Review of Statement of Deficiencies and Corrective Actions

VA Healthcare Network Upstate New York at: **Syracuse**

Nursing Home: _____
Review Certification Period (Dates) From: _____ To: _____

Standard: The local CNH Review Teams, designated with the Network, will receive and analyze the OSCAR and CMS FA QI profile, and all other necessary state survey reports and information. This may include a copy of the most recent Form SSA 2567, Statement of Deficiencies and Plan of Correction, and any complaints against a CNH that are reported to the State. The CNH Review Team will document review of electronic template **Attachment A:** *Review of Statement of Deficiencies and Corrective Actions*. If the reports indicate deficiencies of scope, severity or number that prevent the CNH from meeting substantial compliance, and the plan of correction does not adequately answer these deficiencies, the CHN Review Team will conduct an on-site survey. Team members will include a registered nurse, social worker, and other disciplines as appropriate to evaluate the specific areas of non-compliance. CNH Review Team will use electronic template checklist **Attachment B:** *Inspection Criteria for Community Nursing Homes*.

After review of the current OSCAR, Form SSA 2567 and CMS FA QI profile data, the following has been determined:

☐ The facility is in significant compliance with all standards. Inspection by VA CNH Review Team is not necessary.

☐ The facility had deficiencies of such number and/or significance to warrant further inspection by CNH Review Team.

Or

☐ The State Survey inspection is insufficient to make an assessment of quality of care in the facility. **(Important: if checked, notify local Care Line Manager and Network GEC Clinical Coordinator).**

☐ Initial Review

Reviewed by: _____ Date: _____
CNH Site Coordinator

Concurrence: _____ Date: _____
Local GEC Care Line Manager

Inspection Criteria for Community Nursing Homes

VA Health Care Network Upstate New York at: **Syracuse**

Nursing Home: _____
Inspection Date: _____
Team Members (Names and titles):

1. Patient Record on Each Patient	Met	Not Met
A. Identifying Information	☐	☐
B. Interdisciplinary Patient Assessment	☐	☐
C. Interdisciplinary Patient Care Plan	☐	☐
D. Progress Notes reflect patient goals	☐	☐
E. Patient Care Plan for each patient	☐	☐
F. Patient Care Plan updated quarterly	☐	☐
G. Patient Goals identified and updated	☐	☐
H. History & Physical	☐	☐
I. Ongoing MD Review	☐	☐

2. Evidence of Adequate Patient Care within Facility	Met	Not Met
A. Adequate personal hygiene and dress	☐	☐
B. Program to reduce immobility	☐	☐
C. Program to reduce incontinence	☐	☐
D. Safety/Risk Management Program	☐	☐
E. Call Light Accessible	☐	☐
F. Comfort/Pain Management adequate	☐	☐
G. Adequate nutrition/hydration	☐	☐
H. Restorative Nursing Program	☐	☐
I. Medication documentation reflects effectiveness	☐	☐

3. Quality of Life	Met	Not Met
A. Privacy provided for each patient	☐	☐
B. Innovative Patient Activity Programs	☐	☐
C. Access to Outside Grounds	☐	☐
D. Diversion Activities involving community interaction	☐	☐
E. Resident Council and Patient/Family Advocacy	☐	☐
F. Staff/patient interaction	☐	☐
G. Adequate space per patient	☐	☐
H. Restraint-free environment promoted	☐	☐
I. Patient Satisfaction program	☐	☐

4. Quality Improvement	Met	Not Met
A. Quality Improvement Plan is available that include Clinical Indicators (i.e. development of decubitus ulcers, falls, medications etc.)	☐	☐
B. Quality Improvement data is routinely forwarded to CNH Coordinator for the site	☐	☐
C. Quality Improvement Data is shared with Leadership at the CNH facility	☐	☐
D. Quality Care issues are documented/evaluated on patients re-admitted to VHA from the CNH	☐	☐

5. Clinical Staff	Met	Not Met
A. Current licenses available	☐	☐
B. Policies and procedures are available	☐	☐
C. Ongoing training and education provided	☐	☐
D. Job descriptions and competencies available	☐	☐
E. Age-specific orientation program	☐	☐
F. Adequate staffing pattern	☐	☐

	Day	Evening	Night
RN			
LPN			
N/A			
Staff/Patient Ratio			

6. Fire Safety Findings:
   Recommendations from Fire Safety Report:

Comments:

_____ _____
Name and Title of Staff Who Completed Report Date:

Concurrence: _____ _____
Local GEC Care Line Manager Date: