be sure to bracket ([ ]) confidential information reported in the “Findings” section to preclude public release.

Repeat for each allegation
• **Link Deficiencies to Allegations**

Deficiencies are to be linked to those substantiated allegations for which a deficiency (or deficiencies) has been cited. To link deficiencies to substantiated allegations, access the allegation listing from either the “Allegations” Tab or the Allegations Section of the “Investigation Properties Page.”

Select a specific allegation and click on the “Link Deficiencies” Button.

**Allegations Tab**

![Allegations Tab](image)

**Allegations Section on Investigation Properties Page**

![Allegations Section](image)
On the “Assign Aspen Tags to Allegation” Form mark the “Selected” box in the tag(s) that should be linked to the selected allegation and respond to the verification notice. A check mark will record the tag is linked to the allegation. More than one tag may be linked to any given allegation.

Select the “OK” button.

The linked tags will be listed in the Deficiencies column.

The surveyor report and findings may be submitted for supervisory approval. If the narrative report is prepared in “Investigation Notes,” this may be accomplished by reprinting the “Investigation Report.” (See page 19.) Be sure to post the M3 Activity in the Activities Section. (See page 26.)
4. **Contact/Refer Tab**

Recording of surveyor contacts and witnesses is an optional activity. Surveyors have the opportunity to record interviews with facility staff, complainants, and/or patients.

Select the “Contact/Refer” Tab from the Complaint Record. Click on the “Add” Button at the bottom of the “Contact/Witnesses” section.

The “Add Contact/Witness” window will appear.

Provide information about the contact and click the “OK” Button.

Repeat for additional contacts.
Recording of referrals to another agency is NOT an optional activity.

On the “Contact/Refer” Tab go to the “Referral Details” Section. Select the “Add” Button.

A window listing a number of agencies or entities will appear. A complete listing of the agencies is provided in Attachment Eight.

Darken the appropriate selection and click on the “Select” Button.
This screen will appear, listing the selection:

Post appropriate information in the fields to the right of the identified agency. In all cases, the “Date Referred” field is to be completed.
5. Survey Activity Documentation

- **Attachments**
  Attach the following documents to the complaint record through the ASPEN attachment process:
  - Medical Record/Staff Identifying Information
  - Surveyor Investigative Report (unless posted in Investigative Notes as defined on page 29).

- **Proposed State Actions**
  Select the “Actions/Close” Tab.
  Click the “New” Button in the “Proposed Actions – Federal” section.
  From the drop down list select 33 State Only Actions.
  The proposed date will default to the current date. Enter current date as the imposed date.
  This will activate the “Proposed Actions” for the State Section of the Form.

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Select the “New” Button in the State Proposed Actions Section.

Repeat the process for identifying proposed actions, selecting items from the drop down list. Selection options are as follows:

- 01 POC (No Sanction)
- 02 License Revocation
- 03 Provisional License
- 04 Special Monitor
- 05 Ban on Admissions-New
- 06 Ban on Admissions-All
- 07 Civil Monetary Penalty
- 08 Temporary Manager
- 09 PHL 2803-d Violation
- 10 PHL 2803-c Violation
- 11 No PHL 2803c or d Violation
- 12 State Fine Assessed
- 13 No State Fine Assessed
- 98 Other
- 99 None

Note: The proposed date and the imposed dates should be the same, reflecting action taken by the State Agency.

For example, if deficiencies are identified, the action would be 01 POC. The date the Statement of Deficiencies is issued would be the proposed and the imposed date.

When the complaint review identifies there are no deficiencies to be cited, category 99 None should be posted.
6. Record Processing Activities

- **Investigation Completed Fields**

Post the “Investigated by” field and the date the investigation was completed in the “Investigation Completed” date field. These fields are located on the Investigation Tab.

“Investigation Completed” field is defined as any one or more of the following: (1) the date the Statement of Deficiencies is issued, or (2) the date the complainant is advised of the Department’s findings, or (3) the date the facility is advised of the Department findings. (When the investigation is complete, the surveyor investigative report should be attached to the complaint record or posted in Investigative Notes.)

**IF NO DEFICIENCIES ISSUED, GO TO STEP 7.**

If deficiencies are issued:

- **Survey Properties**

Access the Survey Properties Screen from the Investigation Tab or the Investigation Properties Page.

Post: Date SoD Issued

Note: this date should also be posted on the Investigation Properties Page as noted in Item number seven (7) below.

Date PoC Received

X6 Date

Revisit Status

- **Citation Manager**

After submission of the PoC, access the Citation Manager Screen from the Investigation Tab or the Investigation Properties Page. For each citation:

Post: PoC Received Date

Reminder: PoC received date may vary on the different citations if addendum is submitted specific to any given citation.

X 5 dates

State Agency Approval of PoC Date
- PoC Tracking

The status of the Plan of Correction may be tracked by clicking on the “POC Track” Button on the Investigation Tab or the Investigations Properties Page.

The tracking screen will appear for posting of information:
7. Investigation Properties Page

Click on the 562 View/Upload Button at the bottom of the record to get to the “Investigations Properties Page.” (You may also get to the “Investigations Properties Page” from the Tree View by right clicking on the complaint record, and selecting “Investigation Properties.”)

- Record date the SoD was issued to the facility or notice issued to the facility.
- Record the date the complainant was advised of complaint review findings.

Scroll to the bottom of the Investigation Properties Page to the “Acknowledgement and Parties Notified” Section.

Post the date the SoD was issued to the facility (or the date notice was sent to the facility if no Statement of Deficiencies was indicated) and the date the complainant was notified of the complaint review findings.

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COMPLAINT CLOSURE

Once the Plan of Correction has been accepted and the facility notified, the complaint record is ready for closure.

In the complaint record, go to the Actions/Close Tab.

Scroll to the “Closure Information” and “Finalization” sections.

Post a date in the “In Compliance” field. This date will usually be consistent with the notice of acceptable PoC to the facility.

Place a check mark in the “Finalized” Box. This will activate the “Reason Closed” Section.

Select the reason for complaint record closure (Paperwork Complete, Withdrawn, Referred, No Jurisdiction, Provider/Supplier Termination) and post the “Date Closed” date.

Make appropriate hard copy for office file retention.
Federal Allegation – CMS Authorization Required

INTAKE AND TRIAGE

Before creating the Federal record to request CMS authorization to conduct a Federal allegation survey, a State record should have been created for the complaint as defined in Section One of this manual. Complaints in this category include:

- Complaints against Hospitals and Ambulatory Surgery Centers with Deemed Status, where triage of the allegation has determined there is a potential of identifying condition-level non-compliance.

- Complaints against Hospitals and Ambulatory Surgery Centers with Deemed Status, where condition-level non-compliance has been identified during investigation of a State-only complaint.

- Complaints involving potential EMTALA violations or Death with Restraints against hospitals, with or without Deemed Status.

If CMS created the record and authorized a Federal survey, a separate State complaint record does not need to be established. The Article 28 activities may be accomplished in concert with the Federal allegation survey in the same complaint record since the dates of both surveys will be the same.

1. Complaint Intake

There are several sections for recording information on the Intake Tab.

It should be noted that there is a “Notes” Section at the very bottom of the Intake Tab, which will be addressed in detail in Section 6 (page 56). This section is specifically designed to collect information during the intake of complaints filed verbally. Prompt questions are available to the right of the Notes Section to assist in collecting information necessary to triage the complaint. However, a summarization of the complaint issues identified in written complaints should also be recorded in the Notes Section of the Intake Tab when the complaint record is created.

- Section One: Intake Staff

The intake staff automatically defaults to the person logged into ACTS. This can be modified by clicking on the “Change Staff” button if the staff intake person is different from the person entering the data on the intake page. Clicking the “Change Staff” button activates the staff selection box and the drop down selection option becomes functional.

If the complaint is entered into the system by CMS, the CMS staff person’s name will be posted as the staff intake person. In this case, the intake staff name should not be changed.

The “Status” Box is automatically populated based on activities posted in the record.
• **Section Two: Assignment**

**Intake Type:** The options for “Intake Type” are “01 Complaint” or “02 Entity Reported Incident.” Always select “01 Complaint.”

If the index case is an incident reported to the New York State Department of Health, the record is to be posted as a complaint, with the State Agency (New York State Department of Health) as the source of the complaint.

**Reference Numbers**

The reference numbers located on the right hand side in the Assignment Box should be used as follows:

- **State Complaint ID:** The NYPORTS number should be posted in this field if the request for CMS authorization to proceed with a Federal allegation survey is based on a reported incident or a complaint for which an incident has been reported.

- **CIS number:** This is a Federal field and is not to be used.

- **External Control #:** This field should be used for OPMC tracking numbers.
**Intake Subtype:** For a Federal allegation, select item A.

**Note:** The Hospital Program will not be using category C – *No State or Federal Provider Compliance Issue Involved.*

ACTS allows for data entry of records for which there are no applicable state or Federal requirements. Since we do not record events which are not within our regulatory jurisdiction, the Hospital Program will not be using this field.

**Received By:** Identify the complaint receipt mechanism from the drop down list provided.

**Location Received:** Select the location the complaint was received using a numbered category for Regional offices. You may have to scroll up to locate the numbered categories.

(Regional offices with the prefix “The” are reserved for Long Term Care complaints. The Hospital Program is to select Regional Offices with a number prefix.)
Responsible Parties: The lower half of the Assignment Section relates to “Responsible Parties.”

Click on the “Add S.A.” Button with the green plus sign. (S.A. = State Agency)
This box will appear:

The person identified for the State Agency should be the Regional Hospital Program Director, the clinical complaint coordinator, and the assigned surveyor.

Also enter Bureau of Hospital and Primary Care Services staff, Vickie Ventresca and Judy McCann.

Individual area offices may choose to add additional staff, such as the team leader.

Scroll down on the drop down box to locate the State Agency responsible person. You may begin to type the last name to bring you closer to the person’s location in the drop down box.
Click OK to add the person to the “Responsible Parties” listing.

Follow the same procedure for identifying the Regional Office person using the “Add R.O.” Button with the blue plus sign. (R.O. = CMS Regional Office). Select Richard Minkoff as the first CMS RO person and one additional CMS person as follows:

Hospitals: A to Massena Memorial - Lois Suntzenich, Bill Mullen
Medina to Z - Leila Meltzer, Elizabeth Romani

Ambulatory Surgery Centers:
A to H – Gwen Taylor
I to Z – Sherry Mohammed

Names can be deleted from the “Responsible Parties” listing by highlighting the name and clicking on the “Delete” Button with the red negative sign in the Assignment Section.

**Responsible Team:** Select the responsible team from the drop down box. Again be sure to select the team with a number. You may need to scroll up to locate the team with a number prefix.
• Section Three: Complainant/Patient Information

The next sections of the Intake Tab relate to Complainant and Patient Information.

Complainant Information

The Intake Tab defaults to the Complainant Tab when opened. To record complainant information, type in the complainant last name, and first name (if known) and click the “Find/Add” Button with the green plus sign.
A listing of complainant’s with similar names will appear.

If the complainant is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The complainant will be added to the record complainant listing.

If the complainant is new to the system, it will be necessary to create a record for that person.

Clicking on the “New” Button will allow creation of a new record for this complainant.
Filling in the appropriate information and clicking the “OK” Button will create the record in the ASPEN database and post the complainant in the listing of complainants for the active record.

There is not a specified limit of the number of complainants per intake. However, it should be noted that only three complainants per complaint record will be uploaded to the national database.

The system automatically defaults to recording the complainant as anonymous. This is meant to reflect the complainant wishes to remain anonymous to the facility. If the complainant requests anonymity from all aspects of the complaint process, including the New York State Department of Health, do not use the “Add Anonymous” Button to record the complainant. Rather, type ANON in the last name of the Search Section, click the “Find/Add” Button, and select ANONYMOUS HP from the listing and click the “OK” Button. The ANONYMOUS HP record has the identification number 03JOM3.
Patient Information

Patient identification and information is added in the same format as the complainant information. Click on the Patient Tab, enter the name or part of the name in the search area, and click the “Find/Add” Button with the green plus sign.

If the patient is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The patient will be added to the listing. Again, if the patient is new to the ASPEN system, it will be necessary to create a record for that person.

NOTE: The Residents/Patients Tab includes information on the date and time of the alleged event. These fields are optional for purposes of data entry. If the complaint is specific to an event, you may want to record the actual date and possibly the time. If the complaint involves care generally during a specific hospitalization or time period, you may want to record the admission date.

Alleged Perpetrators

The final tab in this section is for the posting of “Alleged Perpetrators.” Allegations of abuse by facility staff, visitors or other patients may be recorded in this section in the same format as done for identifying the complainant and the patient.
• **Section Four: Source**

Specify the source of the complaint.

Select up to three options which best describe the source of the complaint. If the complainant is anonymous and wishes to remain anonymous, click the 05 Box. This will pre-empt the requirement that the complaint be acknowledged in order to process the upload to the national database.

• **Section Five: Received Date/Association**

*Received Start and End Dates:*

The date/time of the start and end for the complaint receipt defaults to the date and time the Intake Tab was first opened. This may be changed as indicated, if the intake was at a time other than when the intake tab was opened. For the start date, use the date it was determined a request for CMS authorization to proceed with a Federal allegation should be submitted. This determination may be made at triage or at any point during State review activities, if immediate jeopardy or condition-level non compliance, not suspected at triage, is identified.

There is the option to post a different date for the “End Date.” This is to allow the submission of additional information in order to appropriately prioritize the complaint. For these types of complaints, the start and end dates in the Received Field should be the same.
Association:

Below the Received Start and End Date Section is the “Click Here to Associate” Button. Any given complaint may be associated with other complaints at the same facility.

![Click Here to Associate Button]

It is important to associate the complaint record requesting CMS authorization for the Federal allegation survey with the State complaint record posted prior to initiation of the Federal request.

When selecting this button, the following window will appear:

![Intakes Associated With: NY00004383]

Complaints at the facility will be reflected on the left-hand side of the form. The associated complaint should be moved to the right-hand side of the form.

Associated intakes are listed on the Intake and Investigation reports, but information is not combined unless the complaints are linked to the same investigation.
Section Six: Notes

As noted earlier, the final section of the Intake Tab is the Notes Section.

ACTS is designed to record intake at the time the complaint is being filed either verbally or written. The Notes section provides an area for the intake person to record the major issues of the complaint. Also available to the intake person are questions or prompts which may be of assistance in gathering critical information.

It also should be noted there is a spell check feature in the Notes Section, which should always be utilized.
2. **Complaint Triage**

The remaining section of the Intake Tab has to do with the complaint triage process. The section is labeled “Response Information.”

This section is located just above the “Notes” Section of the Intake Page.

*Priority:*

Based on the information provided, the complaint clinical coordinator is to assign a priority to the complaint. Triage priority definitions are provided in Attachment Six and in the Hospital Program Complaint Manual. These definitions are consistent with the Federal priority designations as presented in CMS Memorandum Ref: S&C-04-09 (Attachment Five of this manual).

This task should have already been accomplished in that creation of the record signifies a determination of a prioritization requiring submission of a request to CMS to proceed with a Federal allegation survey.

Establishing the complaint priority will define the processing type and time frames.

When authorization for a Federal allegation survey is issued, CMS will complete the “Investigate within ________ days” and “Investigation Due By” fields.

The “Investigate within ________ days” is the number of days in which CMS requires the on-site survey to be completed (with the day of authorization being day zero). The “Investigate within ________ days” is the actual calendar date corresponding to the working days noted in the “Investigate within ________ days” field.
If the complaint is not an EMTALA allegation, go directly to the “Deemed” Tab at the top of the Complaint Record. When you click on the “Deemed” Tab, this screen will appear:

Place a check mark in the “Deemed for Medicare Participation” box and the rest of the form will be activated.

Post the date of the facility’s last accreditation survey.

Place a check mark in the “Request for RO Approval” box.

Select the Conditions of Participation you believe should be investigated.
If the CMS Regional Office authorizes the State Agency to conduct a Federal allegation survey, they will record “Approved” in the “RO Response” Box. CMS will then fill in the “Investigate within ____ days” and the “Investigation Due By” fields on the Intake Tab of the complaint record. CMS will also make indicated modifications to the selected Conditions of Participation on the Deemed Tab.

**If the CMS Regional Office disapproves the SA request for authorization for a Federal allegation, change the “Priority” to “No Action Necessary” on the Intake Tab and close the complaint record by filling out the appropriate information on the “Actions/Close” Tab.**

**EMTALA**

If the complaint has been identified as a potential EMTALA violation, select the “EMTALA” Tab. **Do not enter any information on the “Deemed” Tab.**
Place a check mark in the “EMTALA Request for RO Approval” Box. This will activate the EMTALA page.

In the date field. Post the date of the request to CMS.

If the CMS Regional Office authorizes the State Agency to conduct an EMTALA survey, they will record “Approved” in the “RO Response” Box. CMS will then fill in the “Investigate within ____ days” and the “Investigation Due By” fields on the Intake Tab of the complaint record. CMS will also fill in the “Type of Emergency” on the EMTALA page.

**Hospital with Deemed Status:**

*If the CMS Regional Office disapproves the SA request for authorization of a Federal EMTALA survey, change the “Priority” to “No Action Necessary” on the Intake Tab and close the complaint record by filling out the appropriate information on the “Actions/Close” Tab, unless the record is needed to issue Federal deficiencies.*

**Hospital without Deemed Status**

*If the CMS Regional Office disapproves the SA request for authorization of a Federal EMTALA survey, process any Federal deficiencies from this complaint record.*

3. **Complaint Acknowledgement**

In most cases, complaints authorized by CMS for a Federal allegation survey are acknowledged and posted by CMS and do not require acknowledgment by the New York State Department of Health.
When CMS authorization is issued, a hard copy of the Investigation Report should be printed and provided to the investigating surveyor or investigating survey team.

Select the “Print” Button at the bottom of the complaint record.

This screen will appear. Select “Investigation Report” and click on the “OK” Button. The form will appear on your screen for printing.
ALLEGATIONS

Allegations are entered by the surveyor on the Allegations Tab.

1. Click on the Allegations Tab

This screen will open:
2. In the Allegations Section, click the “Add” Button with the green plus sign.

The “Allegation Input” window will appear:
3. Specify the Category, Subcategory and Seriousness of each allegation.

When selecting subcategories, be sure to select only those categories preceded by a number or the letter “D” or “E.” (Subcategories with an “A” prefix are specific to long term care complaints.)

A listing of allegation categories and the corresponding subcategories for each allegation category is identified in Attachment Seven.

Click the “OK” button. The allegation will be added to the list of allegations for the complaint.
4. To add details about the allegation, click the “Details” Button to the left of the noted allegation.

Write the details of the allegation in the space provided.

You may use the “Insert Notes” button to insert the text posted in the Notes Section of the Intake. Text may be added or deleted once posted from the Notes Section into the Allegation “Details” section.

Be sure to bracket ( [ ] ) confidential information reported in the “Details” section to preclude public release.
NOTES SPECIFIC TO ALLEGATIONS:

1. Generally only one allegation per category should be selected. The ACTS upload will only submit one allegation per category and a total of five allegations to the national database.

By default, ACTS will automatically select the “Include on OSCAR 562 Form” on the Allegation Input Form.

If the complaint involves more than one allegation per category or more than five allegations in total, deselect the “Include on OSCAR 562 Form” box on the Allegation Input Form for the multiple category selections. Leave the box selected for the most important allegation for each category. You may post several issues related to one category in the “Details” section of the allegation.

If more than five allegation category types are identified, be sure the “Include on OSCAR 562 Form” box on the Allegation Input Form is selected for the most substantive allegations.
2. If the complaint has been identified as a potential EMTALA, and the EMTALA Tab has been completed, forwarding a request to CMS for authorization to proceed with an EMTALA survey or CMS has initiated authorization for an EMTALA survey, an EMTALA allegation will automatically be posted on the Allegation Listing on the Allegation Tab. Once this is posted, the surveyor should select the EMTALA allegation in the Allegation Listing, click on the “Modify” Button and select the appropriate subcategory for the allegation.

3. If the complaint involves an allegation of “Death Associated with the Use of Restraints/Seclusion,” select “05 Restraints/Seclusion – Death” as a category in the Allegation Input Screen.
The “Death Associated with the Use of Restraints/Seclusion” Section will be activated on the Allegations Tab.

In this section, select the Patient’s name, provide the Death Type, Reported Date, and Date of Death from the drop down lists in each box. Provide other available information as noted in the section.
INVESTIGATION

Once CMS authorization to proceed with a Federal allegation has been issued, proceed with the Investigation Phase of the processing.

1. **Schedule the survey activity.**

   Click on the Investigations Tab at the top of the complaint record. This will bring you to the Investigations Page.

   Listed in the “Investigation and Surveys” Section are surveys posted in ACO for this facility. If there is a survey at the facility that has not yet occurred, you may link the investigation of this complaint to that survey. However, due to the time frames required for Federal allegation surveys authorized by CMS, in most instances a survey shell will need to be created for the on-site visit specific to the subject complaint.

   To link the complaint to an already scheduled survey, click on the “Selected” box for that survey. Click “Yes” to the prompt to verify the complaint should be linked to the selected survey.
A check mark will be reflected in the box to the left of the selected survey to denote the complaint has been linked to the survey.

If creating a new survey shell, click on the “New” Button with the green plus sign and completing the Survey Properties information. Respond “Yes” to the prompt to link the complaint to the newly created survey shell.

A check mark will be reflected in the box to the left of the newly created survey to denote the complaint has been linked to the survey.

When linking the complaint to an existing investigation or when creating a new shell in ACTS, the system will automatically select Category “A” Complaint for the “Type of Survey.” (Citations against State regulations should be accomplished in the State Complaint record under the “K - State Licensure” and “3 - Licensure Complaint” categories.)

The extent will automatically default to “D-Other Survey.” Use this for authorized Federal Allegation surveys which require an on-site visit.
To unlink a complaint from a given survey shell, click the “Selected” box to remove the check mark, and respond “Yes” to the message confirming the unlinking action.

**NOTE:** When creating a survey shell for a complaint investigation, the survey dates are to be the actual dates of the on-site visit, even if material is being reviewed or telephone interviews are conducted after the on-site visit as part of the investigative activities.

Complaints for which CMS authorization to proceed is required may only be processed through an on-site visit. However, if, for some reason, the complaint review is being accomplished through an off-site desk review, the survey dates are to be the dates of the surveyor review of the medical record and other facility provided information. The time frame for requesting the medical record and facility information is not to be included in the survey date time frame.
2. Activities

ACTS includes an “Activities” Tab for each complaint record. This is designed to assign specific activities to program staff. The Hospital Program will be using the Activities Section to record actions taken with regard to the specific complaint.

The activities available in the system are as follows:

01 Electronic Contact
02 Letter to Complainant
03 Letter to Provider/Supplier
04 Telephone Contact – Complainant
05 Telephone Contact – Field Office
06 Telephone Contact – Other
07 Hold for Written Report
08 Schedule Onsite Visit
09 File Review
10 Medical Records Requested
11 Additional Information Requested
12 State to Rewrite Deficiencies
13 Received for Final Processing
14 Proofread
15 Mail/File
M1 Administrative Review/Offsite Investigation
M2 CRB Forward to RO for Onsite Invest
M3 Investigation Report Completion
M4 Supervisory Review and Sign Off
M5 Forbearance for AG Investigation
M6 Expungement Required
M7 Expungement Stopped by Complainant Appeal
M8 Administrative Closure
P1 Facility Closure Letter Issued
P2 Complainant Closure Letter Issued

The Hospital Program will be using **ONLY those activities listed in green**. Do not select any of the categories listed in black.

Once one of the noted activities occurs, select the “Activities” Tab and click on the “Add” Button with the green plus sign to define an activity.
The Define Activity Window will appear:

Select the type of activity from the drop down box. Use only those items noted in green on page 72. Fill in the completed date.

Communications with CMS are to be recorded as an activity (05 Telephone Contact – Field Office). Be sure to summarize the essence of communication in the comments section of the “Define Activity” Form.

NOTE: The 08 Schedule an Onsite Visit will automatically be posted in the Activities Tab when the complaint is linked to either an existing survey or a newly created survey. Therefore, it is not necessary to ever define this activity independent of the survey linkage process.

Communication with the complainant may also be recorded in the Activities Listing. However, it should be noted that the complainant acknowledgement letter, if issued, is to be posted on the Investigation Properties Page, through the “Notices” Button as detailed on pages 17 – 18.
3. Findings

Conduct the on-site review activities.

- Prepare Survey Report

The narrative report can be prepared in one of two ways:

1. Prepare the narrative report in memorandum form in Word and attach the document to the complaint record through the ASPEN attachment process.

2. Use the “View Investigation Notes” option on the “Investigations Tab” or the “Investigations Properties Page” to record the narrative report. When the “Investigation Notes” button is selected a blank word processing document appears for writing of the narrative report.

It is recommended the narrative report be prepared through Investigation Notes. The Investigation Report can then be reprinted and a full report (including the allegation details and findings) will be incorporated into one summary document.
- **Post Citations in Citation Manager**

Post deficiencies in the Citation Manager Section from the “Investigation” Tab or the “Investigation Properties” Page.

**Investigation Tab**

![Investigation Tab Image]

**Investigation Properties Page**

![Investigation Properties Page Image]

Note: When posting deficiencies, be sure to select appropriate categories on the “Citation Properties” screen for each tag: “A – Complaint” for Federal tags.

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• **Post Allegation Findings**

For each allegation, the investigation findings are to be recorded.

Go to the “Allegations” Tab or to the Allegation Section of the “Investigations Properties” Page.

Allegations Tab:

Investigations Properties Page

Select the allegation by darkening it from the left-hand side. Click on the “Modify” Button.
In the Findings Section of the Allegation Input Screen, select either “Substantiated” or “Unsubstantiated.”

Definitions for “Substantiated” and “Unsubstantiated” are provided in the CMS Memorandum Ref: S&C 04-09 included in Attachment Five.

Select the appropriate Findings Qualifier in the list box. The selections will vary based on the Findings determination.

The qualifiers for “Substantiated” Findings are as follows:

The qualifiers for “Unsubstantiated” Findings are as follows:
You may add allegation details or non-confidential notes about findings by clicking on the “Find Text” box in the Allegations Listing.

This screen will appear. Only the bottom section is active. The top section is the “Details” Section where specific information about the allegation would have been added when the allegation was posted. See page 65.

Be sure to bracket ([ ]) confidential information reported in the “Findings” section to preclude public release.

Repeat for each allegation
• **Link Deficiencies to Allegations**

Deficiencies are to be linked to those substantiated allegations for which a deficiency (or deficiencies) has been cited. To link deficiencies to substantiated allegations, access the allegation listing from either the “Allegations” Tab or the Allegations Section of the “Investigation Properties Page,” and select the allegation.

Select a specific allegation on the listing and click on the “Link Deficiencies” Button.

**Allegations Tab**

![Allegations Tab Image]

**Allegations Section on Investigation Properties Page**

![Allegations Section Image]
On the “Assign Aspen Tags to Allegation” Form mark the “Selected” box in the tag(s) that should be linked to the selected allegation and respond to the verification notice. A check mark will record the tag is linked to the allegation. More than one tag may be linked to any given allegation.

Select the “OK” button.

The linked tags will be listed in the Deficiencies column.

The surveyor report and findings may be submitted for supervisory approval. If the narrative report is prepared in “Investigation Notes,” this may be accomplished by reprinting the “Investigation Report.” (See page 61.) Be sure to post the M3 Activity in the Activities Section. (See page 72.)
4. Record Contacts and Witnesses

Recording of surveyor contacts and witnesses is an optional activity. Surveyors have the opportunity to record interviews with facility staff, complainants, and/or patients.

Select the “Contact/Refer” Tab from the Complaint Record. Click on the “Add” Button at the bottom of the “Contact/Witnesses” section.

The “Add Contact/Witness” window will appear.

Provide information about the contact and click the “OK” Button.

Repeat for additional contacts.
Recording of referrals to another agency is NOT an optional activity.

On the “Contact/Refer” Tab go to the “Referral Details” Section. Select the “Add” Button.

A window listing a number of agencies or entities will appear. A complete listing of the agencies is provided in Attachment Eight.

Darken the appropriate selection and click on the “Select” Button.
This screen will appear, listing the selection:

Post appropriate information in the fields to the right of the identified agency. In all cases, the “Date Referred” field is to be completed.
5. **Specify Proposed Actions – Federal and Release Findings to CMS**

The State Agency is required to recommend proposed actions to CMS for authorized Federal allegation surveys. Select the “Actions/Close” Tab.

Click the “New” Button in the “Proposed Actions – Federal” section.

Select an action from the drop down list:

Action selection options include:

01 Plan of Correction                21 Criminal Sanction
02 Involuntary Termination - IJ      22 Suspension of Medicare Payment
03 Involuntary Termination – Non-IJ  23 Cancellation of Medicare Payment
04 Denial of Payment for New Admissions
05 Civil Money Penalty               24 Loss of PPS Excluded Status
06 State Monitoring                  25 Denial of Federal Financial Participation
07 Temporary Management             26 Nonrenewal of Time Limited Agreement
08 Denial of Payment for All Individuals
09 Directed Plan of Correction       27 Cancellation of Time Limited Agreement
10 Directed In-Service Training      28 Extension of Time Limited Agreement
11 Transfer of Residents            29 Denial of Payments to ESRD for New Patients
12 State Closure of Facility        30 Reduction of Payments for ESRD
13 Alternate Remedies               31 Withholding of All Payments for ESRD
14 Termination of Swing-Bed Approval
15 Loss of Deemed Status            32 None
16 Semifinal          33 State Only Actions
17 Final                   34 Other
18 Denial of Federal Financial Participation
19 Loss of PPS Excluded Status
20 Civil Suit

Enter a proposed date and select the CMS RO/MSA Action check box to indicate the action is to be included on the CMS 562 form. (The “Proposed Date” is the date the SA recommends an action to CMS to be taken against the facility). The “Imposed Date” will be posted by CMS.
6. **Survey Activity Documentation**

On the Investigations Tab or the Investigation Properties Page:

- *Complete 670 information.*
- *Complete 1539*

Complete the 1539 form by selecting Survey Forms on the Investigations Tab or on the Investigation Properties Page.

Enter 1539 information by selecting the “1539 Entry” Button. Be sure to reference the complaint number in the remarks section.

- *Attach to the complaint record the narrative report (unless the narrative report is posted in “Investigation Notes”), medical record and facility staff identifiers through the ASPEN attachment process.*

7. **Investigation Completed Fields**

Complete the “Investigated by” and “Investigation Completed” fields, located on the “Investigation” Tab.

The “Investigation Completed” date is the date the complainant is advised of the investigative findings. Once CMS issues the 2567, the SA is responsible for issuing notification to the complainant. This date of notification is to be posted in the “Investigation Completed” field and also posted on the “Investigation Properties” page under “Parties Notified” (see page 43 of this manual).

If the complainant is anonymous, the “Investigated Completed” date is the date CMS issues the 2567.
At this point, release the survey report and findings to CMS by placing a check mark in the “Forwarded to RO/MSA” box on the “Investigations” Tab and post the date of this action. Be sure that allegation findings are posted and linked to deficiencies, if indicated.

Also be sure proposed actions are posted on the “Actions/Close” Tab.

- **Submit electronic or telephone notification to CMS that the State investigative activities have been released.** Record the CMS communication in the Activities Tab, specifying the information provided to CMS in the Comments section of the “Define Activity” form.

- **Submit in hard copy format the following documents to CMS:**
  - 2786 Fire Safety Survey Report (if applicable)
  - 2786F Fire Safety Survey Report used with CMS-2786 (if applicable)
  - Hospital/CAH Medicare Database Worksheet
  - Copies of pertinent hospital policies and procedures, if applicable

  For EMTALA complaints also submit the following:
  - CMS 1541B Forms
  - Copies of medical records
  - Evidence of Hospital’s Certification of Benefits Versus Risks of Transfer Form

**COMPLAINT CLOSURE**

For these allegations, CMS is responsible for issuing the Statement of Deficiencies and accepting the Plan of Correction and, therefore, should post SoD and PoC processing milestones. If this is not done by CMS, regional office staff is to maintain communication with CMS staff and post the noted milestones, as indicated.

The complaint is to be finalized, uploaded and closed by CMS.
Federal Allegation – CMS Authorization NOT Required

INTAKE AND TRIAGE

This section applies to processing of Federal allegation surveys not requiring CMS authorization to proceed. There is no need to create a separate State record for complaints established in this category, as long as both the State and Federal survey activities are processed during the same on-site visit or off-site review. Article 28 activities may be processed in the Federal complaint record.

It should be noted, however, that potential EMTALA violations or complaints involving Death with Restraints at hospitals with or without Deemed Status require CMS authorization to proceed with a Federal allegation survey and are to be processed as specified in Sections One and Two of this manual. If a Federal record has been established for a hospital without Deemed Status and a potential EMTALA violation or a Death with Restraints is identified during the complaint review, the existing record should be converted to a State record for processing Article 28 activities. A separate record is to be created to request CMS authorization to proceed with the specified Federal allegation survey, as defined in Section Two of this manual, since the State and Federal survey dates will be different.

Complaints evaluated through desk review rather than on-site visit may be posted as Federal allegations but will not be accepted for upload.

1. Complaint Intake

There are several sections for recording information on the Intake Tab.

It should be noted that there is a “Notes” Section at the very bottom of the Intake Tab, which will be addressed in detail in Section 6 (page 97). This section is specifically designed to collect information during the intake of complaints filed verbally. Prompt questions are available to the right of the Notes Section to assist in collecting information necessary to triage the complaint. However a summarization of the complaint issues identified in written complaints should also be recorded in the Notes Section of the Intake Tab when the complaint record is created.

- Section One: Intake Staff

The intake staff automatically defaults to the person logged into ACTS. This can be modified by clicking on the “Change Staff” button if the staff intake person is different from the person entering the data on the intake page. Clicking the “Change Staff” button activates the staff selection box and the drop down selection option becomes functional.

If the complaint is entered into the system by CMS, the CMS staff person’s name will be posted as the staff intake person. In this case, the staff intake name should not be changed.

The “Status” Box is automatically populated based on activities posted in the record.
• **Section Two: Assignment**

*Intake Type:* The options for “Intake Type” are “01 Complaint” or “02 Entity Reported Incident.” Always select “01 Complaint.”

If the complaint involves an event that was also reported as an incident, the NYPORTS number of the index case is to be posted in the “State Complaint ID” field.

**Reference Numbers**

The reference numbers located on the right hand side in the Assignment Box should be used as follows:

- **State Complaint ID:** The NYPORTS number should be posted in this field if the complaint has also been reported as an incident.

- **CIS number:** This is a Federal field and is not to be used.

- **External Control #:** This field should be used for OPMC tracking numbers.
**Intake Subtype:** For a Federal allegation, select item A.

**Note:** The Hospital Program will not be using category C – No State or Federal Provider Compliance Issue Involved.

ACTS allows for data entry of records for which there are no applicable state or Federal requirements. Since we do not record events which are not within our regulatory jurisdiction, the Hospital Program will not be using this field.

**Received By:** Identify the complaint receipt mechanism from the drop down list provided.

**Location Received:** Select the location the complaint was received using a numbered category for Regional offices. You may have to scroll up to locate the numbered categories.

(Regional offices with the prefix “The” are reserved for Long Term Care complaints. The Hospital Program is to select Regional Offices with a number prefix.)
Responsible Parties: The lower half of the Assignment Section relates to “Responsible Parties.”

Click on the “Add S.A.” Button with the green plus sign. (S.A. = State Agency)
This box will appear:

![Responsible Party window](image)

The person identified for the State Agency should be the Regional Hospital Program Director, the clinical complaint coordinator, and the assigned surveyor.

Also enter Bureau of Hospital and Primary Care Services staff, Vickie Ventresca and Judy McCann.

Individual area offices may choose to add additional staff, such as the team leader.

Scroll down on the drop down box to locate the State Agency responsible person. You may begin to type the last name to bring you closer to the person’s location in the drop down box.

![Responsible Party window](image)
Click OK to add the person to the “Responsible Parties” listing.

Follow the same procedure for identifying the Regional Office person using the “Add R.O.” Button with the blue plus sign. (R.O. = CMS Regional Office).

**Hospitals:**
- A to Massena Memorial - Lois Suntzenich, Bill Mullen
- Medina Memorial to Z - Leila Meltzer, Elizabeth Romani

**ESRDs:**
- A to Metropolitan ESRD – Gwen Taylor
- Metropolitan ESRD to Z – Sherry Mohammed

**CORFs:**
- A to J – Gwen Taylor
- K to Z – Sherry Mohammed

**OPTs:**
- A to NY Neuro – Gwen Taylor
- After NY Neuro to Z – Sherry Mohammed

**RHCs:**
- A to Tri County – Gwen Taylor
- After Tri-County to Z – Sherry Mohammed

**Ambulatory Surgery Centers:**
- A to– H – Gwen Taylor
- I to Z – Sherry Mohammed

Names can be deleted from the “Responsible Parties” listing by highlighting the name and clicking on the “Delete” Button with the red negative sign in the Assignment Section.
**Responsible Team:** Select the responsible team from the drop down box. Again be sure to select the team with a number. (Regional offices with a numbered prefix are to be selected for the Hospital Program.) You may need to scroll up to locate the team with a number prefix.

Section Three: Complainant/Patient Information

The next sections of the Intake Tab relate to Complainant and Patient Information.

Complainant Information

The Intake Tab defaults to the Complainant Tab when opened. To record complainant information, type in the complainant last name, and first name (if known) and click the “Find/Add” Button with the green plus sign.
A listing of complainant’s with similar names will appear.

If the complainant is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The complainant will be added to the record complainant listing.

If the complainant is new to the system, it will be necessary to create a record for that person.

Clicking on the “New” Button will allow creation of a new record for this complainant.
Filling in the appropriate information and clicking the “OK” Button will create the record in the ASPEN database and post the complainant in the listing of complainants for the active record.

There is not a specified limit of the number of complainants per intake. However, it should be noted that only three complainants per complaint record will be uploaded to the national database.

The system automatically defaults to recording the complainant as anonymous. This is meant to reflect the complainant wishes to remain anonymous to the facility. If the complainant requests anonymity from all aspects of the complaint process, including the New York State Department of Health, do not use the “Add Anonymous” Button to record the complainant. Rather, type ANON in the last name of the Search Section, click the “Find/Add” Button, and select ANONYMOUS HP from the listing and click the “OK” Button. The ANONYMOUS HP record has the identification number 03JOM3.
Patient Information

Patient identification and information is added in the same format as the complainant information. Click on the Patient Tab, enter the name or part of the name in the search area, and click the “Find/Add” Button with the green plus sign.

If the patient is recorded in the listing, click on the “Modify” button to verify it is the correct person. If acceptable, select the person and click the “OK” Button. The patient will be added to the listing. Again, if the patient is new to the ASPEN system, it will be necessary to create a record for that person.

NOTE: The Residents/Patients Tab includes information on the date and time of the alleged event. These fields are optional for purposes of data entry. If the complaint is specific to an event, you may want to record the actual date and possibly the time. If the complaint involves care generally during a specific hospitalization or time period, you may want to record the admission date.

Alleged Perpetrators

The final tab in this section is for the posting of “Alleged Perpetrators.” Allegations of abuse by facility staff, visitors or other patients may be recorded in this section in the same format as done for identifying the complainant and the patient.
• **Section Four: Source**

Specify the source of the complaint.

Select up to three options which best describe the source of the complaint. If the complainant is anonymous and wishes to remain anonymous, click the 05 Box. This will pre-empt the requirement that the complaint be acknowledged in order to process the upload to the national database.

• **Section Five: Received Date/Association**

*Received Start and End Dates:*

The date/time of the start and end dates for the complaint receipt defaults to the date and time the Intake Tab was first opened. This may be changed as indicated, if the intake was at a time other than when the intake tab was opened (i.e. date letter received).

For most complaints, the received start and end dates will be the same. There is an option to post a different date for the “End Date.” This is to allow the submission of additional information in order to appropriately triage the complaint. The system allows fourteen (14) working days for the submission of additional information. Different received start and end dates should be utilized only if the initial information provided is so vague the issues of the complaint cannot be identified and additional information is formally requested from the complainant.

Complaints for which additional information is not received within the fourteen-day time frame, are to be closed. It is expected less than five percent (5%) of complaints received will have different received start and end dates.
**Association:**

Just below the Received Start and End Date Fields is the Association Section.

The Association function will be utilized only to associate State complaint records with a Federal record requesting CMS authorization to proceed with an allegation survey. This is addressed in detail in Section Two of this manual.

- **Section Six: Notes**

As noted earlier, the final section of the Intake Tab is the Notes Section.

![Image of ACTS interface](image)

ACTS is designed to record intake at the time the complaint is being filed either verbally or written. The Notes section provides an area for the intake person to record the major issues of the complaint.

Also available to the intake person are questions or prompts, to the right of the Notes Section, which may be of assistance in gathering critical information.

It also should be noted there is a spell check feature in the Notes Section, which should always be utilized.
2. Complaint Triage

The remaining section of the Intake Tab has to do with the complaint triage process. The section is labeled “Response Information.”

This section is located just above the “Notes” Section of the Intake Page.

Priority:

Based on the information provided, the complaint clinical coordinator is to assign a priority to the complaint. Priority definitions are provided in Attachment Six and in the Hospital Program Complaint Manual. These definitions are consistent with the Federal priority designations as presented in CMS Memorandum Ref: S&C-04-09 (Attachment Five of this manual).

Establishing the complaint priority will define the processing type and time frames.

The “Investigate within _______ days” is the number of days in which the on-site or off-site survey is to be completed (with the day of receipt being day zero). The “Investigate within _______ days” is the actual calendar date corresponding to the working days noted in the “Investigate within _______ days” field.

**EMTALA or Death with Restraints**

If on triage or during a survey, the complaint is determined to be a potential EMTALA violation or Death with Restraints, CMS authorization to proceed with an EMTALA or Death with Restraints survey is required. Follow the procedures outlined in Section Two of this Manual. (Note: It may be necessary to create a separate record for the State survey if the dates of the Federal and State surveys are different.)
3. **Acknowledgment Letter to Complainant**

The acknowledgment letter to the complainant is to be posted through the “Notices” Button.

Click the “Notices” Button at the bottom of the screen.

In the “Notification History” section, select the “New” Button.
This screen will appear:

Fill out the fields by selecting items from the drop down boxes:

The selection for “Type” should be 01:

The date the complaint was acknowledged will automatically post in the “Acknowledged” field in the “Acknowlegdement and Parties Notified” Section of the Investigations Properties Page.
At this point a hard copy of the Investigation Report should be printed and provided to the investigating surveyor or investigating surveyor team.

Select the “Print” Button at the bottom of the complaint record.

This screen will appear. Select “Investigation Report” and click on the “OK” Button. The form will appear on your screen for printing.
ALLEGATIONS

Allegations are entered by the surveyor on the Allegations Tab

1. Click on the Allegations Tab

This screen will open:
2. In the Allegations Section, click the “Add” Button with the green plus sign.

The “Allegation Input” window will appear:
3. Specify the Category, Subcategory and Seriousness of each allegation.

When selecting subcategories, be sure to select only those categories preceded by a number or the letter “D” or “E.” (Subcategories with an “A” prefix are specific to long term care complaints.)

A listing of allegation categories and the corresponding subcategories for each allegation category is identified in Attachment Seven.

Click the “OK” Button. The allegation will be added to the list of allegations for the complaint.
4. To add details about the allegation, click the “Details” Button to the left of the noted allegation.

Write the details of the allegation in the space provided.

You may use the “Insert Notes” button to insert the text posted in the Notes Section of the Intake. Text may be added or deleted once posted from the Notes Section into the Allegation “Details” section.

Be sure to bracket ( [ ] ) confidential information reported in the “Details” section to preclude public release.
NOTES SPECIFIC TO ALLEGATIONS:

Generally only one allegation per category should be selected. The ACTS upload will only submit one allegation per category and a total of five allegations to the national database.

By default, ACTS will automatically select the “Include on OSCAR 562 Form” on the Allegation Input Form.

If the complaint involves more than one allegation per category or more than five allegations in total, deselect the “Include on OSCAR 562 Form” box on the Allegation Input Form for the multiple category selections. Leave the box selected for the most important allegation for each category. You may post several issues related to one category in the “Details” section of the allegation.

If more than five allegation category types are identified, be sure the “Include on OSCAR 562 Form” box on the Allegation Input Form is selected for the most substantive allegations.
INVESTIGATION

Once the complaint record has been established and the allegations posted, proceed with the Investigation Phase of the processing.

1. Schedule the survey activity.

Click on the Investigations Tab at the top of the complaint record. This will bring you to the Investigations Page.

Listed in the “Investigation and Survey” Section are surveys posted in ACO for this facility. If there is a survey at the facility that has not yet occurred, you may link the investigation of this complaint to that survey. This allows for the investigation of several complaints at one time, or the investigation of a complaint during another type of survey (i.e. re-certification survey).

To link the complaint to an already scheduled survey, click on the “Selected” box for the survey. Click “Yes” to the prompt to verify the complaint should be linked to the selected survey.
A check mark will be reflected in the box to the left of the selected survey to denote the complaint has been linked to the survey.

If there is not a survey to which the complaint may be linked, create a new survey shell by clicking on the “New” Button with the green plus sign and completing the Survey Properties information. Respond “Yes” to the prompt to link the complaint to the newly created survey shell.

A check mark will be reflected in the box to the left of the newly created survey to denote the complaint has been linked to the survey.

When linking the complaint to an existing investigation or when creating a new shell in ACTS, the system will automatically select Category “A – Complaint” for the “Type of Survey.” In addition, also select “K - State Licensure” and “3 - Licensure Complaint.”

The extent will automatically default to “D-Other Survey.” Use this for complaint investigations unless the review will be done as an “F-Offsite/Paper” review. For desk reviews, deselect “D-Other Survey” and select “F-Offsite/Paper.” Only one selection should be checked for “Extent(s).”
To unlink a complaint from a given survey shell, click the “Selected” box to remove the check mark, and respond “Yes” to the message confirming the unlinking action.

**NOTE:** When creating a survey shell for a complaint investigation, the survey dates are to be the actual dates of the on-site visit. If the complaint review is being accomplished through an off-site desk review, the survey dates are to be the dates of the surveyor review of the medical record and other facility provided information. The time frame for requesting the medical record and facility information is not to be included in the survey date time frame.
2. Activities

ACTS includes an “Activities” Tab for each complaint record. This is designed to assign specific activities to program staff. The Hospital Program will be using the Activities Section to record actions taken with regard to the specific complaint.

The activities available in the system are as follows:

- **01 Electronic Contact**
- **02 Letter to Complainant**
- **03 Letter to Provider/Supplier**
- **04 Telephone Contact – Complainant**
- **05 Telephone Contact – Field Office**
- **06 Telephone Contact – Other**
- **07 Hold for Written Report**
- **08 Schedule Onsite Visit**
- **09 File Review**
- **10 Medical Records Requested**
- **11 Additional Information Requested**
- **12 State to Rewrite Deficiencies**
- **13 Received for Final Processing**
- **14 Proofread**
- **15 Mail/File**
- **M1 Administrative Review/Offsite Investigation**
- **M2 CRB Forward to RO for Onsite Invest**
- **M3 Investigation Report Completion**
- **M4 Supervisory Review and Sign Off**
- **M5 Forbearance for AG Investigation**
- **M6 Expungement Required**
- **M7 Expungement Stopped by Complainant Appeal**
- **M8 Administrative Closure**
- **P1 Facility Closure Letter Issued**
- **P2 Complainant Closure Letter Issued**

The Hospital Program will be using **ONLY those activities listed in green**. Do not select any of the categories listed in black.

Once one of the noted activities occurs, select the “Activities” Tab and click on the “Add” Button with the green plus sign to define an activity.
The Define Activity Window will appear:

Select the type of activity from the drop down box. Use only those items noted in green on page 110. Fill in the completed date.

It is important to specifically record communications with CMS (05 Telephone Contact – Field Office). Be sure to summarize the essence of communication in the comments section of the “Define Activity” Form.

NOTE: The 08 Schedule an Onsite Visit will automatically be posted in the Activities Tab when the complaint is linked to either an existing survey or a newly created survey. Therefore, it is not necessary to ever define this activity independent of the survey linkage process.

Communication with the complainant may also be recorded in the Activities Listing. However, it should be noted that the complainant acknowledgement letter is to be posted on the Investigation Properties Page through the “Notices” Button as detailed on pages 99 – 100.
3. Findings

Conduct the on-site or off-site complaint review activities.

If during the investigation at a hospital, the surveyor identifies a potential EMTALA situation or a Death with Restraints, create a Federal complaint record to request CMS authorization to proceed with a Federal survey, consistent with procedures defined in Section Two of this manual.

If condition level non compliance with federal regulations is identified during the survey, findings are to be released to CMS, as reported on page 124, within three (3) days of the survey.

- Prepare Survey Report

The narrative report can be prepared in one of two ways:

1. Prepare the narrative report in memorandum form in Word and attach the document to the complaint record through the ASPEN attachment process.

2. Use the “View Investigation Notes” option on the “Investigations Tab” or the “Investigations Properties Page” to record the narrative report. When the “Investigation Notes” button is selected a blank word processing document appears for writing of the narrative report.

It is recommended the narrative report be prepared through Investigation Notes. The Investigation Report can then be reprinted and a full report (including the allegation details and findings) will be incorporated into one summary document.
• **Post Citations in Citation Manager**

Post deficiencies in the Citation Manager Section from the “Investigation” Tab or the “Investigation Properties” Page.

**Investigation Tab**

**Investigation Properties Page**

Note: When posting deficiencies, be sure to select appropriate categories on the “Citation Properties” screen for each tag: “A – Complaint” for Federal tags; “K – State Licensure” and “3 – Licensure Complaint” for State tags.

If there are no State regulation deficiencies, select the 0000 tag and post appropriate facility and complaint identifiers and select the statement saying there were no deficiencies identified. It is not required the 2567 be issued for no deficiencies to State regulations.
• Post Allegation Findings

For each allegation, the investigation findings are to be recorded.

Go to the “Allegations” Tab or to the Allegation Section of the “Investigations Properties” Page.

Allegations Tab:

Investigations Properties Page

Select the allegation by darkening it from the left-hand side. Click on the “Modify” Button.
In the Findings Section of the Allegation Input Screen, select either “Substantiated” or “Unsubstantiated.”

Definitions for “Substantiated” and “Unsubstantiated” are provided in the CMS Memorandum Ref: S&C 04-09 included in Attachment Five.

Select the appropriate Findings Qualifier in the list box. The selections will vary based on the Findings determination.

The qualifiers for “Substantiated” Findings are as follows:

The qualifiers for “Unsubstantiated” Findings are as follows:
You may add allegation details or non-confidential notes about findings by clicking on the “Find Text” box in the Allegations Listing.

This screen will appear. Only the bottom section is active. The top section is the “Details” Section where specific information about the allegation would have been added when the allegation was posted. See page 105.

Be sure to bracket ([ ]) confidential information reported in the “Findings” section to preclude public release.

Repeat for each allegation
• **Link Deficiencies to Allegations**

Deficiencies are to be linked to those substantiated allegations for which a deficiency (or deficiencies) has been cited. To link deficiencies to substantiated allegations, access the allegation listing from either the “Allegations” Tab or the Allegations Section of the Investigation Properties Page, and select the allegation.

Select a specific allegation on the listing and click on the “Link Deficiencies” Button.

**Allegations Tab**

![Image of Allegations Tab]

**Allegations Section on Investigation Properties Page**

![Image of Allegations Section]
On the “Assign Aspen Tags to Allegation” Form mark the “Selected” box in the tag(s) that should be linked to the selected allegation and respond to the verification notice. A check mark will record the tag is linked to the allegation. More than one tag may be linked to any given allegation.

Select the “OK” button.

The linked tags will be listed in the Deficiencies column.

The surveyor report and findings may be submitted for supervisory approval. If the narrative report is prepared in “Investigation Notes,” this may be accomplished by reprinting the “Investigation Report.” (See page 101.) Be sure to post the M3 Activity in the Activities Section. (See page 110.)
4. Record Contacts and Witnesses

Recording of surveyor contacts and witnesses is an optional activity. Surveyors have the opportunity to record interviews with facility staff, complainants, and/or patients.

Select the “Contact/Refer” Tab from the Complaint Record. Click on the “Add” Button at the bottom of the “Contact/Witnesses” section.

The “Add Contact/Witness” window will appear.

Provide information about the contact and click the “OK” Button.

Repeat for additional contacts.
Recording of referrals to another agency is NOT an optional activity.

On the “Contact/Refer” Tab go to the “Referral Details” Section. Select the “Add” Button.

A window listing a number of agencies or entities will appear. A complete listing of the agencies is provided in Attachment Eight.

Darken the appropriate selection and click on the “Select” Button.
This screen will appear, listing the selection:

Post appropriate information in the fields to the right of the identified agency. In all cases, the “Date Referred” field is to be completed.
5. Survey Activity Documentation and Release Findings to CMS, if indicated.

- **Specify Proposed Actions**

Select the “Actions/Close” Tab. Click the “New” Button in the “Proposed Actions – Federal” section.

Select an action from the drop down list:

Action selection options include:

- 01 Plan of Correction
- 02 Involuntary Termination - IJ
- 03 Involuntary Termination – Non-IJ
- 04 Denial of Payment for New Admissions
- 05 Civil Money Penalty
- 06 State Monitoring
- 07 Temporary Management
- 08 Denial of Payment for All Individuals
- 09 Directed Plan of Correction
- 10 Directed In-Service Training
- 11 Transfer of Residents
- 12 State Closure of Facility
- 13 Alternate Remedies
- 18 Termination of Swing-Bed Approval
- 19 Loss of Deemed Status 20 Civil Suit
- 21 Criminal Sanction
- 22 Suspension of Medicare Payment
- 23 Cancellation of Medicare Payment
- 24 Loss of PPS Excluded Status
- 25 Denial of Federal Financial Participation
- 26 Nonrenewal of Time Limited Agreement
- 27 Cancellation of Time Limited Agreement
- 28 Extension of Time Limited Agreement
- 29 Denial of Payments to ESRD for New Patients
- 30 Reduction of Payments for ESRD
- 31 Withholding of All Payments for ESRD
- 32 None
- 33 State Only Actions
- 34 Other

Enter a proposed and imposed dates (unless CMS is to formally take the action) and select the CMS RO/MSA Action check box to indicate the action is to be included on the CMS 562 form.
For actions imposed directly by CMS, enter only the “Proposed Date” which is the date the State Agency recommendation for the action is proposed to CMS.

As one of the proposed Federal Actions, select “33 State Only Actions. This will activate the “Proposed Actions” for the State Section of the Form.

Select the “New” Button in the State Proposed Actions Section. Repeat the process for identifying proposed actions, selecting items from the drop down list. Selection options are as follows:

- 01 POC (No Sanction)
- 02 License Revocation
- 03 Provisional License
- 04 Special Monitor
- 05 Ban on Admissions-New
- 06 Ban on Admissions-All
- 07 Civil Monetary Penalty
- 08 Temporary Manager
- 09 PHL 2803-d Violation
- 10 PHL 2803-c Violation
- 11 No PHL 2803c or d Violation
- 12 State Fine Assessed
- 13 No State Fine Assessed
- 14 Receivership
- 98 Other
- 99 None

For actions imposed directly by the State Agency, record both the proposed date and the imposed date which should be the same, reflecting action taken by the State Agency. For example, if deficiencies are identified, the action would be 01 POC. The date the Statement of Deficiencies is issued would be the proposed and the imposed date.

When the complaint review identifies there are no State deficiencies to be cited, category 99 None should be posted.
On the Investigations Tab or the Investigation Properties Page:

- Complete 670 information.
- Attach the narrative report (unless the narrative report is posted in “Investigation Notes”), medical record and facility staff identifiers, letters to complainant and facility through the ASPEN attachment process.
- Complete 1539

Complete the 1539 for by selecting Survey Forms on the Investigations Tab or on the Investigation Properties Page.

Enter 1539 information by selecting the “1539 Entry” Button. Be sure to reference the complaint number in the remarks section.

If the complaint has identified condition-level non-compliance, release the surveyor investigative report and findings to CMS by placing a check mark in the “Forwarded to RO/MSA” box on the Investigations Tab and post the date of this action.

Submit electronic or telephone notification to CMS that the State investigative activities have been released. Record the CMS communication in the Activities Tab, specifying the information provided to CMS in the Comments section of the “Define Activity” form.
Investigation Completed Fields

Post the “Investigated by” field and the date the investigation was completed in the “Investigation Completed” date field. These fields are located on the Investigation Tab.

“Investigation Completed” field is defined as any one or more of the following: (1) the date the Statement of Deficiencies is issued, or (2) the date the complainant is advised of the Department’s findings, or (3) the date the facility is advised of the Department finding, or (4) the date survey findings are released to CMS. (When the investigation is complete, the surveyor investigative report should be attached to the complaint record or posted in Investigative Notes.)

6. Post Processing Activities

IF NO DEFICIENCIES ISSUED, GO TO STEP 7.

If deficiencies are issued:

- Survey Properties

Access the Survey Properties Screen from the Investigation Tab or the Investigation Properties Page.

Post: Date SoD Issued
Note: this date should also be posted on the Investigation Properties Page as noted in Item number seven (7) below.

Date PoC Received

X6 Date

Revisit Status

- Citation Manager

After submission of the PoC, access the Citation Manager Screen from the Investigation Tab or the Investigation Properties Page. For each citation:

Post: PoC Received Date
Reminder: PoC received date may vary on the different citations if addendum is submitted specific to any given citation.

X 5 dates

State Agency Approval of PoC Date
• **PoC Tracking**

The status of the Plan of Correction may be tracked by clicking on the “POC Track” Button on the Investigation Tab or the Investigations Properties Page.

Click on the “POC Track” Button. The tracking screen will appear for posting of information:
7. Investigation Properties Page

Click on the 562 View/Upload Button at the bottom of the record to get to the “Investigations Properties Page.” (You may also get to the “Investigations Properties Page” from the Tree View by right clicking on the complaint record, and selecting “Investigation Properties.”)

- Record date the SoD was issued to the facility or notice issued to the facility.

- Record the date the complainant was advised of complaint review findings.

Scroll to the bottom of the Investigation Properties Page to the “Acknowledgement and Parties Notified” Section.

![Image of Acknowledgement and Parties Notified section]

Post the date the SoD was issued to the facility (or the date notice was sent to the facility if no Statement of Deficiencies was indicated) and the date the complainant was notified of the complaint review findings.
COMPLAINT CLOSURE

Upload Complaint

Once the Plan of Correction has been accepted and the facility notified of the acceptance, the complaint record is ready for upload and closure. **Unlike ACO, uploads are accomplished when the complaint is processed through to completion.**

In the complaint record, click on the 562 View/Upload Button at the bottom of the page.

The Investigations Properties Page will open. There is another tab for Upload.
Select the Upload Tab to navigate to the Upload page. Select the “Prevalidate and Upload” Button to initiate the upload transaction to the national database.

After twenty-four (24) hours, verify the upload transaction and proceed with closing the complaint.

In the complaint record, go to the Actions/Close Tab.
Scroll to the “Closure Information” and “Finalization” sections.

Post a date in the “In Compliance” field. This date will usually be consistent with the date notice was issued to the facility indicating the PoC is acceptable.

Place a check mark in the “Finalized” Box. This will activate the “Reason Closed” Section.

Select the reason for complaint record closure (Paperwork Complete, Withdrawn, Referred, No Jurisdiction, Provider/Supplier Termination) and post the “Date Closed” date.

Make appropriate hard copy for the office file retention.

Submit a hard copy to the Bureau of Hospital and Primary Care Services.
Attachment 47

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 47
Hospital Quality Activities
Hospital and D&TC Complaint Investigation / Survey

Complaint Intake Manual set forth as Attachment 46.
Attachment 48

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 48
Hospital Quality Activities
Hospital Complaint Resolution

This is a new function. Refer to the Hospital Complaint Intake Manual set forth in Attachment 46.
Attachment 49a

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 49
Hospital Quality Activities
NYPORTS Reviews – Central Office

NYPORTS Root Cause Analysis Evaluation Protocol
### NYPORTS ROOT CAUSE ANALYSIS EVALUATION PROTOCOL

<table>
<thead>
<tr>
<th>RCA Item #</th>
<th>STANDARD CRITERIA REQUIRED</th>
<th>Intent Met</th>
<th>Intent Not Met</th>
<th>NA</th>
<th>COMMENTS FOLLOW-UP</th>
<th>Date Intent Met</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Short Form</strong></td>
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<tr>
<td>1a.</td>
<td>Short form category code(s) accurately reflects occurrence described.</td>
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<td>1b.</td>
<td>Detail code (900 series code) accurately reflects occurrence described.</td>
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<td><strong>2. RCA Narrative Description</strong></td>
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<tr>
<td>2a.</td>
<td>A detailed description of the adverse event must include: the date, day of the week, time, area/service involved, unit or department.</td>
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<td>2b.</td>
<td>Identify who was involved by title and a detailed chronology of pertinent facts that includes times.</td>
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<td>2c.</td>
<td>When relevant include: co-morbid conditions, height, weight, serial lab values, surgical procedures, changes in level of care, diagnostic testing results, vital signs, consults, medications, other clinical data, and non-clinical data.</td>
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<td>2d.</td>
<td>Fully explains the event so that a reader unfamiliar with the occurrence understands what happened and why the event happened.</td>
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<td>RCA Item #</td>
<td>STANDARD CRITERIA REQUIRED</td>
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<td>3.</td>
<td>Policy or Process in Which Event Occurred (P), Human Resource Factors &amp; Issues (H), Environment of Care / Equipment/Supplies (E), Information Management &amp; Communication Issues (I), Leadership: Corporate Culture (L), and Other (O)</td>
<td></td>
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<tr>
<td>3a.</td>
<td>Root cause statement(s) are consistent with the 5 rules of causation.</td>
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<tr>
<td>3b.</td>
<td>Root cause statement(s) must clearly show cause and effect relationship (use “due to” or “in the absence of”). Identify the preceding cause, not the human error. Identify the preceding cause(s) of the procedure violation(s).</td>
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<td>3c.</td>
<td>Risk reduction strategies/actions should prevent or minimize future events or close calls.</td>
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<td>3d.</td>
<td>Risk reduction strategies/actions should eliminate, greatly reduce or control the root cause. Include system(s) and individual action(s).</td>
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<tr>
<td>3e.</td>
<td>Title of person responsible for the risk reduction strategies/actions must be entered.</td>
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<td>3f.</td>
<td>Date risk reduction strategies/actions will be implemented must be entered.</td>
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<td>RCA Item #</td>
<td>STANDARD CRITERIA REQUIRED</td>
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<td>3g.</td>
<td>Measure of Effectiveness must measure the impact of risk reduction strategies and include defined timeframes, numerators for audit, realistic thresholds in percentages for performance/compliance and follow-up for non-compliance. Must enter title of person responsible.</td>
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<td>3h.</td>
<td>Hospital policies, clinical practice guidelines, critical pathways or practice protocols related to event are followed as intended, developed, or revised after review of the occurrence.</td>
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<td>3i.</td>
<td>Review identifies all root causes likely to prevent recurrence of event.</td>
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<tr>
<td>3j.</td>
<td>RCA and identified root causes do not leave any obvious unanswered questions.</td>
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<tr>
<td>3k.</td>
<td>RCA is internally consistent and does not contradict itself.</td>
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<td>4.</td>
<td>Literature Search</td>
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<tr>
<td>4a.</td>
<td>Can include books, articles and websites. Include at least 3 sources that are pertinent to the event.</td>
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<td>5.</td>
<td>Leadership: Corporate Culture</td>
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<td>5a.</td>
<td>Leadership is involved in the evaluation of adverse patient care occurrences. They participate in the RCA process and are identified by title.</td>
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<td>6</td>
<td>Executive Summary of</td>
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</table>

764
<table>
<thead>
<tr>
<th>RCA Item #</th>
<th>STANDARD CRITERIA REQUIRED</th>
<th>Intent Met</th>
<th>Intent Not Met</th>
<th>NA</th>
<th>COMMENTS FOLLOW-UP</th>
<th>Date Intent Met</th>
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<tbody>
<tr>
<td><strong>the Analysis</strong></td>
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<tr>
<td>6a.</td>
<td>Root cause analysis review of occurrence is thorough and credible.</td>
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<td>6b.</td>
<td>Any external expert review findings are included.</td>
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<td>6c.</td>
<td>Relevant Q/A findings are summarized.</td>
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<td>6d.</td>
<td>Relevant staff qualifications and credentials, MD complication rate(s), number of procedures performed/year are included when applicable.</td>
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<tr>
<td>6e.</td>
<td>Pertinent findings from literature search are cross-referenced.</td>
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<tr>
<td>6f.</td>
<td>All elements are tied together to justify root causes, risk reduction strategies, and measures of effectiveness.</td>
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<td><strong>7.</strong></td>
<td>RCA Participants</td>
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<tr>
<td>7a.</td>
<td>Individuals in roles involved in the processes and systems under review participate in RCA and are identified by title only. (i.e. RN, Pharmacist, Radiological Technician, LPN, Attending Surgeon, Resident, PCA, etc.).</td>
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<td><strong>8.</strong></td>
<td>Standard of Care Determination</td>
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<tr>
<td>8a.</td>
<td>RCA findings support the facility's standard of care determination.</td>
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<td>8b.</td>
<td>Facility's determination of standard of care is consistent with current practice.</td>
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<td>Item #</td>
<td>STANDARD CRITERIA REQUIRED</td>
<td>Intent Met</td>
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<tr>
<td>8c.</td>
<td>If standard of care not met and is directly linked to an individual practitioner, the full name and license number or certification number must be entered.</td>
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<td>9.</td>
<td>Agencies Notified by Facility if applicable:</td>
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<tr>
<td>9a.</td>
<td>Bureau of Environmental Radiation Protection</td>
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<tr>
<td>9b.</td>
<td>Bureau of Narcotics</td>
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<tr>
<td>9c.</td>
<td>County Health Department</td>
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<tr>
<td>9d.</td>
<td>Department of Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9e.</td>
<td>Food and Drug Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9f.</td>
<td>Office of Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9g.</td>
<td>Wadsworth Laboratories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9h.</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Article 28 Facilities will receive timely feedback from the DOH if their RCA does not meet RCA protocol criteria. Facilities will have 10 business days to add information requested to their RCA. The DOH is responsible for assuring that all RCA Protocol Criteria are met prior to end of RCA review and closure of the case.

Cases should remain open if they are still in the Enforcement process.
Attachment 49b

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

**Unit 49**
Hospital Quality Activities
NYPORTS Reviews – Central Office

NYPORTS RCA Review Screen
The DOH is responsible for documenting all activity done while reviewing the Occurrence and RCA in a timely manner including medical record review, physician reviews, issuance of SODs, and Enforcement actions.
### Occurrence Review Fields

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Locked</td>
<td>If this box is checked, Facility Users will not be able to edit the data on</td>
</tr>
<tr>
<td></td>
<td>the Short Form associated with the Occurrence ID. They will be able to view</td>
</tr>
<tr>
<td></td>
<td>the data on the Short Form. Area Office Users and Central Office Users are</td>
</tr>
<tr>
<td></td>
<td>able to unlock the Short Form &amp; RCA if a facility needs to make an addendum</td>
</tr>
<tr>
<td></td>
<td>to their RCA.</td>
</tr>
<tr>
<td>Investigation Initiated Date</td>
<td>Date that the investigation was initiated in mm/dd/year format.</td>
</tr>
<tr>
<td>Onsite Visit</td>
<td>Date of the onsite visit in mm/dd/year format.</td>
</tr>
<tr>
<td>Desk Review</td>
<td>Date of the desk review in mm/dd/year format.</td>
</tr>
<tr>
<td>Facility Medical Record Requested</td>
<td>Date the medical record was requested in mm/dd/year format.</td>
</tr>
<tr>
<td>Facility Medical Record Received</td>
<td>Date the medical record was received in mm/dd/year format.</td>
</tr>
<tr>
<td>Expert Review</td>
<td>Dates the Expert reviews were sent and received in mm/dd/year format.</td>
</tr>
<tr>
<td>DOH Physician Review</td>
<td></td>
</tr>
<tr>
<td>IPRO Review</td>
<td></td>
</tr>
<tr>
<td>Other/Other</td>
<td></td>
</tr>
<tr>
<td>Sent/Received</td>
<td></td>
</tr>
<tr>
<td>Sent/Received</td>
<td></td>
</tr>
<tr>
<td>SOD Issued</td>
<td>Date the Statement of Deficiency was issued in mm/dd/year format.</td>
</tr>
<tr>
<td>Reason SOD Issued</td>
<td>Checkboxes that indicate the reason the SOD was issued.</td>
</tr>
<tr>
<td></td>
<td>• IPRO Retrospective Review</td>
</tr>
<tr>
<td></td>
<td>• Late Reporting</td>
</tr>
<tr>
<td></td>
<td>• DOH Investigation</td>
</tr>
<tr>
<td>POC Not Required</td>
<td>Box is checked if Plan of Correction is not required.</td>
</tr>
<tr>
<td>POC Due Date</td>
<td>If Plan of Correction is required, the date it was due.</td>
</tr>
<tr>
<td>POC Received Date</td>
<td>If Plan of Correction is required, the date it was received.</td>
</tr>
<tr>
<td>POC Accepted Date</td>
<td>If Plan of Correction is required, the date it was accepted.</td>
</tr>
<tr>
<td>Complaint Number</td>
<td>The DOH number of the complaint.</td>
</tr>
<tr>
<td>OPMC Referral</td>
<td>Date of Office of Professional Medical Conduct referral.</td>
</tr>
<tr>
<td>Enforcement Date</td>
<td>If the occurrence results in enforcement, the date should be filled in</td>
</tr>
<tr>
<td></td>
<td>mm/dd/year format.</td>
</tr>
<tr>
<td>RCA Protocol Met</td>
<td>If RCA protocol was met this should be checked.</td>
</tr>
<tr>
<td>Closure Date</td>
<td>Date the investigation was closed.</td>
</tr>
<tr>
<td>RCA Extension Request Date</td>
<td>Date the RCA extension was requested. This field is</td>
</tr>
<tr>
<td></td>
<td>Automatically populated when a Facility User enters a request for an RCA</td>
</tr>
<tr>
<td></td>
<td>Extension on the Short Form page.</td>
</tr>
<tr>
<td>RCA Extension Request Date</td>
<td>Date the RCA extension was requested. This field is</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Field Name</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Date</td>
<td>Automatically populated when a Facility User enters a request for an RCA Extension on the Short Form page.</td>
</tr>
<tr>
<td>RCA Extension Approval Date</td>
<td>Date the RCA extension was approved by the DOH in mm/dd/year format.</td>
</tr>
<tr>
<td>Initial Review by AO Date</td>
<td>Date the RCA was initially reviewed by the DOH in mm/dd/year format.</td>
</tr>
<tr>
<td>Further RCA Work Required</td>
<td>Check box and notify facility that the RCA requires more work.</td>
</tr>
<tr>
<td>RCA Criteria Met Date</td>
<td>Date the RCA was found to meet the RCA evaluation Protocol Criteria in mm/dd/year format.</td>
</tr>
<tr>
<td>HPD Review Date</td>
<td>Date the case and RCA were reviewed with the HPD in mm/dd/year format.</td>
</tr>
<tr>
<td>Comments/Narrative Area</td>
<td>Extra text area for any additional comments. Deletion date and reason should be entered in this field, if applicable.</td>
</tr>
</tbody>
</table>
Attachment 50

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 50

Hospital Quality Activities
NYPORTS Reviews – Regional Offices

NYPORTS Root Cause Analysis Evaluation Protocol
NYPORTS RCA Review Screen
As both are set forth in full as Attachments 49a and 49b
Attachment 51

Rules, regulations, policies and procedures for which a Unit price is being sought under this RFP, maybe found at the following website addresses or are set forth below:

Unit 51

Hospital Quality Activities
Targeted Surveillance Team
EMERGENCY DEPARTMENT SURVEY

REVIEW PROCESS

The Emergency Department (ED) survey will be conducted as a 1-2 day, onsite visit, focusing on the quality of care provided to patients with delays waiting for admission and an assessment of hospital operations in response to overcrowded situations in the ED.

- Once onsite, DOH will contact the hospital’s administrative offices and notify them that the onsite visit will consist of interviews with various staff (e.g., ED Director, Bed monitor, Director of Housekeeping) and chart reviews of patients held in the ED and admitted within the previous 24-48 hours.

- DOH staff will proceed directly to the ED and begin the survey by interviewing ED administrative staff (e.g., ED Director, Head Nurse, Medical Director) to ascertain census data and ED activities within the past 48 hours.

- Chart reviews will be conducted on a randomly selected number of patient records; two thirds from patients who are currently in the ED and one third from patients who were admitted from the ED within the previous 24-48 hours. Reviews will focus on quality of care while being held in the ED.

- DOH will observe and record information on current status of ED operations.

- Interviews will be conducted with hospital administrator(s) to ascertain the hospital’s plan of action to decompress the ED. Additional interviews with the hospital’s bed coordinator (if the hospital has one), the Director of Discharge Planning and Director of Housekeeping may also helpful to understand the overall hospital plan.
EMERGENCY DEPARTMENT SURVEY
GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>Review Time:</td>
</tr>
<tr>
<td>Hospital CEO, COO or designee::</td>
<td></td>
</tr>
<tr>
<td>Director of Emergency Department:</td>
<td></td>
</tr>
<tr>
<td>Hospital Representative Name(s) (person(s) answering survey):</td>
<td>Title(s)</td>
</tr>
<tr>
<td>Name of “Bed Monitor”(s)</td>
<td>Title</td>
</tr>
<tr>
<td>Who acts as “Bed Monitor” at the following times:</td>
<td>Title:</td>
</tr>
<tr>
<td>Nights:</td>
<td></td>
</tr>
<tr>
<td>Evenings:</td>
<td></td>
</tr>
<tr>
<td>Weekends:</td>
<td></td>
</tr>
</tbody>
</table>

**ED Administrator-answer questions based on status at time of survey**

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Number in ED&gt;8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the ED capacity? (number of beds)</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>What is the total number of patients in the ED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many ED patients are awaiting admission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many ED patients are awaiting discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many ED patients were admitted within the last 48 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waited &gt;8 hours in ED?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the ED have transport services dedicated to the ED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is transport available 24/7?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, what actions are taken when transport not available to allow patients to be admitted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the ED have laboratory services dedicated to the ED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are laboratory services available 24/7?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If No, what actions are taken when laboratory services are not available?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the ED have dedicated Radiology services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are radiology services available 24/7?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If No, what actions are taken when radiology is not available?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>What steps do you take to decompress the ED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who in administration do you notify during periods of high ED volume?</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Who assesses ED staffing levels?</td>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>What steps do you take to monitor and adjust nurse to patient ratio?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What spaces (solariums, hallways) are currently being used for patients waiting in the ED?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many patients are currently located in these areas:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often does administration review ED utilization reports?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is ED utilization data discussed with the hospital’s Board?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How has ED utilization and planning changed as a result of these reports?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who makes the decision to implement ambulance diversions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does administration clear all plans to divert ambulances?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If no, how is administration notified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a review of each diversion to determine:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-Actions that could have shortened diversion time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Actions that could have prevented the diversion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Was the ED placed on Diversion within the past 48 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When on diversion, what is the plan to ensure that specialty patients, eg stroke, STEMI, trauma, receive prompt and adequate care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>What is the plan to facilitate patient transfers during peak periods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To which institutions do you transfer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bed Monitor/Administration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the scope of authority of the bed monitor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To whom does the bed monitor report in administration?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During peak periods, which additional beds are used?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During peak periods, where are additional beds placed (hallways)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was the total (Med/surg) in-house census (at midnight)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all certified beds in use?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>If not, why and what beds/units are currently not operational?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has elective surgery been cancelled within the past 48 hours to admit ED patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is elective surgery cancellation part of the hospital’s overcrowding plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What additional actions does housekeeping take during periods of high ED volume?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What additional actions do discharge planners take during periods of high ED volume?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During peak periods, what other actions are taken to admit ED patients?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# EMERGENCY DEPARTMENT SURVEY
## CHART REVIEW – PATIENTS ADMITTED FROM THE ED

<table>
<thead>
<tr>
<th>Facility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>Review Time:</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>MR#</td>
</tr>
<tr>
<td>Payor:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicare</td>
</tr>
<tr>
<td>Private</td>
<td>Managed Care</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Name of Attending Physician (indicate if Private attending)</td>
<td></td>
</tr>
</tbody>
</table>

**Initial Diagnosis:**

What date did the patient enter the ED? What time did the patient enter the ED?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was patient brought in by ambulance?

If Yes, is it documented how long before ED staff took over from EMS

If Yes, how long?

<table>
<thead>
<tr>
<th>hours &amp;/or minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

What time was the patient admitted to the floor? To which unit/space/floor was the patient admitted?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Admitting diagnosis:

Did the patient have special needs (telemetry, ICU, OR)?

How long was the patient in the ED prior to admission?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What was the patient’s condition when entering the ED? What was the patient’s condition upon admission to the floor?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the patient was admitted to floor or unit that matched their clinical needs/condition or admitted to the next available space if patient had no specific clinical needs.

Comment:
# EMERGENCY DEPARTMENT SURVEY
## CHART REVIEW – PATIENTS IN THE ED

<table>
<thead>
<tr>
<th>Facility:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date:</td>
<td>Review Time:</td>
</tr>
<tr>
<td>Patient Name:</td>
<td>MR#</td>
</tr>
<tr>
<td>Payor:</td>
<td>Medicaid Medicare Private Managed Care Other</td>
</tr>
<tr>
<td>Name of Attending Physician (indicate if Private attending)</td>
<td></td>
</tr>
<tr>
<td>Initial Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>What date did the patient enter the ED?</td>
<td>What time did the patient enter the ED?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was patient brought in by ambulance?</td>
<td></td>
</tr>
<tr>
<td>If Yes, is it documented how long before ED staff took over from EMS</td>
<td></td>
</tr>
<tr>
<td>If Yes, how long?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hours &amp;/or minutes</td>
</tr>
<tr>
<td>Indicate patient’s location at time of review: (check one)</td>
<td></td>
</tr>
<tr>
<td>Stretcher in designated waiting area</td>
<td>Chair in designated waiting area</td>
</tr>
<tr>
<td>Stretcher in examination bay/room</td>
<td>Chair in examination bay/room</td>
</tr>
<tr>
<td>Stretcher in hallway or other non-designated area</td>
<td>Chair in hallway or other non-designated area</td>
</tr>
<tr>
<td>Trauma bay/room</td>
<td>Diagnostic area (Xray,CT)</td>
</tr>
<tr>
<td>Specialized treatment area (asthma, pediatrics)</td>
<td>Other</td>
</tr>
<tr>
<td>Has the patient been seen for a medical evaluation?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have procedures/consults/diagnostic testing been ordered?</td>
<td></td>
</tr>
<tr>
<td>Have orders been carried out in a timely manner?</td>
<td>(list orders) Time Ordered Time Carried Out</td>
</tr>
<tr>
<td>Does the patient have personal privacy?</td>
<td></td>
</tr>
<tr>
<td>Is the patient’s medical record stored to protect confidentiality?</td>
<td></td>
</tr>
<tr>
<td>Does the patient have access to a call bell or another means of asking for assistance?</td>
<td></td>
</tr>
<tr>
<td>Does the patient have assigned nursing/support staff?</td>
<td></td>
</tr>
<tr>
<td>Insert observation items here</td>
<td></td>
</tr>
<tr>
<td>How regularly is the patient being monitored for vital signs, neurological status, pain status, or symptoms related to their condition?</td>
<td></td>
</tr>
<tr>
<td>Type of Observation</td>
<td>None</td>
</tr>
<tr>
<td>---------------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If patient is waiting for admission, what is the reason for their continued stay in the ED? (check all that apply)

<table>
<thead>
<tr>
<th>Reason for continued stay</th>
<th>None</th>
<th>Constant</th>
<th>&lt;15m</th>
<th>30m-1 hour</th>
<th>2 hour</th>
<th>4 hour</th>
<th>6 hour</th>
<th>Irregular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting for transport to the floor/unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for specialized unit bed (CCU, ICU)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for procedure/test to be performed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for specialist consult</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting for completion of medical admission orders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Other (describe)</td>
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<tr>
<td>Waiting for Med/Surg bed</td>
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<td>Waiting for admission documentation to be completed</td>
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<td>Waiting for procedure/test result</td>
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<td>Waiting for OR availability</td>
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**SUMMARY**

<table>
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<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. The patient was located in a ED area appropriate to their condition and needs.</td>
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<td>If No, comment:</td>
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<td>2. The patient was seen by a physician in ED and H&amp;P completed within 2 hours</td>
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<td>If No, comment:</td>
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<td>3. All orders in ED were performed in a timely manner as ordered</td>
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<td>4. Patient quality of care has been consistently maintained (privacy, confidentiality and physical comfort)</td>
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<td>If No, comment:</td>
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<td>5. The patient waiting for admission had assigned nursing/support staff and regular monitoring of vital signs and condition status</td>
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<td>760</td>
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<tr>
<td>If No, comment:</td>
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</table>

6. The patient was admitted to floor or unit that matched their clinical needs/condition or admitted to the next available space if patient had no specific clinical needs.

<table>
<thead>
<tr>
<th>If No, comment:</th>
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