

Survey Guide

Hospitals, Critical Access Hospitals, End Stage Renal Disease Centers, Ambulatory Surgical Centers, Rural Health Clinics, and Outpatient Physical Therapy and Speech Pathology Service Clinics.



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

State of Wisconsin

Department of Health Services

Division of Quality Assurance

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DQA / Bureau of Health Services Contact Information

Central Office – BHS / Acute Care Compliance Section (ACCS)

Wisconsin Department of
Health Services
Division of Quality
Assurance
Attn: BHS, ACCS - Room
E300
201 E. Washington Ave.
Madison, Wisconsin 53703

Phone: 608-266-8481

[Send an Email](#)

Fax: 608-264-9847

For additional contact information see:

Hospitals

<https://www.dhs.wisconsin.gov/regulations/hospital/contacts.htm>

Critical Access Hospitals

<https://www.dhs.wisconsin.gov/regulations/cah/contacts.htm>

End Stage Renal Disease (ESRD) Provider

<https://www.dhs.wisconsin.gov/regulations/esrd/contacts.htm>

Ambulatory Surgical Centers

<https://www.dhs.wisconsin.gov/regulations/asc/contacts.htm>

Rural Health Clinics

<https://www.dhs.wisconsin.gov/regulations/rhc/contacts.htm>

Outpatient Rehabilitation Facilities

<https://www.dhs.wisconsin.gov/regulations/outptrehab/contacts.htm>

Important Links

- Stay up to date with regulatory changes by signing up for the [DQA Listserv](#)
- This DQA publication ([P-63075 Survey Guide – Home Health and Hospice Licensure and Certification](#)) is available online in the [DHS Informative Documents and Publications Library](#)
- The post-survey questionnaire is your opportunity to give us feedback. We need your help as we work together. We want to provide you and patients with good services. Comments and responses to the questions will be used to evaluate and review the survey system and to improve the quality of the survey process. The survey takes a couple of minutes to fill out and can be submitted anonymously. Please fill it out with any positive or constructive feedback.



This survey guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the state and federal legal requirements for hospitals and other health services providers, please rely on the applicable legal requirements.

I. Introduction

The following information has been prepared to serve as a guide to the survey process for hospitals and other health care providers in the state of Wisconsin. The Division of Quality Assurance (DQA) has the responsibility to conduct unannounced surveys at hospitals and other health care providers. The purpose of all surveys is to ensure that the provider entity meets state approval and federal certification requirements. See the Appendix on page 11 of this publication for a list of entity types surveyed by the Bureau of Health Services of the DQA.

II. Overview of the Survey Process

Depending on the entity under review, the survey team will consist of one or more of the following: registered nurse, engineer or architect, dietitian, or pharmacist. The purpose of the survey is to determine whether the entity meets applicable state administrative codes and federal regulations. Survey types include initial certification surveys, recertification surveys, follow up or verification visit surveys, validation surveys for deemed status providers, and complaint surveys initiated by an allegation of entity noncompliance with state or federal regulations.

A. Off-site Survey Preparation

1. Office staff reviews the historical file of the entity kept in the DQA file center.
2. As part of a complaint investigation, the surveyor contacts the complainant for additional information.

B. On-Site Survey Activities

1. Entrance Conference
 - *Staff Introductions.* The surveyor(s) and other DQA staff will make formal introductions to entity staff. The entity will identify a member of their staff to serve as a liaison/contact person during the survey.
 - *Explanation of Visit.* The surveyor(s) will explain the purpose of the visit and the survey process. Time frames for the survey process will also be outlined.
 - *Audio/Video Taping.* If an entity wishes to make an audio or video tape recording of the entrance conference, they must first obtain permission and consent from the surveyor(s). An identical, simultaneous recording is to be given to the surveyor(s). Any audio or video taping or eavesdropping, without the express knowledge and permission of the surveyor(s), is considered impeding the survey process. This may result in termination of the survey.
 - *Certification.* The surveyor(s) will explain the federal certification process and how it differs from the state process.
 - *Preliminary Survey Results and Statement of Deficiencies.* The surveyor(s) will

explain general ramifications of citations that may be issued to an entity.

- *Request for Information.* The surveyor(s) will request information needed to conduct the survey. The entity will also be asked for a current and accurate list of all locations within the primary entity and satellite facilities, where the entity's Medicare/Medicaid provider number is used.

2. Orientation Tour (if necessary)

- The orientation tour allows the surveyor(s) to be introduced to essential staff members and become familiar with the layout of the entity's facilities.
- Surveyors may separate by discipline for the orientation tour depending on the number of surveyors participating in the survey.

3. Environmental Assessment (when appropriate)

The purpose is to observe physical features in the entity's environment that affect patients' quality of life, health, and safety.

4. Quality of Care Assessment

- *Patient Care Review.* Assessment of the quality of patient care may include observations, interviews with staff and patients, review of relevant policies, procedures, bylaws and committee meeting minutes, review of quality assurance activities, and medical record reviews.
- *Personnel Records.* Personnel records of a representative sample of employees, including physicians, are reviewed for compliance with rules and regulations including caregiver background checks as applicable to the provider. Peer review records are not exempt from review by the surveyor(s). The surveyor(s) may request these documents but will not make copies.
- *Authority to Review Patient Medical Records.*
State: Wis. Stat. § 50.35(4), and Wis. Admin. Code § DHS 124.14(1)
Federal: Medicare 42 CFR 1001.1301

5. Satellite Facilities Visit

To ensure that both quality of care and necessary supervision are being provided, visits may be conducted at satellite locations if the entity's Medicare/Medicaid provider number is used at these facilities.

6. Service Systems

The surveyor(s) verifies regulatory compliance of all service systems that are addressed in the State Regulations and/or Conditions of Participation/Conditions of Coverage for the provider (e.g., dietary, medical records, nursing, pharmacy, discharge planning, patients' rights, etc.) by observation, interview, and record review.

C. Information Analysis and Decision Making

The surveyor(s) reviews and analyzes all collected information to decide whether the entity has adhered to all applicable federal and state regulations. The surveyor uses the Medicare State Operations Manual (SOM) as a guide for analysis and decision making. Decision-

making is an ongoing process throughout the survey.

1. Daily Communication

The surveyor(s) will maintain ongoing communication with the entity's liaison. This occurs informally as questions arise. Surveyors will conduct a daily report of findings.

2. Exit Conference

During the exit conference, the surveyor(s) will summarize their findings regarding regulations that are not in compliance and the facts or examples that prove the deficiencies. The entity is given the opportunity to discuss the findings and supply additional information. Because of the ongoing dialogue between surveyor(s) and entity staff during the survey, there should be few instances when the entity is not aware of concerns of the surveyor(s) before the exit conference.

The entity administrator determines which staff, board members, etc. should attend the exit conference. The entity may have legal counsel present but should give advance notice of this to the survey team. Since the survey results are preliminary, surveyors cannot respond to questions raised by legal counsel during exit regarding the findings.

A court reporter may not attend the exit conference. If an entity wishes to make an audio or video tape recording of the exit conference, they must first obtain permission and consent from the surveyor(s). An identical, simultaneous recording is to be given to the surveyor(s). Any audio or videotaping or eavesdropping, without the express knowledge and permission of the surveyor(s), is considered impeding the survey process. This may result in termination of the survey.

State survey findings will be served within 10 working days following the exit conference. If the provider is deemed through an Accrediting Organization, the survey findings report (CMS-2567) will be sent by the Centers for Medicare and Medicaid Services (CMS), Chicago Regional Office.

At the conclusion of the exit, the surveyor(s) will provide information about completing the optional post survey questionnaire.

III. Explanation of Survey Findings

The surveyor(s) will summarize their findings in a final report. If there are findings that the entity is out of compliance with rules or regulations, the surveyor(s) will document and justify their findings to serve as a basis for the entity to analyze its deficient practices or system failures and to develop a plan of correction. Federal survey findings are documented on a CMS-2567. State findings are documented in a similar format.

A. State Rules and Standards of Noncompliance

A violation exists when an entity fails to comply with a state rule or standard. The Department of Health Services promulgates and enforces rules and standards necessary to provide safe and adequate care and treatment of patients and protect the health and safety of the patients and employees of the entities. The department authority is derived from the following statutes and administrative rules:

Wisconsin State Statutes

[Chapter 50:](#) Uniform Licensure

Wisconsin Administrative Code

[Chapter DHS 12](#): Caregiver Background Checks

[Chapter DHS 13](#): Reporting and Investigating Caregiver Misconduct

[Chapter DHS 124](#): Hospitals

B. Federal Deficiencies

A federal deficiency exists when a provider/supplier fails to comply with a federal regulation. Entities electing to participate in the federally sponsored Title XVIII (Medicare) and Title XIX (Medicaid) programs will be surveyed for compliance with federal regulations. A table with federal regulation citations is attached to this guide. There are four categories in which federal deficiencies are recorded, beginning with the most severe:

1. *Statutory Requirements*. A statutory requirement created by an Act of Congress. Noncompliance with a statutory requirement may subject an entity to termination of its provider agreement with Medicare and/or Medicaid.
2. *Conditions of Participation/Conditions for Coverage*. The essential requirements of each of the major divisions of administration and other services are known as Conditions of Participation/Coverage. A failure to meet a Condition of Participation/ Coverage indicates a breakdown in one of the major health care systems of the provider. Any existing agreement may be subject to cancellation or termination if a Condition of Participation/Coverage is not met.
3. *Standards*. A standard is a major subdivision of the requirements in the Conditions of Participation/Conditions for Coverage. Noncompliance with a standard may be so serious that it causes noncompliance with the Condition of Participation/Coverage.
4. *Requirements*. A requirement is a subdivision of a standard in some provider types, including hospitals.

IV. Plan of Corrections

A statement of survey findings may not be appealed. However, the entity is offered an opportunity to consult with a supervisor.

A. Content

1. The provider's plan of correction (POC) should be prepared in accordance with DQA instructions and signed by an authorized representative of the provider.
2. To be considered complete, each action plan should include the following:
 - What the entity will do to correct the citation and ensure continued compliance
 - How correction will be accomplished and monitored
 - Who will implement the plan and monitor for future compliance
 - When correction will be completed
3. Correction should be accomplished within the timeframe specified in the information accompanying the survey findings report (CMS-2567); typically between 45 and 60 calendar days.

B. Correction of State Violations

1. The entity may receive a Wisconsin statement of survey findings from DQA following the exit conference if there are any findings specific to state regulations. If the entity has questions regarding the survey findings, it may consult with the surveyor's supervisor informally concerning compliance and noncompliance with rules and standards. [Wis. Stat. § [50.36\(4\)](#)]
2. An entity found out of compliance with state rules and standards is requested to submit a plan of correction concerning the state violations. Failure to submit a POC is subject to public disclosure under public record disclosure rules. The POC should be submitted to the attention of the lead surveyor.

C. Correction of Federal Deficiencies

A plan of correction is required for all federal deficiencies to retain certification in the Medicare and/or Medicaid programs.

A federal plan of correction from a non-accredited entity that does not meet content standards will be rejected. In such cases, the Bureau will identify why the POC was not acceptable and request that revisions be made.

A federal plan of correction must be submitted to the office that served the statement of deficiency. The entity should carefully review the cover letter to determine whether the plan should be submitted to CMS Chicago Regional Office or the DQA surveyor.

Failure to submit an acceptable POC within 10 calendar days could result in nonrenewal of the entity's Medicare or Medicaid provider agreement.

Confirmation of an acceptable Plan of Correction will be provided electronically by the lead surveyor. A provider may want to save this e-mail communication as it is often needed for insurance and other purposes.

D. Verification of Correction

DQA may verify correction of all citations after the accepted completion dates have passed through an unannounced onsite visit, or, when appropriate, through desk review.

E. Failure to Correct Deficiencies

Failure to correct a deficiency may result in the following adverse actions:

1. The entity may be subject to license non-renewal, license revocation, or may be issued a conditional license.
2. Entities participating in the Medicare and Medicaid programs are subject to termination of certification when certain criteria are not met, e.g., Conditions of Participation/Coverage not corrected within 45 calendar days or less.
3. The Department of Health Services may, in the event of an emergency condition that imminently threatens the health or safety of patients of a hospital, suspend new admissions to all or a part of the hospital until the Department decides that the hospital has removed or corrected the causes of deficiencies creating the emergency. [Wis. Stat. § 50.39(5)(a)]

V. Appeals Process

The following information is for general purposes only. An entity should refer to the applicable legal requirements in effect at the time it receives notice of a Department or federal action that may be subject to appeal.

A. State Appeals

An entity may appeal state adverse actions or decisions of the Department of Health Services in accordance with Wis. Stat. ch. 227. A statement of survey findings may not be appealed. However, the entity is offered an opportunity to consult with a supervisor regarding survey findings before submitting a corrective action plan.

1. A written hearing request must be sent within 10 calendar days of receipt of the notices of an adverse action. Submit requests to:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request must include a copy of the notice of action that is being contested.

2. A written request for a hearing on termination/non-renewal of Medicaid certification must be sent within 20 calendar days of receipt of the notices of action. A written request for a hearing on revocation or non-renewal of a license must be sent within 10 calendar days of receipt of the notice. Send hearing requests to:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Include a copy of the notice of action that is being contested.

B. Federal Appeals

Information about federal appeals is provided in the CMS certification letter sent to the entity with the Statement of Deficiencies.

VI. Complaints

A. Entity Patient Complaints

The Division of Quality Assurance responds to two types of health care complaints, entity practices and caregiver misconduct. The Bureau of Health Services receives complaints and conducts complaint surveys for entity practice concerns such as inappropriate or inadequate health care, lack of entity staff training, understaffing, poor quality care, etc.

Please see <https://www.dhs.wisconsin.gov/guide/complaints.htm> for more information on filing a complaint.

A patient may use any of the following methods for submitting a complaint:

- **Online:** File a complaint online by completing the [Complaint Intake Survey, F-00607 \(link is external\)](#)
- **Telephone** toll-free hotline: 1-800-642-6552

Hospitals and other health services providers are required to provide patients with the written address of the Division of Quality Assurance to allow patients to submit complaints directly to the Division. Complaints may be submitted in writing to:

Wisconsin Department of Health Services
Division of Quality Assurance
Attn: BHS, ACCS - Room E300
201 E. Washington Ave.
Madison, Wisconsin 53703

Emergency Medical Treatment and Labor Acts (EMTALA)

Medicare participating hospitals, including CAHs that have a dedicated emergency department, must meet the federal Emergency Medical Treatment and Labor Acts (EMTALA) statute and regulations found in 42 CFR 489.24 and related requirements at 42 CFR 489.20(l), (m), (q), and (r). All hospitals are expected to be familiar with, and in compliance with, this set of regulations.

EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. EMTALA prescribes requirements for appropriate transfer of individuals with an emergency medical condition.

DQA surveyors conduct EMTALA investigations as fact-finders for CMS. CMS determines, with the assistance of expert physician review when indicated, whether an EMTALA violation has occurred. Hospitals that violate the EMTALA provisions are subject to civil monetary penalties. If the conditions leading to the EMTALA violation are not corrected, CMS may terminate the hospital's Medicare certification.

B. Caregiver Misconduct

Complaints about caregiver misconduct relate to specific incidents between a caregiver and patient such as:

- Abuse — hitting, slapping, verbal or sexual actions;
- Neglect — intentional carelessness or disregard of policy or care plan;
- Misappropriation — theft; using property without consent, such as telephone or credit cards.

All entities regulated by the Division of Quality Assurance must immediately protect patients from subsequent incidents of caregiver misconduct, investigate all allegations of caregiver misconduct, and determine whether or not the allegation must be reported to DQA.

Swing Bed Units: please note that swing bed units of acute care and critical access hospitals are required by federal law to report alleged incidents of Resident Mistreatment, Neglect, or Abuse immediately and no later than 24 hours after discovery of the incident. Swing bed units also must submit [DQA Form F-62447](#) Misconduct Incident Report within five working days.

To report allegations of caregiver misconduct see [DQA Form F-62447](#) — Misconduct Incident Report.

The [Misconduct Incident Reporting \(MIR\)](#) system is a secure, web-based system for entities to

submit the Misconduct Incident Report, F-62447 form.

Entities must create and register an account to access the MIR system. It may take up to three business days to process a registration. Refer to [DQA Misconduct Incident Reporting \(MIR\) System: How to Sign Up, P-02312](#) (PDF) for instructions.

If the [MIR system](#) cannot be accessed, reports will be accepted via postal mail, fax, or email at:

Department of Health Services
Division of Quality Assurance
Office of Caregiver Quality
Wisconsin Department of Health Services
Division of Quality Assurance
Attn: OCQ - Room E300
201 E. Washington Ave.
Madison, Wisconsin 53703

Fax: 608-264-6340

Email: DHSCaregiverIntake@wi.gov

VII. Appendix

Regulations, Rules, and Statutes

Enforced by the Division of Quality Assurance, Bureau of Health Services

Provider Type	Code of Federal Regulations	Wisconsin Administrative Code
Ambulatory Surgical Center	42 CFR 416	N/A
Comprehensive Outpatient Rehabilitation Facilities	42 CFR 485.50 to 485.74	N/A
Critical Access Hospitals	42 CFR 485.601 to 485.649 *	DHS 124
End Stage Renal Disease	42 CFR 494	N/A
Hospital General & Specialty	42 CFR 482.1 to 482.62	DHS 124
Psychiatric and Rehabilitation Prospective Payment Exempt Unit	42 CFR 412	N/A
Outpatient Physical Therapy or Speech Pathology Services	42 CFR 485.701 to 485.729	N/A
Rural Health Clinic	42 CFR 491	N/A
Swing Bed	42 CFR 482.58	N/A

* 42 CFR 485.645 Optional: Special Requirements for CAH Providers of LTC – “Swing Bed”

Note: N/A = Not Applicable

DHS = Department of Health Services

CFR = Code of Federal Regulations