|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02544 (09/2019) | | | | | **STATE OF WISCONSIN** | | | | | | |
| **NURSING HOME IMMEDIATE JEOPARDY (IJ) CITATION REMOVAL PLAN** | | | | | | | | | | | |
| **GENERAL INSTRUCTIONS** | | | | | | | | | | | |
| This form is intended for use by facility administrators and/or corporate consultants immediately following notification of an IJ citation. Following verification of IJ with the State Agency (SA) and Bureau of Nursing Home Resident Care (BNHRC) regional office, the survey team must immediately notify the facility that IJ has been identified. In most cases, the facility must submit a removal plan to the SA as soon as possible and as soon as it has identified the steps it will take to ensure that no recipients are suffering **or are likely** to suffer serious injury, serious harm, serious impairment, or death as a result of the facility’s noncompliance.  A removal plan documents the immediate action a facility will take to prevent serious harm from occurring or recurring and identifies all actions the entity will take to immediately address the noncompliance that has resulted in or made serious injury, serious harm, serious impairment, or death likely by detailing how the facility will keep recipients safe and free from serious harm or death caused by the noncompliance.  The removal plan must:   * Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and, * Specify actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the actions will be complete.   Unlike a plan of correction, it is not necessary that the removal plan completely correct all noncompliance associated with the IJ; rather, it must ensure serious harm will not occur or recur. The removal plan must include a date by which the facility asserts the likelihood for serious harm to any recipient no longer exists. Removing the IJ does not ensure that substantial compliance has been achieved. Once IJ has been removed, the SA will issue a completed *Statement of Deficiencies* (form CMS-2567) and request a plan of correction that achieves substantial compliance. The removal plan will be evaluated and approved by the SA.  NOTE: Use of this form is voluntary. It is designed to provide a standardized and more efficient and timely process.  **Submission**: Submit completed form via email to your BNHRC Regional Field Office Director (RFOD). Regional office contact information is available at: <https://www.dhs.wisconsin.gov/dqa/bnhrc-regionalmap.htm>  **Inquiries:** Direct questions regarding the completion of this form to your BNHRC Regional Field Office Director. Regional office contact information is available at: <https://www.dhs.wisconsin.gov/dqa/bnhrc-regionalmap.htm>  **IMPORTANT NOTES**   * **If an IJ is identified at more than one F-tag, the required information must be provided for each individual F-tag in the response fields.** * **With the exception of the name of facility staff who is the point of contact for this form, do NOT use staff / resident names or other personally identifiable information (PII) on this form. Use only position titles or identifiers; e.g., NHA, DON, RN, LPN, CNA, Resident 1, 2, 3.** * **Use of this form does not constitute facility agreement with the SA determination of IJ or the details of the IJ determination listed below.** | | | | | | | | | | | |
| **IJ DETERMINATION SUMMARY** | | | | | | | | | | | |
| **The nursing home requests removal of the IJ, based on completion of the removal plan outlined below.** | | | | | | | | | | | |
| Name – Facility | | | | | | | | | | | |
| Position – Staff Notified of IJ by SA *(e.g., NHA, DON, Corporate Consultant)* | | | | | | IJ F-Tag(s) | | | | | |
| State Agency Region  NERO  NRO  SERO  SRO  WRO | | | | Date – Notified of IJ by SA *(MM/dd/yyyy)* | | | | | Time | | AM  PM |
| Date – IJ Began (as determined by SA) *(MM/dd/yyyy)* | | | | | Date Requested – IJ Removal Effective *(MM/dd/yyyy)* | | | | | | |
| Name – Facility Contact Submitting Form | | | | | | | Phone No. – Facility Contact Submitting Form | | | | |
| Date Form Submitted to SA *(MM/dd/yyyy)*: | | |  | | | | Time: |  | | AM  PM | |
| 1. **Residents Who Have Suffered, or are Likely to Suffer, a Serious Adverse Outcome as a Result of the Non-Compliance** | | | | | | | | | | | |
| **F-Tag(s):** |  | | | | | | | | | | |
| *Identify residents involved and those who have the potential for similar outcomes.*  ***Example:*** *The failure to ensure that nurses had the appropriate training and components to care for a new G-tube created a finding of immediate jeopardy for Resident 1.This had the potential to impact three facility residents with G-tubes.* | | | | | | | | | | | |
| *Enter response(s) here and ensure a separate response is provided for each F-tag cited at the IJ level (e.g., F-600, F-602, F-603).* | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 1. **Actions the Facility will Take** | | | | | | | | | | | |
| **F-Tag(s):** | |  | | | | | | | | | |
| *Describe the actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring and indicate when the actions will be complete.* | | | | | | | | | | | |
| **Education / Training** | | | | | | | | | | | |
| *Detail education / training completed, who was educated, and when. Education should start prior to next shift. Education should focus on all staff with the potential to be impacted by the non-compliance and not be limited to staff involved in the actual incident. Include reviews / updates to staff competency, if appropriate. Provide specific dates and times.*  ***Example:***   * *All nursing staff to be educated on ensuring physician order, including appropriate G-tube size; date initiated, percentage completed as of date* * *All nursing staff to be educated on facility policy and procedure on G-tube, including checking placement (initiated (date) and change of G-tube (initiated date). Nurses will complete a competency for G-tube placement/checking per current standards of practice; initiated date, percentage completed as of date.* * *All nursing staff to be educated on the need for RN assessment for any dislodged tube or G-tube needing replacement; date initiated, percentage completed as of date* * *All nursing staff to be educated to check physician orders as to when to replace and when to notify the MD to send to the hospital per policy; date initiated, percentage completed as of date* * *All nursing staff to be educated on resident care plans that include approaches for G-tube care. Nursing staff will be educated on care plan development for G-tube; date initiated, percentage completed as of date* * *All training noted above to be completed by next working shift. Any nurses who do not complete the competency will not be scheduled until completed. Competencies and education will be conducted by nursing management and/or a nurse who has passed the competency education and has been designated to give an education.* | | | | | | | | | | | |
| *Enter response(s) here and ensure a separate response is provided for each F-tag cited at the IJ level (e.g., F-600, F-602, F-603).* | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Systems, Policies and Procedures** | | | | | | | | | | | |
| *Note specific review and/or updates to**policies and procedures that assist in removing the IJ and how they will be implemented / disseminated. Provide dates.*  ***Example:*** *On [date], facility reviewed policy and procedure on G-tube in coordination with medical director, including checking placement and change of G-tube to ensure policy meets current standards of practice. Policy updated related to required components being available for G-tube care to include…* | | | | | | | | | | | |
| *Enter response(s) here and ensure a separate response is provided for each F-tag cited at the IJ level (e.g., F-600, F-602, F-603).* | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Monitoring, Audits, QAPI, and Facility Assessment** | | | | | | | | | | | |
| *Note specific monitoring procedures for policy and procedure updates as well as procedures for audits and mock drills. Detail how the removal plan will be integrated into the quality assurance process (QAPI) and facility assessment, as required.*  ***Example:*** *Nursing managers and DON will conduct audits daily x 2 weeks, weekly x 8 weeks, and monthly x 3 months of residents with G-tubes to ensure all required components are in place. Results of the audits will be reviewed at the QA meeting for further recommendations. Facility assessment will be updated related to G-tube resident care requirements.* | | | | | | | | | | | |
| *Enter response(s) here and ensure a separate response is provided for each F-tag cited at the IJ level (e.g., F-600, F-602, F-603).* | | | | | | | | | | | |
|  | | | | | | | | | | | |