MAYERS MEMORIAL
HEALTHCARE DISTRICT

Quality Committee
Meeting Agenda

May 28, 2025 @ 9:30 am
Mayers Memorial Healthcare
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

Attendees

Les Cufaude, Director and Chair of Quality
James Ferguson, Director

Ryan Harris, CEO
Jack Hathaway, Director of Quality
Ashley Nelson, Board Clerk

1	**CALL MEETING TO ORDER**	Chair Les Cufaude		
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
3	**APPROVAL OF MINUTES**			
	3.1 Regular Meeting – April 23, 2025		Attachment A	**Action Item**
4	**DIRECTOR OF QUALITY REPORT**	Jack Hathaway	Attachment B	Report
5	**ACHC PLAN OF CORRECTIONS**		Attachment C	**Action Item**
5	**OTHER INFORMATION/ANNOUNCEMENTS**			Information
6	**ADJOURNMENT:** Next Regular Meeting – June 25, 2025			

Agenda Posted: 05.23.25

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Quality Committee
Minutes
April 23, 2025 @ 9:30 am
Mayers Memorial Healthcare
Burney Annex Boardroom
20647 Commerce Way
Burney, CA 96013

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1	**CALL MEETING TO ORDER:** Les Cufaude called the meeting to order at 9:42 am on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Les Cufaude, Director Jim Ferguson, Director		Ryan Harris, CEO Ashley Nelson, Board Clerk Jack Hathaway, Director of Quality	
	Excused ABSENT:			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF THE MINUTES:**			
	3.1	Regular Meeting – March 26, 2025 A motion was moved, seconded and the minutes were approved.	***Ferguson, Hathaway***	**Approved by All**
4	**DIRECTOR OF QUALITY:** Jack submitted his report. Jack explained the service lines represented in the graphs he provided. He also explained Patient Experience regarding our physicians and service. He also discussed the ED dashboard and Med Error section with the committee.			
5	**OTHER INFORMATION/ANNOUNCEMENTS:** None.			
10	**ADJOURNMENT:** at 10:38 am Next Meeting is May 28, 2025 in Burney			

Board Quality Report May 2025

Mortality In the hospital

For encounters January 1, 2024, to March 31, 2025

- Denno: 803 Encounters; 9 deaths = 1.12%
- Dykes: 1083 Encounters; 2 deaths = 0.19%
- Leach: 1278 Encounters; 5 deaths = 0.4%
- Magno: 2368 Encounters; 4 deaths = 0.17%
- Riedeman: 62 Encounters; 1 death = 1.61%
- Watson: 1258 Encounters; 1 death = .08%
- Winter: 1967 Encounters; 6 deaths = .31%

For encounters in April 2025

- Magno: 150 encounters; 1 death = 0.667%
- Winter: 120 Encounters; 1 death = 0.833%

Patient Experience

Most current data attached –

PI Review

We will review the most current PI data in Teams.

Risk (RL6) Review

See the following pages for graphs – I moved them for a better data view.

State

All outstanding Plans of Correction (POCs) have been accepted and the work is underway.

Complaints

We have received 3 complaints since we last met – one financial complaint that was resolved by applying additional insurance – one that had to do with timeliness of care

(or the perception of timeliness) that led to an AMA – one that had to do with overall care and treatment of the unhoused and addicted with a local provider noting that a number of their patients (who are unhoused and addicted) now avoid our ED due to poor treatment by the providers and staff.

DHCS QIP Program

We are currently tracking the following measures that have a possibility for success in PY7:

Here are the numbers:

Measure	PY6 - 2023	PY7 - 2024	PY7 PBM*	Targets^	Performance	AV
Q-WCV	11/41 or 26.82%	20/40 or 50%	42.99%	30.41%	+17.09% over Target	
Q-CMS 147	32/124 or 25.80%	165/337 or 48.90%	25.51%	30.78%	+18.32% over Target	

*PBM = Performance Benchmark—Each measure has a minimum performance benchmark that must be met in order to be used for reporting. We must show that we have met the PY7 PBM and had an increase of 10% over PY6 to get an achievement value (AV) of 1 and full payment.

^Targets = target values are calculated one of 2 ways. 1. Using a formula found in the PY7 manual or 2. Based on a formula that is built into the reporting portal for DHCS. Our WCV target was found using the formula in the manual because we have not done that measure before. Our CMS 147 target was calculated in the portal based off of our PY6 performance.

Update:

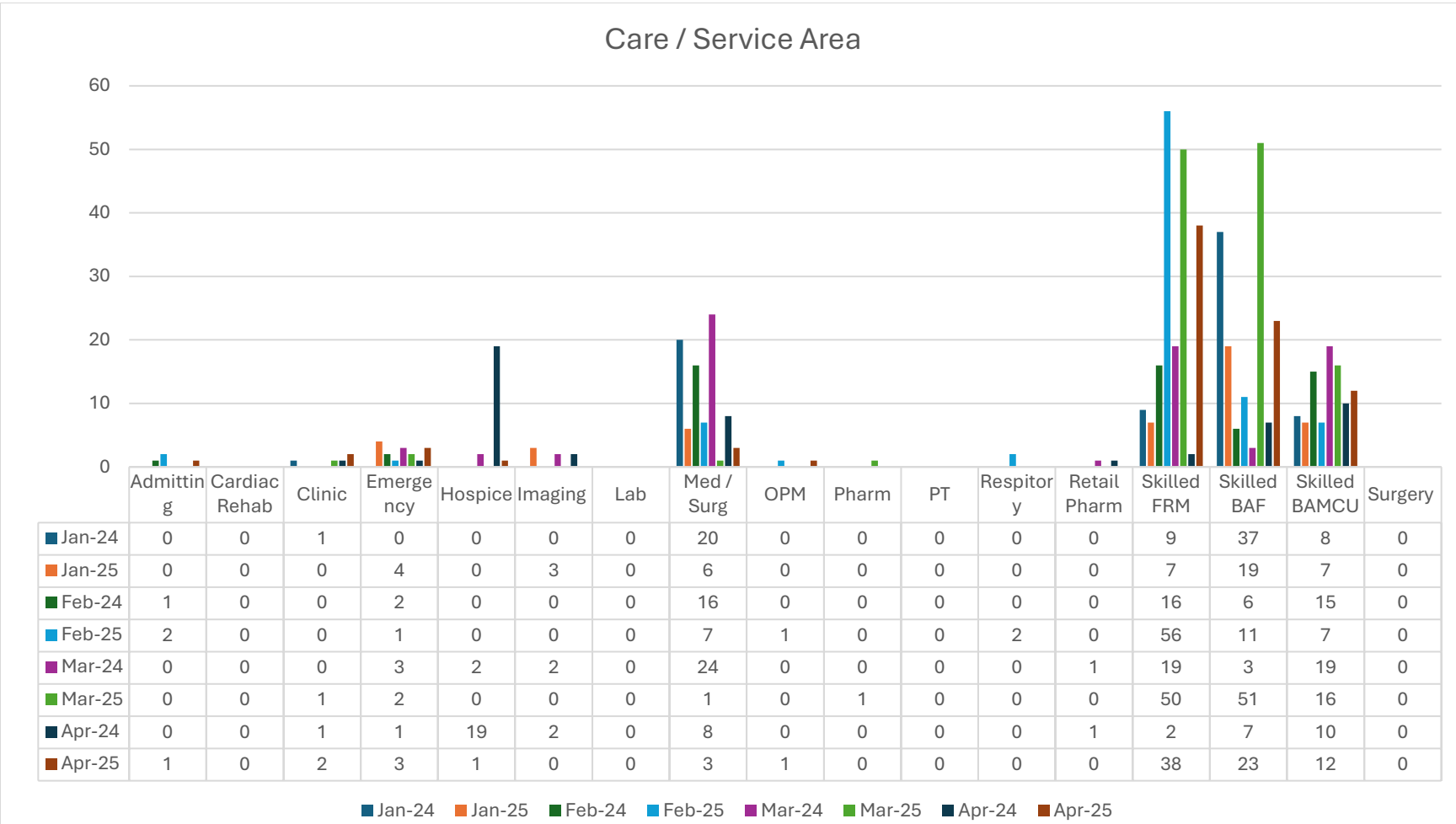
As I was running numbers and verifying the data around continuous enrollment for the WCV measure, I came to an impasse in my knowledge, as this is the first time we have attempted to report a measure with a continuous enrollment requirement. Luckily, we have our i2i Tacks and PRiZM up and running – we are currently uploading all of the 2024 membership data that we have received from Partnership Health Plan, and next week, we will be able to review the data with the audit team at i2i to be sure that our data is ready for submission.

The WCV measure looks different in i2i tracks right now because the 2024 data has not been uploaded and has not had the rules applied to it. I have a meeting to review the uploaded data on the 28th at 08:30, so I should be able to give you a good update then.

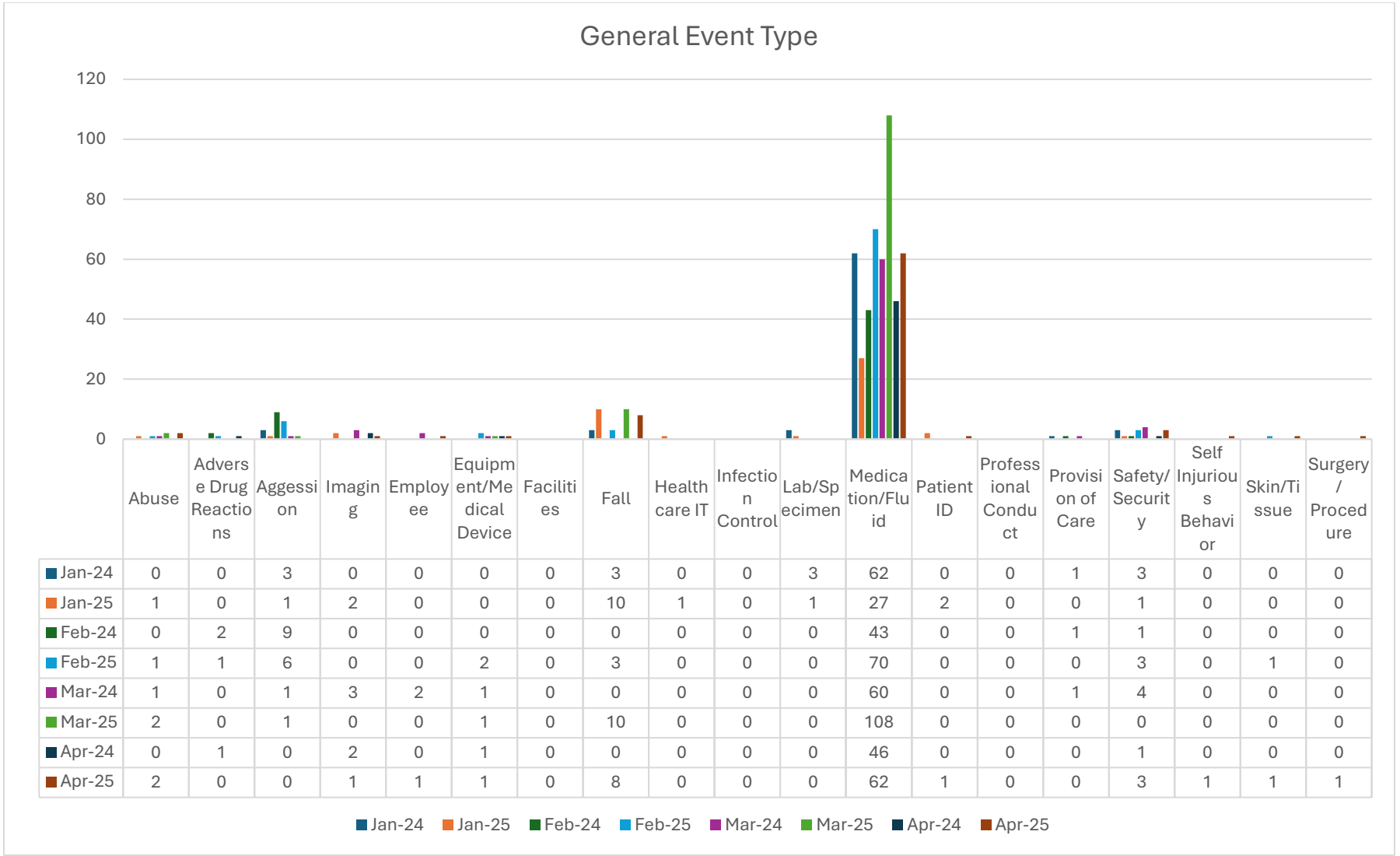
Conclusion

I look forward to seeing how the reporting for QIP plays out, and I will let you all know what I learn as I enter those numbers into the system.

Respectfully submitted, Jack Hathaway – DOQ

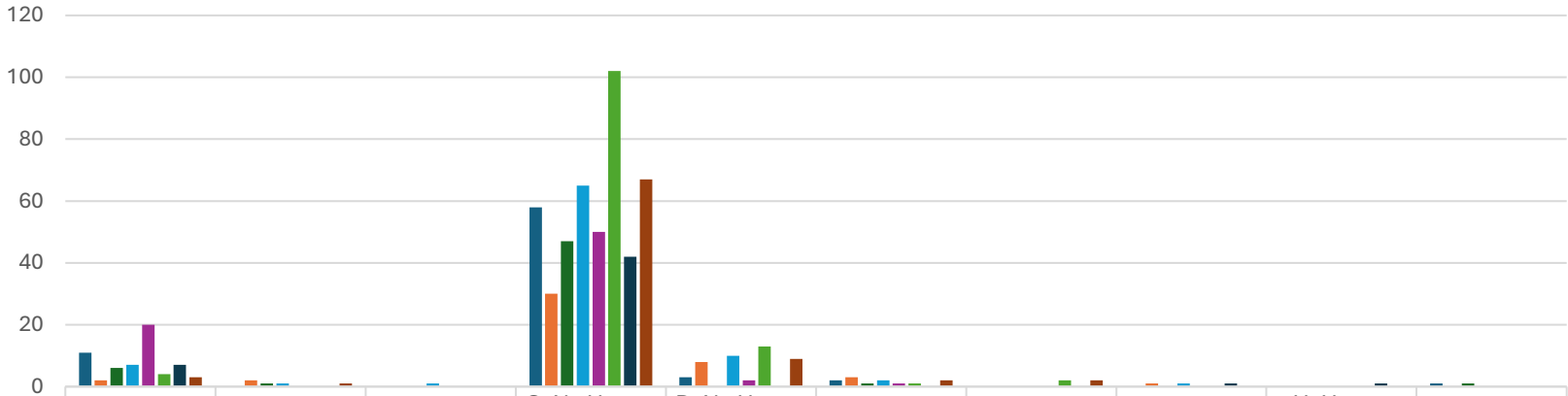


	Admitting	Cardiac Rehab	Clinic	Emergency	Hospice	Imaging	Lab	Med / Surg	OPM	Pharm	PT	Respitory	Retail Pharm	Skilled FRM	Skilled BAF	Skilled BAMCU	Surgery
Jan-24	0	0	1	0	0	0	0	20	0	0	0	0	0	9	37	8	0
Jan-25	0	0	0	4	0	3	0	6	0	0	0	0	0	7	19	7	0
Feb-24	1	0	0	2	0	0	0	16	0	0	0	0	0	16	6	15	0
Feb-25	2	0	0	1	0	0	0	7	1	0	0	2	0	56	11	7	0
Mar-24	0	0	0	3	2	2	0	24	0	0	0	0	1	19	3	19	0
Mar-25	0	0	1	2	0	0	0	1	0	1	0	0	0	50	51	16	0
Apr-24	0	0	1	1	19	2	0	8	0	0	0	0	1	2	7	10	0
Apr-25	1	0	2	3	1	0	0	3	1	0	0	0	0	38	23	12	0



	Abuse	Adverse Drug Reactions	Aggession	Imaging	Employee	Equipment/Medical Device	Facilities	Fall	Healthcare IT	Infection Control	Lab/Specimen	Medication/Fluid	Patient ID	Professional Conduct	Provision of Care	Safety/Security	Self Injurious Behavior	Skin/Tissue	Surgery/Procedure
Jan-24	0	0	3	0	0	0	0	3	0	0	3	62	0	0	1	3	0	0	0
Jan-25	1	0	1	2	0	0	0	10	1	0	1	27	2	0	0	1	0	0	0
Feb-24	0	2	9	0	0	0	0	0	0	0	0	43	0	0	1	1	0	0	0
Feb-25	1	1	6	0	0	2	0	3	0	0	0	70	0	0	0	3	0	1	0
Mar-24	1	0	1	3	2	1	0	0	0	0	0	60	0	0	1	4	0	0	0
Mar-25	2	0	1	0	0	1	0	10	0	0	0	108	0	0	0	0	0	0	0
Apr-24	0	1	0	2	0	1	0	0	0	0	0	46	0	0	0	1	0	0	0
Apr-25	2	0	0	1	1	1	0	8	0	0	0	62	1	0	0	3	1	1	1

Severity Level Reported



	A: Unsafe Condition (No Event)	B: Near Miss caught by chance	B2: Near Miss caught by staff	C. No Harm - Reached Patient No Monitoring Required	D. No Harm - Reached Patient Monitoring Required	E. Harm - Temporary, Intervention Needed	F. Harm - Temporary, Hospitalization Needed	G. Harm - Permanent	H. Harm - Permanent, Intervention Required to Sustain Life	I. Death
Jan-24	11	0	0	58	3	2	0	0	0	1
Jan-25	2	2	0	30	8	3	0	1	0	0
Feb-24	6	1	0	47	0	1	0	0	0	1
Feb-25	7	1	1	65	10	2	0	1	0	0
Mar-24	20	0	0	50	2	1	0	0	0	0
Mar-25	4	0	0	102	13	1	2	0	0	0
Apr-24	7	0	0	42	0	0	0	1	1	0
Apr-25	3	1	0	67	9	2	2	0	0	0

Dashboard Name: Survey Detail View | System Name: Mayers Memorial Hospital - System| System ID: 33270| Facility Name: Mayers Memorial Hospital| Facility ID: 33270| Service Line: Inpatient| Metric: Top Box Score| Date Type: Received Date| Time Frame: Last Quarter| Peer Group: All PG Database | eSurvey Adjustment: Applied| CMS Reportable Responses: Not Applied| Skip Logic: Not Applied| Current Benchmarking Period: 01/01/2025 - 03/31/2025 | Fiscal Start Month: 01 | Download Date & Time: May 19, 2025 2:18 am EDT

▲ Positive ▼ Negative

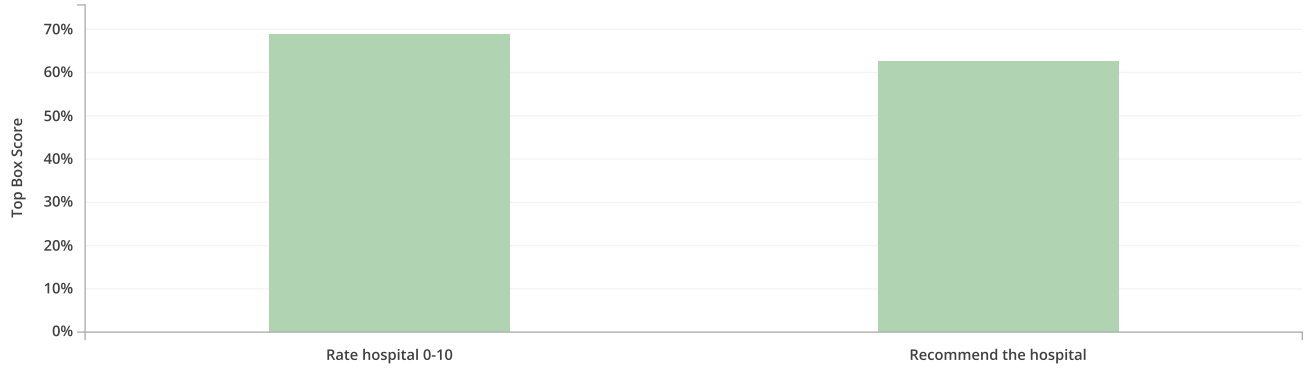
Survey Type	Sections/Domains	Items	Current n	Percentile Rank	Current Period (Q1 2025)	Previous Period (Q4 2024)	Change	
CAHPS	Global Items	Rate hospital 0-10	16	47	68.75%	71.43%	-2.68%	▼
CAHPS	Global Items	Recommend the hospital	16	24	62.50%	28.57%	33.93%	▲
CAHPS	Comm w/ Nurses	Nurses treat with courtesy/respect	16	4	75.00%	85.71%	-10.71%	▼
CAHPS	Comm w/ Nurses	Nurses listen carefully to you	16	38	75.00%	42.86%	32.14%	▲
CAHPS	Comm w/ Nurses	Nurses expl in way you understand	16	13	68.75%	85.71%	-16.96%	▼
CAHPS	Response of Hosp Staff	Help toileting soon as you wanted	7	24	57.14%	100.00%	-42.86%	▼
CAHPS	Response of Hosp Staff	Received help as soon as needed	7	43	57.14%	N/A	--	—
CAHPS	Comm w/ Doctors	Doctors treat with courtesy/respect	16	23	81.25%	85.71%	-4.46%	▼
CAHPS	Comm w/ Doctors	Doctors listen carefully to you	16	31	75.00%	57.14%	17.86%	▲
CAHPS	Comm w/ Doctors	Doctors expl in way you understand	16	47	75.00%	66.67%	8.33%	▲
CAHPS	Hospital Environment	Cleanliness of hospital environment	14	4	57.14%	71.43%	-14.29%	▼
CAHPS	Comm About Medicines	Tell you what new medicine was for	12	52	75.00%	100.00%	-25.00%	▼
CAHPS	Comm About Medicines	Staff describe medicine side effect	10	93	60.00%	100.00%	-40.00%	▼
CAHPS	Discharge Information	Staff talk about help when you left	16	27	81.25%	71.43%	9.82%	▲
CAHPS	Discharge Information	Info re symptoms/prob to look for	15	36	86.67%	71.43%	15.24%	▲
CAHPS	Restful Hosp Environment	Quietness of hospital environment	16	24	50.00%	57.14%	-7.14%	▼
CAHPS	Restful Hosp Environment	Able to rest as needed	10	86	50.00%	N/A	--	—
CAHPS	Restful Hosp Environment	Staff help you rest and recover	10	5	60.00%	N/A	--	—
CAHPS	Care Coordination	Staff informed about your care	10	1	50.00%	N/A	--	—
CAHPS	Care Coordination	Staff worked together for you	10	19	70.00%	N/A	--	—
CAHPS	Care Coordination	Staff helped with care plan	10	37	70.00%	N/A	--	—
CAHPS	Info About Symptoms	Staff gave info on symptoms	9	25	66.67%	N/A	--	—
CAHPS	Additional Ratings	Call button help soon as wanted it	5	56	60.00%	40.00%	20.00%	▲
CAHPS	Additional Ratings	Hosp staff took pref into account	6	9	33.33%	20.00%	13.33%	▲
CAHPS	Additional Ratings	Good understanding managing health	6	2	33.33%	20.00%	13.33%	▲
CAHPS	Additional Ratings	Understood purpose of taking meds	6	19	50.00%	42.86%	7.14%	▲
PG	Room	Courtesy of person cleaning room†	6	34	66.67%	40.00%	26.67%	▲
PG	Room	Room temperature†	6	6	33.33%	33.33%	0.00%	—
PG	Meals	Temperature of the food†	6	76	50.00%	28.57%	21.43%	▲
PG	Meals	Quality of the food†	6	43	33.33%	50.00%	-16.67%	▼
PG	Nurses	Nurses' attitude toward requests†	6	2	50.00%	50.00%	0.00%	—
PG	Nurses	Attention to needs	15	47	66.67%	66.67%	0.00%	—
PG	Nurses	Nurses kept you informed	16	70	68.75%	33.33%	35.42%	▲

PG	Nurses	Nurses expl daily plan of care	10	39	60.00%	N/A	--	▬
PG	Nurses	Nurses took time to answer quests	10	10	60.00%	N/A	--	▬
PG	Doctors	Time doctors spent with you†	6	62	50.00%	33.33%	16.67%	▲
PG	Doctors	Doctors' concern questions/worries	15	97	80.00%	50.00%	30.00%	▲
PG	Doctors	Doctors kept you informed†	5	99	80.00%	50.00%	30.00%	▲
PG	Doctors	Doctors took time to answer quests	10	12	60.00%	N/A	--	▬
PG	Doctors	Doctors' effort decision making	10	91	80.00%	N/A	--	▬
PG	Personal Issues	Staff concern for privacy†	6	8	50.00%	42.86%	7.14%	▲
PG	Personal Issues	Staff addressed emotional needs†	6	17	50.00%	50.00%	0.00%	▬
PG	Personal Issues	Response to concerns/complaints†	6	15	50.00%	50.00%	0.00%	▬
PG	Personal Issues	Staff include decisions re:trtmnt†	6	79	66.67%	16.67%	50.00%	▲
PG	Overall Assessment	Staff worked together care for you†	6	37	66.67%	60.00%	6.67%	▲
PG	Overall Assessment	Likelihood of recommending†	5	89	80.00%	20.00%	60.00%	▲
PG	Overall Assessment	Overall rating of care†	6	40	66.67%	50.00%	16.67%	▲

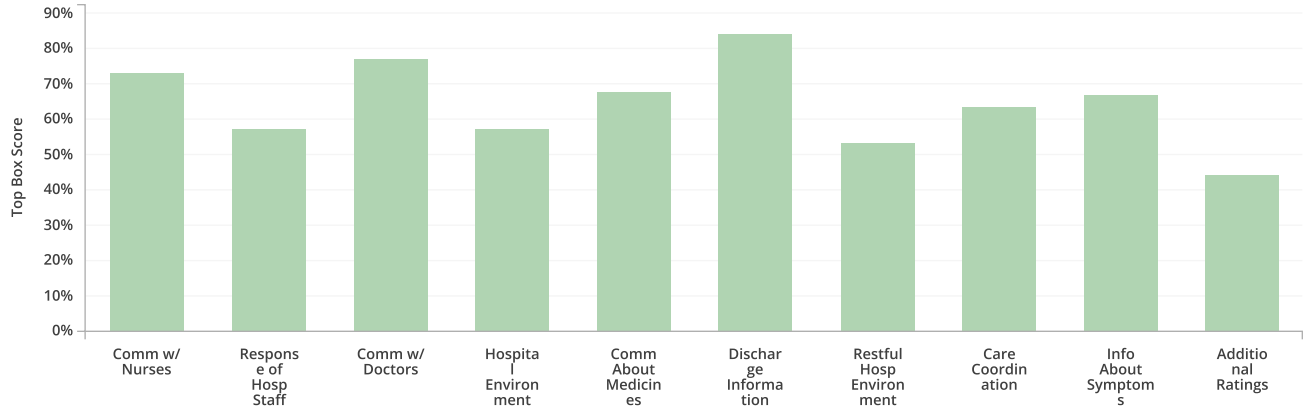
† Custom Question ^ Focus Question

Dashboard Name: CAHPS Summary| System Name: Mayers Memorial Hospital - System| System ID: 33270| Facility Name: Mayers Memorial Hospital| Facility ID: 33270| Service Line: Inpatient| Metric: Top Box Score| Date Type: Received Date| Time Frame: Last Quarter| Peer Group: All PG Database | Priority Index - Survey Type: CAHPS| Priority Index View: External| eSurvey Adjustment: Applied| CMS Reportable Responses: Not Applied| Skip Logic: Not Applied| Current Benchmarking Period: 01/01/2025 - 03/31/2025 | Fiscal Start Month: 01 | Download Date & Time: May 19, 2025 2:35 am EDT

HCAHPS Global Comparison



Domain Comparison



Domains and Questions

Peer Group: All PG Database
CAHPS Section/Domain Level N=2476

Domains	Questions	Current n	Previous Period (Q4 2024)	Current Period (Q1 2025)	Change	Percentile Rank
Global Items	Rate hospital 0-10	16	71.43%	68.75%	-2.68%	47
	Recommend the hospital	16	28.57%	62.50%	33.93%	24
Comm w/ Nurses		16	71.43%	72.92%	1.49%	12
	Nurses treat with courtesy/respect	16	85.71%	75.00%	-10.71%	4
	Nurses listen carefully to you	16	42.86%	75.00%	32.14%	38
	Nurses expl in way you understand	16	85.71%	68.75%	-16.96%	13
Response of Hosp Staff		11	100.00%	57.14%	-42.86%	31
	Help toileting soon as you wanted	7	100.00%	57.14%	-42.86%	24
	Received help as soon as needed	7	N/A	57.14%	--	43
Comm w/ Doctors		16	69.84%	77.08%	7.24%	33
	Doctors treat with courtesy/respect	16	85.71%	81.25%	-4.46%	23
	Doctors listen carefully to you	16	57.14%	75.00%	17.86%	31
	Doctors expl in way you understand	16	66.67%	75.00%	8.33%	47
Hospital Environment		14	71.43%	57.14%	-14.29%	4
	Cleanliness of hospital environment	14	71.43%	57.14%	-14.29%	4
Comm About Medicines		12	100.00%	67.50%	-32.50%	84
	Tell you what new medicine was for	12	100.00%	75.00%	-25.00%	52
	Staff describe medicine side effect	10	100.00%	60.00%	-40.00%	93
Discharge Information		16	71.43%	83.96%	12.53%	29
	Staff talk about help when you left	16	71.43%	81.25%	9.82%	27
	Info re symptoms/prob to look for	15	71.43%	86.67%	15.24%	36
Restful Hosp Environment		16	57.14%	53.33%	-3.81%	31
	Quietness of hospital environment	16	57.14%	50.00%	-7.14%	24
	Able to rest as needed	10	N/A	50.00%	--	86
	Staff help you rest and recover	10	N/A	60.00%	--	5
Care Coordination		10	N/A	63.33%	--	9
	Staff informed about your care	10	N/A	50.00%	--	1
	Staff worked together for you	10	N/A	70.00%	--	19
	Staff helped with care plan	10	N/A	70.00%	--	37
Info About Symptoms		9	N/A	66.67%	--	25
	Staff gave info on symptoms	9	N/A	66.67%	--	25
Additional Ratings		6	30.71%	44.17%	13.45%	12
	Call button help soon as wanted it	5	40.00%	60.00%	20.00%	56
	Hosp staff took pref into account	6	20.00%	33.33%	13.33%	9
	Good understanding managing health	6	20.00%	33.33%	13.33%	2
	Understood purpose of taking meds	6	42.86%	50.00%	7.14%	19

Priority Index

PG Report Period: 6 months | CAHPS Report Period: 12 months
Benchmark: All Respondents | Benchmarking Period: 02/01/2025 - 04/30/2025

Current Order	Survey Type	Question	Percentile Rank	Correlation
1	CAHPS	Quietness of hospital environment	16	0.53
2	CAHPS	Nurses listen carefully to you	13	0.45
3	CAHPS	Nurses expl in way you understand	14	0.34
4	CAHPS	Recommend the hospital	49	0.55
5	CAHPS	Cleanliness of hospital environment	54	0.56
6	CAHPS	Hosp staff took pref into account	16	0.28
7	CAHPS	Call button help soon as wanted it	70	0.46
8	CAHPS	Nurses treat with courtesy/respect	52	0.45
9	CAHPS	Doctors listen carefully to you	36	0.23
10	CAHPS	Doctors treat with courtesy/respect	41	0.27

† Custom Question ^ Focus Question

Reports from Press Ganey are for internal improvement purposes. Only CMS can provide your facility with your official CAHPS survey results.

Dashboard Name: Patient Needs| System Name: Mayers Memorial Hospital - System| System ID: 33270| Facility Name: Mayers Memorial Hospital| Facility ID: 33270| Service Line: Inpatient| Survey Type: Integrated| Metric: Top Box Score| Date Type: Received Date| Time Frame: Rolling 12 Months| Peer Group: All PG Database| eSurvey Adjustment: Applied| CMS Reportable Responses: Not Applied| Skip Logic: Not Applied| Current Benchmarking Period: 02/01/2025 - 04/30/2025| Fiscal Start Month: 01| Download Date & Time: May 19, 2025 2:58 am EDT

COMPASSIONATE CONNECTED CARE: All

PERCENTILE THRESHOLD: 50

Above Threshold | Below Threshold

Compassionate Connected Care	Patient Need	Survey Type	Survey Items	n	Top Box Score	Percentile Rank
Culture	Teamwork	PG	Staff worked together care for you†	34	70.59%	46
Clinical	Discharge Prep	CAHPS	Staff talk about help when you left	48	87.50%	72
		CAHPS	Info re symptoms/prob to look for	47	87.23%	41
		CAHPS	Good understanding managing health	35	42.86%	21
		CAHPS	Understood purpose of taking meds	35	57.14%	44
Caring Behaviors	Personalize	CAHPS	Nurses listen carefully to you	50	70.00%	13
		PG	Nurses' attitude toward requests†	35	68.57%	34
		PG	Attention to needs	47	70.21%	58
		CAHPS	Doctors listen carefully to you	50	76.00%	39
		PG	Time doctors spent with you†	35	54.29%	69
	Courtesy	CAHPS	Nurses treat with courtesy/respect	50	86.00%	55
		CAHPS	Doctors treat with courtesy/respect	50	84.00%	45
		PG	Courtesy of person cleaning room†	34	58.82%	8
	Inform	PG	Nurses kept you informed	48	66.67%	60
		CAHPS	Nurses expl in way you understand	49	69.39%	15
		PG	Doctors kept you informed†	34	61.76%	66
		CAHPS	Doctors expl in way you understand	49	73.47%	40
		CAHPS	Tell you what new medicine was for	36	75.00%	56
		CAHPS	Staff describe medicine side effect	33	60.61%	93
	Privacy	PG	Staff concern for privacy†	36	58.33%	20
	Choice	PG	Staff include decisions re:trtmnt†	35	57.14%	28
		CAHPS	Hosp staff took pref into account	35	37.14%	16
	Empathy	PG	Doctors' concern questions/worries	48	66.67%	53
		PG	Staff addressed emotional needs†	35	54.29%	25
	Service Recovery	PG	Response to concerns/complaints†	35	57.14%	24
	Responsiveness	CAHPS	Call button help soon as wanted it	34	58.82%	70
		CAHPS	Help toileting soon as you	n<30	N/A	N/A

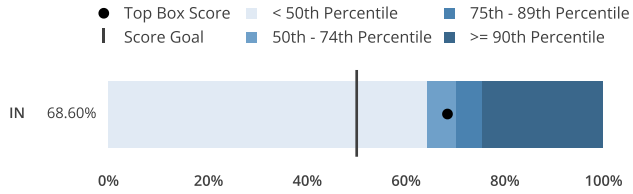
			wanted				
Operational	Environment	CAHPS	Cleanliness of hospital environment	48	72.92%	53	
		CAHPS	Quietness of hospital environment	48	45.83%	14	
		PG	Room temperature†	36	38.89%	18	
	Amenities	PG	Temperature of the food†	37	37.84%	35	
		PG	Quality of the food†	32	34.38%	46	
Global	Global	PG	Overall rating of care†	36	75.00%	67	
		CAHPS	Rate hospital 0-10	50	76.00%	75	
		PG	Likelihood of recommending†	34	64.71%	35	
		CAHPS	Recommend the hospital	50	70.00%	49	

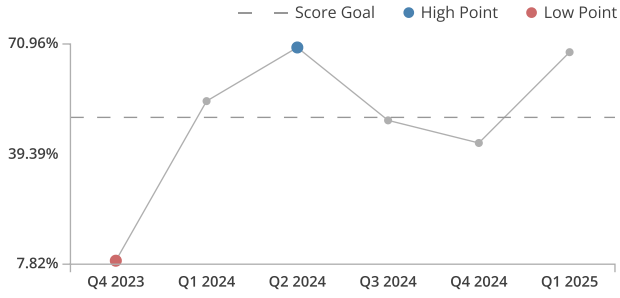
† Custom Question ^ Focus Question

Dashboard Name: Facility Scorecard | System Name: Mayers Memorial Hospital - System | System ID: 33270 | Facility Name: Mayers Memorial Hospital | Facility ID: 33270 | Service Line: Inpatient | Measure: PG Overall | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | Priority Index - Survey Type: Integrated | Priority Index View: External | eSurvey Adjustment: Applied | Current Benchmarking Period: 01/01/2025 - 03/31/2025 | Fiscal Start Month: 01 | Download Date & Time: May 19, 2025 3:31 am EDT

Service Line Performance

PG Overall





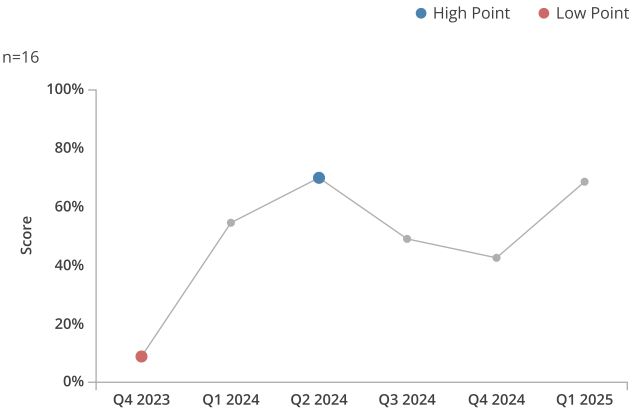
n	16
Top Box Score	68.60%
Score Goal	50.00%
Percentile Rank	68

Time Period	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025
n	2	18	15	13	7	16
Top Box Score	8.82%	54.58%	69.96%	49.06%	42.57%	68.60%
Percentile Rank	1	25	87	5	2	68

Top Box Score

68.60%

PG Overall

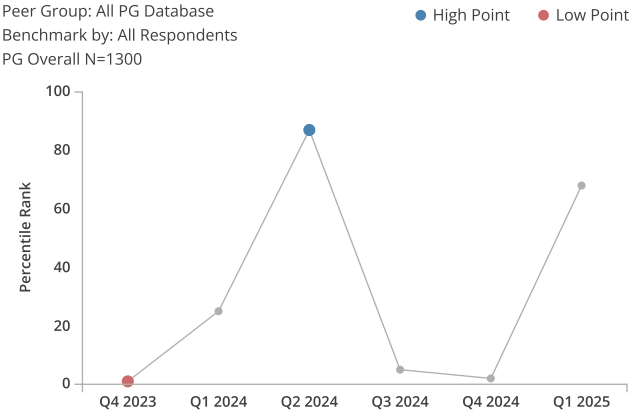


Top Box Percentile Rank

68th

PG Overall

Peer Group: All PG Database
Benchmark by: All Respondents
PG Overall N=1300



Time Period	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025
n	2	18	15	13	7	16
Top Box Score	8.82%	54.58%	69.96%	49.06%	42.57%	68.60%
Percentile Rank	1	25	87	5	2	68

Section Performance

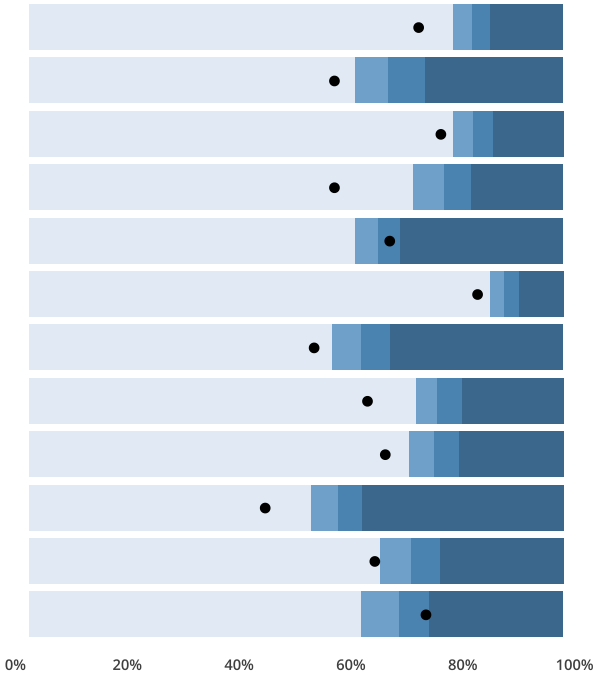
SORT BY: Default

SELECT: Standard

Peer Group: All PG Database
CAHPS Section/Domain Level N=2476 | PG Overall N=1300

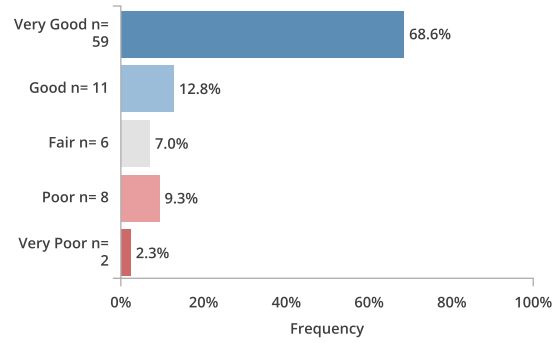
● Top Box Score < 50th Percentile 50th - 74th Percentile 75th - 89th Percentile >= 90th Percentile

Survey Type	Section	n	Top Box Score	Percentile Rank
CAHPS	Comm w/ Nurses	16	72.92%	12
CAHPS	Response of Hosp Staff	11	57.14%	31
CAHPS	Comm w/ Doctors	16	77.08%	33
CAHPS	Hospital Environment	14	57.14%	4
CAHPS	Comm About Medicines	12	67.50%	84
CAHPS	Discharge Information	16	83.96%	29
CAHPS	Restful Hosp Environment	16	53.33%	31
CAHPS	Care Coordination	10	63.33%	9
CAHPS	Info About Symptoms	9	66.67%	25
CAHPS	Additional Ratings	6	44.17%	12
PG	Nurses	16	64.71%	44
PG	Doctors	16	74.29%	88



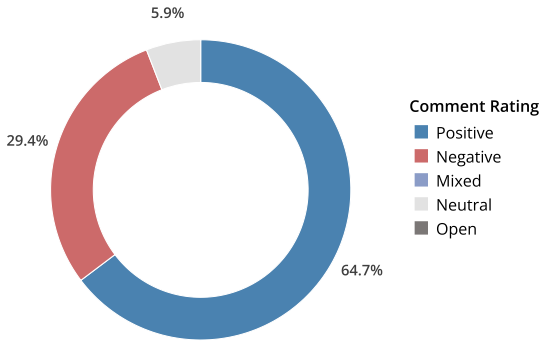
Distribution of Responses

PG Overall



Comment Distribution

Data from Press Ganey surveys. CAHPS surveys do not collect comments.



N/A
PG Overall

Above Goal Below Goal

No Data Available

N/A
PG Overall

Above Goal Below Goal

No Data Available

Priority Index

PG Report Period: 6 months | CAHPS Report Period: 12 months
Benchmark by: All Respondents | Benchmarking Period: 02/01/2025 - 04/30/2025

Current Order	Survey Type	Question	Percentile Rank	Correlation
1	PG	Room temperature†	18	0.59
2	CAHPS	Quietness of hospital environment	16	0.53
3	CAHPS	Nurses listen carefully to you	13	0.45
4	PG	Nurses' attitude toward requests†	36	0.55
5	PG	Staff addressed emotional needs†	48	0.57
6	PG	Staff concern for privacy†	23	0.44
7	CAHPS	Nurses expl in way you understand	14	0.34
8	PG	Likelihood of recommending†	49	0.56
9	CAHPS	Recommend the hospital	49	0.55
10	PG	Attention to needs	64	0.61

† Custom Question ^ Focus Question

Dashboard Name: Key Performance Indicators| System Name: Mayers Memorial Hospital - System | System ID: 33270 | Facility Name: Mayers Memorial Hospital | Facility ID: 33270 | Service Line: Inpatient | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Quarter | Peer Group: All PG Database | eSurvey Adjustment: Applied| CMS Reportable Responses: Not Applied| Skip Logic: Not Applied| Current Benchmarking Period: 01/01/2025 - 03/31/2025 | Fiscal Start Month: 01 | Download Date & Time: May 19, 2025 3:45 am EDT

Percentile Rank 1 - 49 Percentile Rank 50 - 74 Percentile Rank 75 - 89 Percentile Rank 90 - 99

Peer Group: All PG Database | PG Overall N=1300 | CAHPS Item Level N=2471 | Received Date | 01 Jan 2025 - 31 Mar 2025

CAHPS LTR	CAHPS Rate 0-10	PG Overall	PGLTR†
Top Box Score	Top Box Score	Top Box Score	Top Box Score
62.50%	68.75%	68.60%	80.00%
Percentile Rank	Percentile Rank	Percentile Rank	Percentile Rank
24th	47th	68th	89th

	Top Box Score	Percentile Rank
Comm w/ Doctors **CAHPS: During this hospital stay, how often did doctors explain things in a way you could understand?**	75.00%	47th
Comm w/ Nurses **CAHPS: During this hospital stay, how often did nurses listen carefully to you?**	75.00%	38th
Doctors **PG: How well doctors kept you informed†**	80.00%	99th
Nurses **PG: Nurses' attitude toward your requests†**	50.00%	2nd

† Custom Question ^ Focus Question

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

Attachment C

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.00.03 Equipment Availability *The items available must include the following:* • *Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.* §485.618(b)(2) Tag C-**0888**	This standard is not met as evidenced by: Based on a review of the crash cart policies and interview, the facility has not designated anyone responsible for cleaning the crash carts. This finding was verified by the Emergency Room Staff.
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. All staff involved in the process (EVS staff and ED staff) will be educated on the change in process around cleaning the crash carts.	EVS / ED manager /DON Acute	03/31/25	In Progress
2. Cleaning Logs and policies will be updated to include the changes made in process.	DON Acute	03/31/25	In Progress
3. The crash cart was cleaned by EVS staff shortly after the deficiency was noted in survey.	EVS Staff	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All policy and log changes and action items have been approved by the CNO and put into process for approval through the policy committee process.	CNO	02/28/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education was delivered in person to the EVS staff on the change in process and the additions to the logs.	EVS Manager	02/28/25	Completed
2. Education for nursing staff is currently underway and all staff involved in emergency response will be educated on their responsibilities for cleaning the crash cart after use in critical events.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This process will be monitored by our internal quality committee and progress will be reported to the Board Quality Committee to ensure oversight and visibility for the governing Board of Directors.	DON Acute	04/01/25 12/31/25	Monthly
2. This monitoring will consist of auditing the cleaning logs to confirm that crash carts are cleaned regularly per policy and on schedule.	EVS Manager	04/01/25 12/31/25	Monthly
3. The monitoring process will also include infection prevention conducting "magic pen" audits with a black light marker to ensure that the carts are cleaned thoroughly.	Infection Prevention	04/01/25 12/31/25	Quarterly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.00 Additional Required Policies The Emergency Services must have policies addressing: 1. The mechanism for initial evaluation and triage of patients. (See 489.20 and 489.24 for EMTALA Standards.) 2. Mechanisms for providing sufficient diagnostic and stabilization services for persons whose care will be managed by transfer to another acute care facility. 3. The determination of the level of service to be provided is under the direction of a physician member of the medical staff. 4. The assessment of each patient by a registered nurse. 5. The provision of services appropriate to the assessed needs of the patient, which results in a disposition plan. 6. The mechanisms for evaluating the quality and appropriateness of emergency services provided. 7. 7Provision of care for disasters. 8. The mechanism for management of medical emergencies in non-Emergency Department (ED) settings on the hospital main	This standard is not met as evidenced by: Based on interviews and a review of policies in the Emergency Room, the Emergency Services policies are silent on the initial evaluation and triage of patients in the non-ED main campus location of the parking lot. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

campus, unless present in a non-Emergency Services hospital policy.	
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Part A. What actions will you take (Add rows if needed.)

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
1. The Code Blue policy has been updated to include specific procedures for responding to medical emergencies in the parking lot.	DON Acute	02/28/25	Completed
2. A notification process has been implemented to ensure rapid response, requiring staff to page "Code Blue - Parking Lot" and notify the Nursing Supervisor in the event of an emergency.	DON Acute	03/31/25	In Progress
3. A Relias read and sign education module has been assigned to all relevant staff to acknowledge and understand the policy change and additional notification.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The updated Code Blue policy was reviewed and approved by the DON Acute and is currently in the policy approval process.	DON Acute	03/26/25	In Progress
2. All action plans and education have been approved by the CNO.	CNO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff responsible for emergency responses have been trained on their specific roles and responsibilities, including CPR initiation, emergency notification, and patient transport.	DON Acute	03/31/25	In Progress
2. A Relias read and sign module has been assigned requiring staff to read and acknowledge the policy and process updates.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Education will be tracked and reported from our Relias learning platform to ensure that all staff have been made aware of and acknowledged the policy and process changes.	DON Acute	04/01/25 12/31/25	Quarterly
2. This process will be monitored by the internal quality committee in the code blue review.	Director of Quality	04/01/25 12/31/25	Monthly

PLAN OF CORRECTION

3. This process will be monitored in the mortality rate review to Board Quality committee to ensure oversight and visibility to our governing Board of Directors.	Director of Quality	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.03 Emergency Room Log Permanent logs shall be maintained of persons seeking emergency care. These may be manual or electronic with periodic back up. The register provides data regarding: 1. Date, time and mode of arrival. 2. Age, sex, and name of patient. 3. Nature of complaint. 4. Name of physician responsible for care. 5. Brief description of services provided. 6. Disposition (treated/released, admitted to facility, transferred to another acute facility, or death in ER). 7. Condition on discharge. 8. Time of discharge.	This standard is not met as evidenced by: Based on interview and review of the Emergency Room Log, the description of services provided and condition on discharge was missing. This finding was verified by the Emergency Room Registered Nurse.
Date of POC (date written, date revised)	02/13/25, revised 03/07/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Initial efforts made to add the missing fields to our Cerner ED log by the ED manager and the Director of Quality we unsuccessful.	Director of Quality	02/28/25	In Progress
2. An SR ticket is in the process of being created to elevate the issue to our Cerner support team to assist in the addition.	Director of Quality (DOQ)	03/07/25	In Progress
3. As a short term fix - the missing elements of the ED log have been found in other reports by the ED manager and the information is available upon request when or if the need arises.	ED Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. All of the corrective actions for this issue have been approved by the CNO	CNO	04/06/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. When the log fix is completed with the SR ticket staff will be alerted to the change and we will educate on how to run the fixed complete report.	ED Manager / DON Acute	04/06/25	In Progress
2. Staff will be educated by the ED Manager on how to find the missing elements in the other reports so the information can be available when / if necessary.	ED Manager / DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Progress on the SR ticket will be monitored by the internal quality committee weekly until completion.	DOQ	03/03/25 – 04/06/25	Weekly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

02.01.04 Change in Treatment Plan Log A separate log is maintained as part of the quality management program for the emergency service. The log provides information about patients whose initial treatment plan later resulted in the need for modification based upon significant variation in the final interpretation of radiographic, cardiographic, or laboratory findings.	This standard is not met as evidenced by: Based on the interview and a review of the "Change in Treatment Log," the required radiographic and cardiographic elements were missing. This finding was verified by the Emergency Room Staff.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A SR ticket was created with Cerner to help us get this change in treatment log working for Radiology.	ER Manager	02/28/25	Completed

PLAN OF CORRECTION

2. All of the cardiology reports that are done in our ED (EKGs) are read by the providers who are in the ED. The EKG reads completed by the ED providers in the ED are final reads. There are no other reads completed on the EKGs that could cause a discrepancy that would require a change in treatment for those patients.	ED Manager	02/28/25	Completed
3. To address the issue with radiology in the short term, a log will be created to capture all of the radiology reports that come in as final.	ED Manager	03/31/25	In Progress
4. The created log will be used to alert providers when the treatment that they documented for their ED patient is inconsistent with the final radiology reports that come back from our radiology group as final reads.	ED Manager	03/31/25	In Progress
5. ED staff will be responsible for comparing the treatment plans documented by the ED providers and the final reads that come back from our radiology group and documenting changes in the log created.	ED Manager	03/31/25	In Progress
6. This process will be in place until we can get a long term fix from Cerner to show that the change in treatment log will capture that necessary radiology studies.	ED Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the CNO	CNO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the log will be done face to face by the ED manager to ED staff who will be managing the new process.	ED Manager	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.			
Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The ED change in treatment log will be monitored monthly, and audited by the number of final reads received from our radiology group.	ED Manager	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.01.10 Eyewash Stations and Emergency Showers Where the eyes or body of any person may be exposed to injurious corrosive materials, ASNI Z358.1-2014 approved eyewash stations and/or emergency showers shall be provided within the work area for immediate emergency use. §485.623(b)(1) C-0914	This standard is not met as evidenced by: 1. Based on the building tour, the eyewash stations in the following areas were not ANSI compliant. Neither of them was configured with mixing valves: a. Kitchen eyewash station b. Outpatient Medical Unit eyewash station 2. Based on document review, the annual inspection of eyewash stations and emergency showers was not available. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. The kitchen weekly and annual eyewash inspections were located and will continue to be the basis of our safety and compliance reviews moving forward.	Facilities Manager	02/28/25	Completed
2. The OPM eyewash station was removed after a risk assessment was performed and approved by our safety officer.	Facilities Manager	02/28/25	Completed
3. Weekly and annual inspections of the eyewash station in the kitchen will be conducted.	Facilities Manager	03/31/25	In Progress
4. The mixing valve was configured for the eyewash station in the kitchen and is in working order - pending completion of the drain.	Facilities Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective actions were approved by the Director of Operations.	Director of Operations (DOO)	02/28/25	Completed
2. The risk assessment was approved by the safety officer.	Safety Officer	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the steps and timing of the weekly and annual eyewash inspections will be conducted in person by the facilities manager.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Weekly eyewash inspection logs will be audited monthly and reported to our safety committee.	Facilities Manager	04/01/25 12/31/25	Monthly
2. The facilities manager will report on the results of the audit quarterly to the quality committee, so that all of the information can be reported up to Board Quality so the governing Board of Directors have visibility and oversight on all findings and actions taken.	Facilities Manager	04/01/25 12/31/25	Quarterly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.06.09 Plant Equipment and Systems-Maintenance There is an established, scheduled preventive maintenance program for plant equipment and systems, maintained and tested periodically in accordance with the manufacturers' recommendations. As an alternative approach, CAHs may choose to employ alternative maintenance activities and/or schedules provided they develop, implement, and maintain a documented Alternate Equipment Management (AEM) Program, to minimize risks to patients and others in the CAH associated with the use of facility equipment. *All essential mechanical and electrical equipment is maintained in safe operating condition.* §485.623(b) §485.623(b)(1) **Tag C-0914**	This standard is not met as evidenced by: Based on document review, the annual inspection of the Line Isolation Monitors was not available. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Annual inspections of the line isolation monitors will be kept and available for inspection upon request.	Facilities Manager	02/28/25	Completed
2. Annual inspections will be calendared and done in accordance with all applicable standards.	Facilities Manager	02/28/25	Completed
3. A log was created and an entry was made for the annual inspection of the line isolation monitors.	Facilities Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. All corrective actions have been approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the timing and requirements around the annual inspection of the line isolation monitors will be conducted in person to facilities personnel by the facilities manager.	Facilities Manager	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Facilities manager will report out on the line isolation monitors annual inspection as it becomes time to have that annual inspection completed.	Facilities Manager	04/01/25 04/01/26	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

03.07.03 Ventilation, Light, and Temperature Controls *There must be proper ventilation, lighting, and temperature controls in pharmaceutical, patient care, and food preparation areas.* §485.623(b)(5) **Tag C-0926**	This standard is not met as evidenced by: Based on the building tour and document review, the following issues were identified. 1. The Biohazard Storage Room at Station 3 Hall was neutral pressure to the corridor and should be negative pressure. Upon observation, there was no exhaust fan in the room. 2. The Scope Cleaning Room was neutral pressure to the OR corridor and should be negative pressure. 3. The Organization has elected to apply the Categorical Waiver for 20% relative humidity in its policy but has not performed the required risk assessment to assess the equipment and supplies used in the OR. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The biohazard room has been moved to a compliant space in a different part of the hospital. The space that was non-compliant for biohazard storage because of lacking ventilation will now be used for normal storage. All equipment (hopper and sharps containers) has been removed from the non-compliant space and relocated to the compliant space (sharps container) or removed completely from facility (hopper).	Facilities Manager	03/31/25	In Progress
2. The issue with the motor responsible for making the scope cleaning room has been repaired.	Facilities Manager	02/28/25	Completed
3. A weekly log and inspection schedule have been created to ensure that the motor responsible for making the scope cleaning room negative pressure has been created.	Facilities Manager	02/28/25	Completed
4. OR has had a risk assessment completed, as a short term fix. Noting that there is no surgery conducted in the space and weighing the risks involved with the procedures that are conducted there.	Safety Officer	02/28/25	Completed
5. The facilities manager is assessing the scope of work necessary to repair the existing disconnected and dysfunctional humidity system that would feed our surgery space.	Facilities Manager	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. These corrective actions were approved by the DOO and CEO	DOO	02/28/25	Completed

PLAN OF CORRECTION

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. All staff have been alerted to the fact that the biohazard room has been moved.	Facilities Manager	02/28/25	Completed
2. Facilities staff have been educated to the new log and schedule for inspection of the motor that maintains the negative pressure for the scope cleaning room.	Facilities Manager	02/28/25	Completed
3. Surgery staff understand the nature of the risk assessment and the work that will be necessary to update their space and the impact that this could / will have on their space.	Facilities Manager / Surgery Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Inspection logs will be reported monthly to safety.	Facilities Manager	04/01/25 / 12/31/25	Monthly
2. Facilities manager will report to quality committee quarterly with the results of the inspection log audit.	Facilities Manager	04/01/25 / 12/31/25	Quarterly
3. All of the reports from quality committee move forward to Board Quality and to the governing Board of Directors to ensure visibility and oversight.	Director of Quality	04/01/25 / 12/31/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.00 Periodic Appraisal of Members *The Medical Staff must periodically conduct appraisals of its members.* §482.22(a)(1)	This standard is not met as evidenced by: A. Based on a review of six (6) initial credential files, in one of six (1/6) files, the Medical Executive Committee and the Governing Body granted admitting privileges to a Physician's Assistant, which is outside the scope of practice. B. Based on a review of seven (7) reappointment credential files, in three of seven (3/7) files, the Medical Executive Committee and the Governing Body privileges to physicians which were inconsistent with the hospital's current services or the applicant's requested privileges (for example, general surgery). These findings were verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Corrections to the privileges and services were made for physicians and midlevel providers.	Director of Quality	02/28/25	Completed
2. New credentialing packages for midlevel providers have been created based on the scope of services provided by the hospital to align with privilege requests. These changes have been reviewed by the Med Staff Coordinator and put into place.	Director of Quality	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective actions were approved by the Director of Quality.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. All packages updated and ready for use. Education on and around the new credentialing packets was given in person to the medical staff services department by the Medical Staff Coordinator.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. Credentialing packages and services will be reviewed as the providers come up for re-credentialing, to ensure that they are current, reflect services provided, and are compliant to the scope of the provider. The results of this review will be reported to Board Quality and the Board of Directors.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.13 Required Application-Initial and Reapplication Information for Review. Information covering each of the following areas must be reviewed for each applicant/re-applicant during the review and approval process. A. Licensure History: current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held. B. Medical Education and Postgraduate Training C. Malpractice Insurance and History: 5-year history. D. Specialty Board Status: (if applicable). E. Sanctions or Disciplinary Actions: actions taken by healthcare facilities, specialty boards, federal or state agencies, malpractice carriers. F. Criminal History: felony convictions/ criminal history (7-10 years). G. Healthcare Employment History: healthcare related employment/ appointment history (work history).	This standard is not met as evidenced by: Based on review of initial appointment credential files and interview, the following documents were missing from the files: 1. DO-Rheumatology-malpractice insurance 2. MD-Oncology-work history 3. NP-Family Medicine-one (1) peer reference 4. Clinical Activity was missing on the following: a. MD-Radiology Telemedicine x2 b. NP-Family Medicine c. MD-Emergency Room d. DO-Rheumatology These findings were verified by the Medical Staff Coordinator.

PLAN OF CORRECTION

H. Professional References: current competence and peer recommendations/references, ability to perform privileges requested (health status). For physicians seeking reapplication, peer references include: peers familiar with their practice of medicine, reviews under the hospital's peer review activities, reviews by the hospital's Credentials Committee, Department Chair, or Medical Executive Committee. I. Clinical Activity: procedure logs with outcomes to support privilege requests for procedures not attested to in postgraduate references. J. Information Verified for Comparison: comparison of applicant - provided information and verified information. K. Meeting Attendance is required consistent with the medical staff bylaws.	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. All of the following cited practitioners credential files were updated to ensure documentation is contained within the respective file as follows: 1. DO Rheumatology: malpractice insurance 2. MD Oncology: work history 3. NP Family Medicine: one peer reference 4. MD Radiology Telemedicine x 2: clinical activity logs 5. NP Family Medicine: clinical activity logs 6. MD Emergency Medicine: clinical activity logs 7. DO Rheumatology: clinical activity logs	Med Staff Coordinator	02/28/25	Completed
2. A check list was updated to ensure that all of the required documents were on the list and placed in provider files.	Med Staff Coordinator	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The Medical Staff Coordinator educated the DOQ to her process changes so they could both know and understand the changes made and the necessity behind them.	Medical Staff Coordinator	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. All provider files will be reviewed as they come up for re-credentialing by Board Quality and the Board of Directors to ensure compliance.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.01.23 Ongoing Professional Practice Evaluation (OPPE) Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), and/or to revoke an existing privilege prior to or at the time of renewal.	This standard is not met as evidenced by: Based on review of seven (7) reappointment credential files, seven of seven (7 of 7) files lacked evidence of OPPE documentation in the following files: a. MD-Family Medicine b. MD-Hospitalist c. MD-General Surgeon d. MD-Infectious Disease x2 e. MD-Pathologist f. Physician's Assistant These findings were verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. The OPPE work was reinitiated for the following cited providers: 1. MD Family Medicine 2. MD Hospitalist 3. MD General Surgeon 4. MD Infectious Disease x 2 5. MD Pathologist 6. Physician's Assistant	DOQ	02/28/25	Completed
2. We have received one OPPE form back and have sent ticklers to the participating providers to ensure that the other forms are completed.	DOQ	03/31/25	In Progress
3. We have calendared the cycle for OPPE and will follow up with providers to ensure that the program moves forward as necessary.	DOQ	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. All corrective actions were approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education around the OPPE process was completed at the medical executive committee meeting.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. OPPE is tracked as an ongoing part of our OPPE/FPPE/ Peer Review process and reported to Board Quality and the Board of Directors monthly.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.01 Rapid Response System The medical staff has approved a written policy for the early recognition and response to signs of patient deterioration, ensuring prompt rescue and treatment.	This standard is not met as evidenced by: Based on review of hospital policies and interview, the "Rapid Response" policy has not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. This Rapid Response Systems policy was placed into the policy process to be approved through MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Rapid Response Policy shall be reviewed by the medical staff via MEC on a annual basis.	DOQ	04/01/25 / 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.02 Blood Transfusion Administration Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.	This standard is not met as evidenced by: Based on the interview and document review, the "Blood Transfusion Administration" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. This Blood Transfusion Administration policy was placed into the policy process to be approved through MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Blood Transfusion Administration Policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.03 Ventilator Bundle. The medical staff has approved a written policy or protocol for the care of patients on a mechanical ventilator.	This standard is not met as evidenced by: Based on document review, hospital policy, "Ventilator Bundle" has not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Ventilator Bundle policy was placed was placed into the policy process to be approved via MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. The Ventilator Bundle policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.04 Venous Thromboembolism (VTE) The medical staff has approved a written policy or protocol for the assessment, prevention, and treatment of venous thromboembolism (VTE).	This standard is not met as evidenced by: Based on interview and document review, the "Venous Thromboembolism" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Venous Thromboembolism policy was placed into the policy process to be approved via MEC and the Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The DOQ approved of this corrective action.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The Venous Thromboembolism policy shall be reviewed by the medical staff via the MEC annually.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

05.02.06 Prevention of Pressure Ulcers The medical staff has approved a written policy or protocol for the assessment, prevention, and treatment of pressure ulcers.	This standard is not met as evidenced by: Based on interview and document review, the "Prevention of Pressure Ulcer" policy had not been approved by the Medical Executive Committee or the Governing Board. This finding was verified by the Medical Staff Coordinator.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The Prevention of Pressure Ulcers policy was placed into the policy process to be approved via the MEC and Governing Body.	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process will be continued for all staff as a part of our annual re-orientation.	DOQ	03/31/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. The Prevention of Pressure Ulcers policy shall be reviewed by the medical staff via MEC on an annual basis.	DOQ	04/01/25 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.00.02 Policy Development. *The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of* ***standard 05.00.01****.* *These policies are reviewed at least* ***biennially*** *by the professional personnel* ***indicated above*** *and* ***updated*** *as necessary by the CAH.* §485.635(a)(2) §485.635(a)(4) Tag C-0272	This standard is not me as evidenced by: Based on interview and review of policies, the following were observed: A. All patient care policies are not referred to the Governing Board for consideration after the Policy and Procedure Committee (the Advisory Group) makes its recommendations as required by standard 06.00.02. B. The following policies have not been reviewed/approved within the past two (2) years: 1. Automatic Stop Orders: last reviewed 6/2020 2. Drug Samples: last reviewed 1/2020 3. Warfarin: last reviewed 9/2020 4. Controlled Drug Distribution: last reviewed 8/2020 5. CAH-Staffing and Staff Responsibilities: last reviewed 7/2020 6. Dietary policies (for example - Dietary Quality of Care - last reviewed in 2021, 7. Rehab Therapy - no policies have been updated since 2021/22 8. Human Resources policies (example - Reference Check last reviewed 9/2021, Hiring Process last reviewed 11/2022)

PLAN OF CORRECTION

	These findings were verified by the Pharmacist, Medical Staff, Dietary Manager, Director of Clinical Services, and Human Resource Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The process for policy development has been updated to ensure that all patient care policies and other policies around the operation of the hospital move through our policy advisory group and the MEC and Governing Body on the appropriate schedule.	DOQ	04/01/25	In Progress
2. The following cited policies have been reviewed by the MEC and Governing Body: 1. Automatic Stop Orders 2. Drug Samples 3. Warfarin 4. Controlled Drug Distribution 5. CAH-Staffing and Staff Responsibilities 6. Dietary policies 7. Rehab Therapy 8. Human Resources Policies	DOQ	04/01/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. This corrective action was approved by the DOQ.	DOQ.	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the policy process and the expectations around that process will be reeducated to all managers through the Relias platform to ensure that all understand their part in the process as a whole.	DOQ	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. All policies manuals will be reviewed annually as a part of our annual program evaluation by the medical staff via the MEC and Governing Body.	DOQ	04/01/25 04/30/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.07.06 List of Contracted Services (3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided. §485.635(c)(3) §482.12(e)(2) Tag C-0291	This standard is not met as evidenced by: Based on document review and interview, the facility's contracted service list did not contain: 1. The service (s) being offered 2. Whether the services are offered on- or off-site. 3. Whether there is any limit on the volume or frequency of the services provided. 4. When the service(s) are available. This finding was verified by the Directory of Quality.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. The contract review template was updated to include all of the required elements to be compliant with the standard.	DOQ	02/28/25	Completed
2. The updated template will be used moving forward to ensure that all reviewed contracts are reviewed using all of the required elements to meet the standard.	DOQ	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The DOQ re-read the standard and applied his learning to updating the template he uses for contract review.	DOQ	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Contract review will be completed as contracts come up for renewal - evergreening contracts are being phased out by the district as they come up for review. This process will be reported on quarterly to Board Quality and the governing Board of Directors.	DOQ	04/01/25	Quarterly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

		12/31/25	

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.08.03 Nursing Plan of Care *A nursing care plan must be developed and kept current for each inpatient.* §485.635(d)(4) §482.23(b)(4) Tag C-0296	This standard is not met as evidenced by: Based on medical records review, five of five (5/5) records did not include care plans related to the admitting diagnosis/treatment plan or assessment for the following: a. C-diff - no isolation or infection control plan b. COPD, respiratory compromised - no respiratory plan c. High risk for aspiration - no identified plan d. High risk for falls - no identified plan e. COPD, Lung deficits - No respiratory plan These findings were reviewed by the Director of Nursing.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. A new policy has been developed outlining the Individualized Plan of Care (IPOC) process for nursing	DON Acute	03/31/25	In Progress
2. A meeting was held with a Cerner Representative where we were able to add 8 new care plan options to ensure alignment with standards.	DON Acute	03/31/25	In Progress
3. Education was provided in-person to all Med/Surg RN's at our staff meeting on February 20th and an additional training document was sent virtually to include expectations and the new policy.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The new policy, Developing Nursing Care Plans (IPOC) has been reviewed and approved by the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	CNO	04/01/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Training sessions will be scheduled to ensure staff understand how to document and implement IPOCs within Cerner, including options for individualization.	DON Acute	03/31/25	In Progress
2. Additional guidance and support resources will be provided for nurses to improve compliance and consistency in care planning.	DON Acute	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Care plans will be audited in the following way, ten medical records will be audited for documentation compliance that the care plans are related to the admitting diagnosis and treatment plans/assessment monthly. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.08.10 Patients at Risk The facility has a written policy for identifying patients on admission that are at-risk for developing the following complications: 1. Pressure ulcers 2. Deep vein thrombosis (DVT/venous thromboembolism (VTE) 3. Aspiration 4. Malnutrition 5. Fall Risk/Prevention	This standard is not met as evidenced by: Based on documentation review, medical records review, and interview, the following issues were identified: 1. Two of five (2/5) medical records did not contain a DVT risk assessment. 2. The DVT policy indicated that nurses were to notify the physician after completing a risk assessment of the numeric score. However, five of five (5/5) records did not contain evidence that a physician was notified of the assessment. 3. The DVT Policy did not identify the meaning of the "numeric score" or the preventative measures that would be implemented for patients considered at risk. Additionally, staff were unable to articulate an understanding of these processes. 4. Five of five (5/5) records lacked evidence that the physician participated in the DVT risk assessment or ordered preventative measures as appropriate based on a DVT risk assessment. These findings were verified by the Director of Nursing.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Our current policy was updated to reflect the process for performing VTE assessments on adult patients, updated VTE scoring criteria, communication with the provider, and proper documentation.	DON Acute	03/31/25	In Progress
2. An option has been identified to the bottom of the assessment tab for documenting the provider's notification, ensuring clear communication between nursing staff and the healthcare team.	DON Acute	03/31/25	In Progress
3. We have standardized the way in which we complete the VTE assessment, ensuring that all team members are documenting in the same place.	DON Acute	03/31/25	In Progress
4. Education was provided in-person to all Med/Surg RNs at our staff meeting on February 20th, and an additional training document was sent virtually to include expectations and the new policy.	DON Acute	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. 1. The updated policy, "Venous Thromboembolism – Prevention," has been reviewed and approved by the Director of Nursing and is undergoing the Committee Advisory Process. It will be reviewed by the Board of Directors for final approval on March 26th.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Our training plan has already been executed as discussed in action items. Education was provided in-person to all Med/Surg RNs at our staff meeting on February 20th, and an additional training document was sent virtually to include expectations and the updated policy.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. VTE scores and documentation compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of VTE scores. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.01 Notice of patient rights ***A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under state law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.*** **§ 485.614(a)** **§ 485.614(a)(1)**	This standard is not met as evidenced by: Based on policy review, observation, and interview the Facility is in violation of its policy, "EMTALA Signage," which states, "The hospital will post signage that, at a minimum, meets the following requirements: a. "Signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (e.g., entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property." b. "Signage must be readable from anywhere in the area." c. "Wording on signage must be clear and in simple terms in a language(s) that is/are understandable by the population the hospital serves." There was an EMTALA sign located at the main entrance in a glass case on the bottom shelf, which was in English only. There were no signs posted in the other areas listed in the policy. These findings were verified by the Chief Nursing Officer.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. EMTALA signs and Patient's Rights signs were blown up and placed in all appropriate places to be in compliance with hospital policy.	DOQ	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. This corrective action was approved by the DOQ	DOQ	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the EMTALA signage policy was reviewed by the DOQ to ensure that the signs and placement would be in compliance with the policy.	DOQ	02/28/25	Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.			
Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Signs and placement will be monitored on EOC rounds monthly.	DOQ	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.02 Notice and promotion of patient rights **The Patient's Rights document includes, at a minimum, that the patient has:** • ***The right to participate in the development and implementation of his or her plan of care.*** **§485.614(b)(1)** • ***Or his or her representative (as allowed under state law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.*** **§485.614(b)(2)** • ***The right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §§489.100, 489.102, and 489.104 of this chapter.***	This standard is not met as evidenced by: Based on documentation review, observation, and interviews, the following were observed related to Patient Rights: 1. Notices of Patient Rights are not prominently displayed as they are located in an enclosed glass case and cannot be easily read in this location. 2. California law requires hospital documents to have a minimum font size of 12 points for patient readability. The Patient Rights document provided to patients is smaller than a 12-point font. These findings were verified by the Chief Nursing Officer and Hospital Leadership.

PLAN OF CORRECTION

§485.614(b)(3)

- ***The right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.***

§485.614(b)(4)

- ***The right to personal privacy.***

§485.614(c)(1)

- ***The right to receive care in a safe setting.***

§485.614(c)(2)

- ***The right to be free from all forms of abuse or harassment.***

§485.614(c)(3)

- ***The right to the confidentiality of his or her clinical records.***

§485.614(d)(1)

- ***The right to access their medical records, including current medical records, upon an oral or written request, in the form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form and format as agreed by the***

PLAN OF CORRECTION

facility and the individual and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of the individual to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. **§485.614(d)(2)** • ***The right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.*** **§485.614(e)** • ***The right to safe implementation of restraint or seclusion by trained staff.*** **§485.614(f)** ***A CAH must*** • ***Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or***	

PLAN OF CORRECTION

limitation on such rights, when he or she is informed of his or her other rights under this section. **§485.614(h)(1)** ***Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.*** **§485.614(h)(2)** • ***Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.*** **§485.614(h)(3)** • ***Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.*** **§485.614(h)(4)**	
Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Patient's rights signs were blown up to meet the size requirements for reading and were placed around the hospital in prominent places to ensure that patient's rights were promoted appropriately.	DOQ	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The DOQ approved of this corrective action	DOQ	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education of patient's rights will be included to the onboarding education for new hires that is conducted by the DOQ so staff is aware of the appropriate promotion of patient's rights.	DOQ	03/31/25	In Progress

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Placement and promotion of patient's rights will be monitored on EOC rounds by the DOQ.	DOQ	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

06.10.08 Patient and safety: Safe setting *The patient has the right to receive care in a safe setting.* §485.614(c) §485.614(c)(2)	This standard is not met as evidenced by: Based on tour, medical records review, and interview, the following were observed: A. Five of five (5/5) Emergency Room patient records lacked evidence that patients were screened for harm to others. B. Unsecure needles and syringes (35+) were found in the Preoperative area. These findings were verified by the Director of Nursing and the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Needles have been relocated to a locked cabinet to ensure compliance with safety standards.	DON Acute	03/31/25	In Progress
2. Additional keys have been ordered and distributed to nursing staff to maintain accessibility while ensuring security.	DON Acute	03/31/25	In Progress
3. The Triage of Emergency Patients policy was updated to include the requirement for assessing assault and homicidal risk factors.	DON Acute	03/31/25	In Progress
4. The Adhoc form in Cerner – Assault and Homicide Risk Assessment was identified as the standard tool for documentation.	DON Acute	03/31/25	In Progress
5. Training has been distributed virtually, with a required read/sign of the associated policy.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The revisions made to the Triage of Emergency Patients policy have been reviewed and approved by the Director of Nursing and are currently undergoing the Committee Advisory Process. The policy will be presented to the Board of Directors for final approval on March 26, 2025.	DON Acute	03/31/25	In Progress
2. The updated process around needles has been reviewed and approved by the Surgery Manager and Director of Nursing.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the new secured storage process has been provided virtually. In-person training for reinforcement will occur the week of March 10th, the next available date for surgery.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Staff are responsible for ensuring all needles remain locked and for reporting any security concerns immediately			
2. Education on completing the Adhoc form – Assault and Homicide Risk Assessment has been distributed virtually to reinforce expectations and the new policy. In – person pop up sessions will be scheduled as needed based on audit results. Monitoring and reinforcement will be ongoing to ensure successful implementation and sustainability of this change in practice	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This will be monitored in the following way, ten medical records will be audited monthly for documentation compliance of screening for harm to others. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.00.01 Scope of Services The surgery department has a written scope of services. §482.51(a) §485.639 Tag C-**1140**	This standard is not met as evidenced by: Based on interview and document review, the surgical scope of services did not reflect the scope currently provided in the operating room. The facility had plans to do more General Surgery cases, but due to unforeseen circumstances, they are only performing scope procedures. This finding was verified by the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Part A. What actions will you take (Add rows if needed.)

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
1. The scope of services around the scope of our surgical services will be updated to reflect the services that are being provided currently.	DON Acute	03/31/25	In Progress
2. The updated scope of services will be taken to the Board of Directors for approval.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. These corrective active plans will be approved by the CEO and the Board of Directors during the March meeting.	CEO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the scope of services standard and alignment of our services will be provided to the management team to allow us to assess and align as necessary.	DOQ	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. The hospital scope of services plan shall be reviewed by the MEC and Governing Body on an annual basis.	DOQ	04/01/25 – 12/31/25	Annually

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.01.00 Anesthesia Risk and Evaluation *(1) A qualified practitioner, as specified above in 42 CFR §485.639(a), must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.* *(2) A qualified practitioner, as specified below in 42 CFR §485.639(c), must examine each patient before surgery to evaluate the risk of anesthesia.* *(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified below in 42 CFR §485.639(c).* §482.51(b)(1) §482.52(b)(1)(ii) §482.52(b)(3) §485.639(b) §485.639(b)(1-3) Tag C-**1144**	This standard is not met as evidenced by: Based on a review of postoperative patient records and interview, two of five (2/5) records lacked a post-op anesthesia evaluation. This finding was verified by the Surgery Manager.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A read/sign has been developed to ensure compliance with the post anesthesia risk and evaluation standards.	DON Acute	03/31/25	In Progress
2. The Anesthesia Record has been amended to provide clarity regarding the required charting elements, ensuring accuracy and consistency in documentation.	DON Acute	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The updated process has been reviewed and approved by the Surgery Manager and the Director of Nursing to ensure alignment with regulatory and patient safety standards.	DON Acute	03/31/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. Education on the new anesthesia risk and evaluation process will be provided to the Certified Registered Nurse Anesthetist (CRNA) in person. This training is scheduled to take place during the week of March 10th, coinciding with the next available surgical schedule.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Compliance with the updated anesthesia evaluation process will be audited in the following way, ten medical records will be audited monthly for documentation compliance of the post anesthesia assessment. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.	DON Acute	03/31/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

08.03.06 Equipment Safety All anesthetizing equipment utilized is maintained to conform to Safe Medical Devices/Food Drug Administration requirements.	This standard is not met as evidenced by: Based on a review of post-op patient records and interviews, five of five (5/5) records lacked evidence that the anesthesia machine "number" was documented, and the "machine safety check" was not documented as complete prior to use. This finding was verified by the Surgery Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Each anesthesia machine has been assigned a unique name to facilitate identification and tracking.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

2. A designated area for required documentation has been added to the "Anesthesia Record" to ensure accurate and consistent record-keeping.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The updated process has been reviewed and approved by the Surgery Manager and the Director of Nursing to ensure alignment with regulatory and patient safety standards.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the new anesthesia risk and evaluation process will be provided to the Certified Registered Nurse Anesthetist (CRNA) in person. This training is scheduled to take place during the week of March 10th, coinciding with the next available surgical schedule.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance with the updated anesthesia evaluation process will be audited in the following way, ten medical records will be audited monthly for documentation compliance of the anesthesia machine and completed safety check. Quality data shall be reported to the Quality Committee as Performance Improvement (PI) indicators and reported out to our Board Quality	DON Acute	04/01/25 / 12/31/25	Monthly

PLAN OF CORRECTION

Committee until compliance is sustained for three consecutive months to ensure that the governing Board of Directors has visibility into the changes. Monthly target compliance rate shall be set at 90%.			

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

10.00.05 Staff Education and Death Record Review *The CAH must have and implement written protocols that—* • *Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.* • *For purpose of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multi visceral organs).* §485.643(e-f) §482.45(a)(5) Tag C-0349	This standard is not met as evidenced by: Based on interview, the Facility had not trained its employees on organ donation. They planned to start training on 2-1-25, but this has not come to fruition. This finding was verified by the Educator
Date of POC (date written, date revised)	02/13/25, revised 03/11/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. We have contacted our representative from the organ procurement center to obtain comprehensive training programs and resources that can be electronically embedded in our online learning system.	CCO	03/31/25	In Progress
2. The organ donation policy is accessible via the facility's internal portal, allowing staff to reference it at any time.	CCO	03/31/25	In Progress
3. We created a read/sign for all Emergency Department and Med/Surg staff for the Policy Identification of Potential Organ and/or Tissues Donors and associated form Record of Death/ Permit to Release Body.	CCO	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. The organ donation education program has been reviewed and approved by the Director of Nursing and the Chief Clinical Officer.	CCO	03/31/25	In Progress
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			

PLAN OF CORRECTION

1. The organ donation training program will be embedded in the online learning system and assigned to all required staff by March 21st. The training will include an assessment to evaluate comprehension.	CCO	03/31/25	In Progress
2. Staff will be given three weeks to complete the training, allowing time to identify and address any cases of non-compliance.	CCO	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. The implementation and compliance of this education program will be monitored by the internal Quality Committee and reported to the Board Quality Committee, ensuring visibility for the governing Board of Directors.	DOQ	04/01/25 – 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.01 Resident rights *The CAH must be in substantial compliance with the following skilled nursing facility requirements:* 1. *In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.* §483.10(b)(7) 2. *To be informed of, and participate in, his or her treatment.* §483.10(c) 3. *To be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.* §483.10(c)(1) 4. *To be informed, in advance, of changes to the plan of treatment.*	This standard is not met as evidenced by: Based on a medical record review, five of five (5/5) records lacked evidence that the facility had provided a written list of resident rights to the resident upon admission to the program. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(c)(2)(iii)

5. *To request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.*

   §483.10(c)(6)

6. *To choose his or her attending physician.*

   §483.10(d)

7. *To retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.*

   §483.10(e)(2)

8. *To share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.*

   §483.10(e)(4)

9. *To have immediate access to the resident's immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.*

   §483.10(f)(4)(ii)

PLAN OF CORRECTION

10. *To have immediate access to others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.* §483.10(f)(4)(iii) 11. *To send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than the postal services.* §483.10(g)(8) 12. *To be informed at time of admission, when the resident becomes eligible for Medicaid, and periodically during the resident's stay of items and services included under the State plan for which the resident may not be charged; and those other items and services the facility offers for which the resident may be charged and the amount of charges for those services.* §483.10(g)(17); §483.10(g)(18) 13. *To have personal privacy and confidentiality of personal and medical records.* §483.10(h) §485.645(d)(1)	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Part A. What actions will you take (Add rows if needed.)

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
1. The admission process has been updated to ensure all residents receive the correct Resident Rights documentation upon admission for their status of care.	DON Acute	03/31/25	In Progress
2. The admission packet has been revised to include all required documentation, ensuring compliance with regulatory standards.	DON Acute	03/31/25	In Progress
3. All appropriate documentation has been changed in our policy manager system, and any inaccurate documents that have been deleted from the system are not available for use.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

PLAN OF CORRECTION

1. The updated admission packet and process have been reviewed and approved by the Admitting/ Patient Access Manager and the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and Resident Rights documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

.Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.06 Choice of attending physician *The resident has the right to choose his or her attending physician.* 1. *The physician must be licensed to practice, and* 2. *If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation.* 3. *The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.* 4. *The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.* 5. *If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.*	This standard is not met as evidenced by: Based on document review (including a patient rights welcome letter, welcome packet information, and medical record reviews), the facility lacked evidence that residents were informed of their right to choose a personal physician. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(d) §483.10(d)(1) §483.10(d)(2) §483.10(d)(3) §483.10(d)(4) §483.10(d)(5) §485.645(d)(1) Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. The admission process has been updated to ensure all residents receive the correct Resident Rights documentation upon admission for their status of care.	DON Acute	03/31/25	In Progress
2. The admission packet has been revised to include all required documentation, ensuring compliance with regulatory standards.	DON Acute	03/31/25	In Progress
3. All appropriate documentation has been changed in our policy manager system, and any inaccurate documents that have been deleted from the system are not available for use.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The updated admission packet and process have been reviewed and approved by the Admitting/ Patient Access Manager and the Director of Nursing and is currently undergoing the Committee Advisory Process and will be reviewed by the Board of Directors by March 26th for final approval.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and Resident Rights documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

PLAN OF CORRECTION

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

11.01.12 Medicare and Medicaid Notification. *The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.* *The facility must--* *(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-* *(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;* *(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and* *(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in 42 CFR 483.10(g)(17)(i)(A) and (B).* §483.10(g)(18)	This standard is not met as evidenced by: Based on documentation reviews (including patient rights welcome letter, welcome packet information, and medical record reviews), the facility lacked evidence that residents are given information regarding other items and services that the facility offers, for which the resident may be charged, and the amount of charges for those services. This finding was verified by the Director of Nursing.

PLAN OF CORRECTION

§483.10(g)(17) §483.10(g)(17)(i) §483.10(g)(17)(i)(A) §483.10(g)(17)(i)(B)(i) §483.10(g)(17)(i)(B)(ii) §485.645(d)(1) Tag C-0361	
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The admission process for swing patients has been updated and includes notice of information regarding other items and services that the facility offers, for which the resident may be charged, and the amount of charges for those services.	DON Acute	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the CNO.	CNO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the revised admission packet and documentation will be provided to all admissions staff and will include a read/sign.	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance will be audited in the following way, ten medical records will be audited monthly for documentation compliance of all required elements of residence rights receipt on admission. Quality data shall be reported to the Quality Committee and Board of Directors until compliance is sustained for three consecutive months. Monthly target compliance rate shall be set at 90%.	DON Acute	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.01 Doors. Corridor doors and doors to hazardous rooms shall be provided with positive latching hardware. Roller latches are not permitted on corridor doors that are required to latch. Corridor doors shall be capable of resisting the passage of smoke. Doors in the path of egress must be side-hinged or pivot-swing type.	This standard is not met as evidenced by: Based on the building tour, 1. The Dietary entry door was fire-rated and did not close and latch. 2. The Main Mechanical Room door did not close and latch. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Corrections to latching speed have been made to ensure that latching happens as required by all applicable standards.	DOO	03/31/25	In Progress

PLAN OF CORRECTION

2. A PI measure will be created to monitor this corrective action.	DOO	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action has been approved by the DOO.	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the inspection log and corrective action will take place in person and will be conducted by the Facilities Manager	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. The weekly door inspection log will be audited monthly and reported to the safety committee monthly and quality committee quarterly. This will ensure that the monitoring process will go through Board Quality to the Board of Directors.	DOO	04/01/25 / 12/31/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.03 Corridor Clutter The exit access corridor must be maintained to the full required width.	This standard is not met as evidenced by: 1. Based on the building tour, corridor clutter was observed in the following areas: A. In Med/Surg Unit 1, an IV cart was observed to be stored in the corridor. This finding was corrected on-site during the survey, but a plan of correction is still indicated. B. In the corridor leading to the OR area, a pedestal sign, a computer on wheels not in use, and a chair were observed stored. This finding was corrected on-site during the survey, but a plan of correction is still indicated. 2. Based on document review, the OR is not identified on the LS drawings as a suite, and a cart with plastic bins was observed to be stored in the corridor. This finding was corrected on-site during the survey, but a plan of correction is still indicated. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The clutter found was removed during survey.	DOO	02/28/25	Completed
2. Policy was updated and educated to staff.	DOO	03/31/25	In Progress
3. A corridor clutter log was created and this issue will be monitored by EOC rounding.	DOO	03/31/25	In Progress
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. These corrective actions were approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the policy and standard will be given in person in real time by the EOC rounding team as the issues are discovered.	EOC Team	03/31/25	In Progress
2. A read and sign will be added for the policy to our Relias platform for all staff.	DOO	03/31/25	In Progress

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.			
Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Data on the clutter found during EOC will be reported to the safety committee monthly and to the quality committee quarterly.	Facilities Manager	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.01.05 Signage Exits shall be marked by an approved sign readily visible from any direction of exit access and be illuminated. Illuminated signs must be legible in both the normal and emergency lighting mode. Access to exits shall be marked by approved signs in all cases where the way to reach the exit is not readily apparent to the occupants. Exit signs shall be visually inspected monthly for operation of the illumination sources. This inspection is documented.	This standard is not met as evidenced by: Based on the building tour, 1. An exit sign was not observed indicating the rear exit from the kitchen to the outside. 2. The exit door near the Outpatient Medical Unit was observed without an exit sign. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. Phot luminescent signs will be installed and staff will be educated to keep lights on as a short term fix.	Facilities Manager	03/31/25	In Progress
2. A long term solution will be to install hardwired exit signs in these spaces to be in compliance with the standard. This will be an HCAI project so it will take some time.	DOO	04/06/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	04/06/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff will be educated to the standard by the facilities manager in real time when compliance issues arise. EOC rounding will ensure compliance.	DOO	04/06/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Monitoring of this plan will take place during EOC rounding and the results of the rounding will be reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

		12/31/25	

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.02.01 Fire Alarm System - Installation and Maintenance A fire alarm system required for life safety shall be installed and maintained in accordance with sections 18/19.3.4 of the Life Safety Code (2012 edition), and in accordance with NFPA 72, 2010 edition. §485.623(c)(1)(i-ii) C-0930	This standard is not met as evidenced by: Based on the building tour, a smoke detector was observed installed less than 36 inches from a supply diffuser in the receiving area. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Facilities will move smoke alarms that are not in compliance with the standard.	Facilities Manager	03/31/25	In Progress
2. New smoke alarms will be installed to be compliant with the standard.	Facilities Manager	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard was given in person by the facilities manager.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. Compliance with the standard will be monitored during EOC rounding and reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.02.02 Fire Alarm System- Testing. Fire alarm systems, and all their components, shall be tested according to NFPA 72 National Fire Alarm Code (2010 edition), Table 14.4.2.2 Test Methods, and Table 14.4.5 Testing Frequencies. All testing results are documented.	This standard is not met as evidenced by: Based on document review, the following documents for the Fire Alarm system were unavailable at the time of the survey: 1. The quarterly low air pressure switch testing documentation. 2. The annual smoke damper interconnected equipment testing documentation. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/31/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The contractor that is currently providing services will be on site in late March to preform testing.	Facilities Manager	03/31/25	In Progress

PLAN OF CORRECTION

2. While on site a conversation about the contractors ability to meet the standard will be conducted and the result of that conversation will potentially lead to compliance or finding a new vendor.	Facilities Manager	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOO	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided by the Facilities Manager to the contractor while on site in late March.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

1. Results of the contractor testing will be made available to the safety committee and the quality committee when available.	Facilities Manager	04/01/25 12/31/25	Quarterly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.03.01 Water-Based Fire Protection System: Installation and Maintenance A water-based fire protection system must be installed and maintained in accordance with section 18.3.5 of the Life Safety Code (2012 edition) in all new construction, remodeled and renovated areas. A water-based fire protection system must be installed and maintained in accordance with section 19.3.5 of the Life Safety Code (2012 edition) where required in existing construction, or renovated areas.	This standard is not met as evidenced by: Based on the building tour of the OR, a sprinkler escutcheon was observed loose from the ceiling. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The sprinkler escutcheon that was observed to be loose from the ceiling was fixed by facilities.	Facilities Manager	02/28/25	Completed

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education to the standard will be provided by the facilities manager in person to his facilities team for observation.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This standard will be monitored during EOC rounding and reported to safety on a monthly basis and quality on a quarterly basis.	Facility Manager	04/01/25 – 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.03.02 Water-Based Fire Protection System: Testing and Inspection If provided water-based fire protection systems and all their components must be tested, inspected and maintained in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 edition. All results of testing, inspection and maintenance activities are documented.	This standard is not met as evidenced by: 1. Based on document review of the sprinkler inspection report dated 6/7/24, the Main Drain quarterly inspection report was unavailable for review. 2. Based on document review, inspection and/or testing of the 50-year SR sprinkler heads were not available. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. The required inspection reports needed to be in compliance with the standard will be completed and kept to be available to review upon request. These inspections will be completed by our contracted plumbing partner Murry Plumbing.	Facilities Manager	03/31/25	In Progress

PLAN OF CORRECTION

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided by the facilities manager as needed in person to ensure compliance can be maintained.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. This process will be monitored by the facilities manager and reported to safety at a cadence to maintain compliance with the standard.	Facilities Manger	04/01/25 / 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.04.07 Fire-rated Door Assemblies Fire door assemblies must meet the provisions of NFPA 80 *Standard for Fire Doors and Fire Windows*, 2010 edition. All fire-rated doors assemblies, whether they are located in a fire-rated barrier or not, must be tested and inspected on an annual basis according to NFPA 80, 2010 edition. The test and inspection are documented. §485.623(c)(1)(i-ii) C-0930	This standard is not met as evidenced by: Based on document review of the side-hinged fire door report dated 7/1/2024, 8 doors had failed inspection and had not been repaired. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Part A. What actions will you take (Add rows if needed.)

1. Remedi8 is scheduled for April 4th to come and repair the doors - to ensure that we are in compliance with the standard.	DOO	04/04/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO	DOO	04/06/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Education on the standard will be provided to our contracting partner to help them understand the needs on the standard.	DOO	04/06/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
1. A PI will be created and monitored by the EOC rounding. This will be reported to safety and quality as appropriate to be compliant with the standard.	Facilities Manager	04/01/25 / 12/31/25	Monthly

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.04.09 Ceilings Ceilings which are required to limit the passage of smoke, such as ceilings containing smoke or heat detectors, and sprinklers, and used in conjunction with corridors and hazardous rooms that have smoke resistant barriers, are free from cracks, holes or missing tiles.	This standard is not met as evidenced by: Based on the building tour: 1. The water heater closet area was observed to have two (2) ceiling tiles with penetrations greater than 1/8 inches. 2. Double fire doors labeled 11138370 were observed to have ceiling tiles above them with penetrations/gaps greater than 1/8 inches 3. Conduits located in Clean Utility Room #118 were observed to have ceiling tiles with greater than a 1/8-inch gap. 4. In the Satellite IT Room across from the Pharmacy, ceiling tiles were observed to have penetrations greater than a 1/8-inch gap. 5. In the Main IT room, multiple ceiling tiles (4) were observed with wires and conduit having greater than a 1/8-inch gap around them. These findings were verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. All ceiling tile penetrations have been filled to be in compliance with the standard.	Facilities Manager	02/28/25	Completed
Part B. Internal approval process - policy, process, or action (Add rows if needed.)			
1. This corrective action plan was approved by the DOO	DOO	02/28/25	Completed
Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)			
1. Education on the standard will be provided by the facilities manager as needed in person to ensure that we are compliant with the standard.	Facilities Manager	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.			
		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. Ceiling tile penetrations will be monitored on EOC rounding and reported to safety monthly and quality quarterly.	Facilities Manager	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

14.05.10 Medical Gas Systems and Equipment: Maintenance There is a routine monitoring and maintenance system for oxygen, compressed air, and vacuum systems and equipment. CAH medical gas systems and equipment must be installed, inspected, tested and maintained in accordance with NFPA 99 (2012 edition) chapter 5 and chapter 11. Storage of all medical compressed gas cylinders must comply with NFPA 99, Standard for Health Care Facilities, 2012 edition.	This standard is not met as evidenced by: Based on the tour of the main bulk medical gas system, vehicles were observed parked less than 10 feet from the system. This finding was verified by the Facilities Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/31/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. A ten (10) foot barrier will be constructed with bollards to ensure that there are no obstructions.	DOO	03/31/25	In Progress

PLAN OF CORRECTION

2. As a short term fix caution tape has been set up to designate the space that has to be cleared of obstructions.	DOO	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action has been approved by the DOO.	DOO	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. Staff have been made aware of the need to keep the space clear and notice has been provided about the change and requirements.	DOO	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. There will be bollards up to prevent non-compliance.	DOO	02/28/25 02/28/26	Annually

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

18.02.01 Risk Mitigation Measures for Infection Prevention The hospital has identified activities to mitigate risks associated with acquiring infections. *The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings.* §482.42(a)(2)	This standard is not me as evidenced by: A. During tour of the Emergency Room, the following equipment was observed to have an accumulation of dust on top: 1. Ice Machine 2. Blanket Warmer 3. Pyxis Med Supply. B. During the tour of Surgery, the following issues were identified: 1. Rust found on: a. CO2 tank b. Casters on the Bovie c. Back Table d. Trash can 2. Expired Supplies-two (2) containers of Clavicide were being used past their expiration date of 1-31-25. C. During document review and observation, the Kitchen was noted to have: 1. A significant number of corrugated boxes within the department and mixed within open items of products, including:

PLAN OF CORRECTION

	a. > 10 boxes on a small shelf unit for daily use of dry items b. > 10 boxes in refrigerator c. > 15 boxes in storage refrigerator d. >15 boxes in freezer e. > 15 boxes in the dry storage area 2. Torn opened corrugated boxes to store items in all areas addressed above. 3. The corrugated boxes risk assessment was limited regarding actions taken or considered to reduce risks. These findings were verified by the Emergency Room Staff, Surgery Manager, and the Dietary Manager.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed
Part A. What actions will you take (Add rows if needed.)			
1. Dusting high spaces has been added to the EVS daily cleaning.	EVS Manager	02/28/25	Completed

PLAN OF CORRECTION

2. The areas found with dust were cleaned after they were discovered as dusty during survey.	EVS Manager	02/28/25	Completed
3. All rusted objects and expired products were removed after they were discovered during survey.	Facilities Manger	02/28/25	Completed
4. All corrugated boxes were moved and a new process was implemented to ensure that we are in compliance with the standard.	Dietary Manager	02/28/25	Completed
5. A risk assessment for corrugated boxes was completed to evaluate our facilities space and layout in the kitchen and to account for the infection prevention issues and other factors that make corrugated boxes problematic for use in that space. The risk assessment was completed to show what changes would be necessary (such as placement of corrugated boxes at the bottom of the racks), to ensure that we could have a space that met all necessary standards.	DOO	02/28/25	Completed

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. This corrective action plan was approved by the DOO.	DOO	02/28/25	Completed

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. The standard will be educated in real time by the facilities, EVS, and dietary manager(s) as necessary to be in compliance, education was give to facilities, EVS, and dietary staff.	DOO	02/28/25	Completed

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

		Start Date	

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually
Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)			
1. This process will be monitored via EOC rounding by the addition of dust accumulation in the ED and rust in the doors were added to EOC monthly rounds. Rounding audits shall be reported monthly to the Safety Committee and Quarterly to the Quality Committee.	DOO	04/01/25 12/31/25	Monthly

Communication LOG:

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

Section 1: Complete this section using your Deficiency Report. Cut and paste the standard number and title, its description, and the surveyor comments. Use a separate Plan of Correction (POC) template for each deficiency cited.

19.00.03 Discharge planning evaluation ***A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.*** **§485.642(a)(2)** **§482.43(a)(2)**	This standard is not met as evidenced by: Based on the interview and a review of the policy, "Discharge Planning," the policy does not address patient/family requests for discharge planning. This finding was verified by the Social Worker.
Date of POC (date written, date revised)	02/13/25, revised 03/24/25

Section 2: Think first! Use a team approach to identify why the problem exists and develop interventions that will resolve it and sustain compliance. Use one row for each action and complete the entire row.

Corrective Action(s) – Describe each action you will take to correct the deficiency, including details and timelines for full implementation. Be very specific in your narrative description of intended actions addressing all areas and instances of non-compliance identified in the Deficiency Report. Attach documentation (receipts, work orders, photographs, meeting minutes, etc.) when submitting your POC.	**Title of Responsible Individual** – Identify the title of the individual (not group) assigned responsibility for POC completion and compliance for each POC element.	**Expected Date of Completion (EDOC)** – Not more than 60 days beyond the end of survey.	**Current Status** – Enter either: ▪ In Progress ▪ Resolved/Completed

Part A. What actions will you take (Add rows if needed.)

PLAN OF CORRECTION

1. The Discharge Planning Policy has been reviewed and updated to ensure compliance with patient and family rights regarding discharge planning evaluations.	DON Acute	03/31/25	In Progress
2. Training has been completed in-person with the discharge planner and virtually with the nursing team.	DON Acute	03/31/25	In Progress

Part B. Internal approval process - policy, process, or action (Add rows if needed.)

1. The revised Discharge Planning Policy has been reviewed and approved by the Director of Nursing and is currently undergoing the Committee Advisory Process. The updated policy will be presented to the Board of Directors for final approval by March 26th, 2025.	DON Acute	03/31/25	In Progress

Part C. Education on Compliance and Process (Retain and submit evidence and add rows if needed.)

1. In- person education has been provided to the discharge planner and an additional reinforcement of a read/sign will be distributed.	DON Acute	03/31/25	In Progress
2. A read/sign will be obtained by all nursing staff	DON Acute	03/31/25	In Progress

Section 3: Identify how you will measure your corrective actions (quality indicators) to ensure that they are effective and sustainable.

Monitoring & Reporting Plan – List your quality indicators and include documentation when submitting your POC. Refer to the instructions for guidance on labeling.	**Title of Responsible Individual**	**Start Date** / **End Date**	**Frequency** –Daily/ Weekly/Monthly/ Quarterly/Annually

Part D. Data to be collected (quality indicators), monitored and reported (Retain and submit evidence and add rows if needed.)

Plan(s) of Correction are due within 10 calendar days of receiving your post-survey Deficiency Report.

PLAN OF CORRECTION

1. Compliance will be audited by verifying training completion for all required personnel by March 15th, 2025. The process will be audited monthly and reported to quality quarterly to ensure compliance.	DON Acute	04/01/25 12/31/25	Quarterly

Communication LOG: