2026 Oregon Rural Health Conference Presentation Slides

OREGON HEALTH AUTHORITY

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RHC Compliance Clarity

43rd Annual Rural Health Conference

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Rural Health Clinics

End Stage Renal Disease Facilities

Agenda

1. Agency Overview
2. Survey Process
3. Common Citations
4. FAQs
5. Additional Role of the SA
6. Questions & Contact Information

Overview of OHA

- Oregon Health Authority
  - Public Health
    - Center for Health Protection
      - Health Care Regulation & Quality Improvement Section
        - Health Facility Licensing & Certification Program
          - Survey and Certification
          - Hospital Staffing
          - Facilities Planning and Safety

Health Facility Licensing & Certification

Three programs

- Facilities Planning & Safety (FPS) - Conducts reviews of acute and long-term health care facility construction projects – Matt Gilman, Manager
- Survey & Certification – Jerry Walker, Manager
- Hospital Staffing and Regulatory – Anna Davis, Manager

Regulated non-long term care entities:

Hospitals (CAH, ACU, PSY) including Satellites

Outpatient Renal Dialysis Facilities (ESRDs)

Home Health Agencies

Freestanding Birth Center

Non-Transplanted Anatomical Research Recovery

Portable X-Ray

Hospital Nurse Staffing

Hemodialysis Techs

Rural Health Clinics/FQHCs

In-Home Care Agencies

Extended Stay Centers

Ambulatory Surgical Centers

Hospice Agencies

Out-Patient Therapy

Caregiver Registries

Special Inpatient Care Facilities

Survey and Certification

Team of:

- 10 surveyors specializing in one or more facility types. CMS surveyors are RNs.
- FPS Administrative assistants also assist Survey & Certification
- 2 managers

Program Workload:

- **Fixed:** Standard surveys required to satisfy state licensure &/or federal certification requirements
- **Variable:** Federal and state complaint investigations, federal EMTALA reports & immediate jeopardy situations.

Oregon Rural Health Clinics

RHCs (as of October 2026)

Total: 102 Active Clinics

- Deemed: 16 (Surveyed by Accrediting Organization)
- Non-Deemed: 86 (Surveyed by CMS representatives through the State Agency)

Annual RHC Workload

- RHC initial Certification Surveys: If time permits; AO is an alternative
- RHC Recertification Surveys: No set number, but has been 10-15 per year
- RHC/FQHC Complaint Investigations: varies
- Changes of ownership

CMS Priority Work for RHCs

Tier 1

Complaint Investigations prioritized as IJ – Non-deemed and deemed within 2 days

Tier 2

Initial Certification – Provider/Supplier's application to Medicare exceeds 150 days with a deeming option – If more than 150 days has passes since the MAC has recommended approval of the application

Complaint investigations prioritized as non-IJ High

Tier 3

7- year interval for recertifications

Initial certifications

Complaint investigations prioritized as Non-IJ Medium

Tier 4

Seldom. Clinics can be surveyed at 6-year intervals

Survey Process

Pre-Survey Preparation

Develop survey plan and review facility information including:

- Mid-level staffing waivers; Visiting Nurse Services offered; Ownership; Services provided; Prior surveys & complaints and review of facility's location and website information

- **ALL RHC surveys, including initial certification, recertification, complaint and revisit, are unannounced. Once a surveyor enters a facility, the survey must proceed, even if an administrator is not present.**

Surveyors will typically wait no more than 10-15 minutes to start a survey. If an administrator is not on-site, then there must be someone available as we get started.

- **Refer to 42 CFR 1001.1301 – Failure to grant immediate access**
- **Refer to 42 CFR 489.53(13) – Termination by CMS -** The provider or supplier refused to permit copying of any records or other information by, or on behalf of CMS, as necessary to determine or verify compliance with participation requirements.

Survey Process

RHC surveys typically are completed in 1 day by 1 surveyor

Complaint surveys can be done with 1 surveyor and can take as long as needed to complete investigation

Entrance Activities

- The survey begins when we walk into the lobby. We will introduce ourselves and why we are on-site. We will ask for a room to work during the survey.
- Once we get set up in a room, usually the facility's conference room, we begin the entrance conference with the available administrator and the survey process is explained
- Provide needs list detailing documents to be provided to surveyor

Survey Process

- Entrance Conference
  - It is up to the facility to decide who will participate in the entrance conference.
  - Surveyors go over the “needs list” that details the documents to be provided to surveyor.
  - CMS 29 to be completed by facility administration before end of survey.

Survey Process

Information Gathering Includes

- On-site observations
- Patient Observation
- Interviews with staff and patients
- RHC binder review - Policies, procedures, contracts, program evaluation(s)
- Personnel record review
- Medical record review of approximately 20 patients seen at the facility over the last 2 months
- Emergency Preparedness review

- **Exit Conference with Facility Administration**

Survey team shares preliminary findings & next steps (if exit conference is recorded, all parties must have a copy. AI may not be involved)

Note: Survey closure date will be later if survey team asks provider to submit additional information to clarify outstanding questions

Survey Process

10 Business Days Post Survey

- **Agency Issues Survey Report**

Statement of Deficiencies (SOD), CMS form 2567, documents any deficiencies identified during on-site survey or complaint investigation

Issued to facility leadership. Facility will receive one SOD that includes both Federal and EP deficiencies **10 Calendar Days After Facility Receives SOD Report**

- **Facility Submits Plan of Corrections (POC)**

Written response to each deficiency identified during onsite audit or complaint investigation

POC documents facility's plan to return to compliance

Currently, we are focusing heavily for facilities to include the processes that led to the deficiency, basically a root cause analysis

CMS guidelines for unacceptable POCs

Revisits

- **Conditions Out - Required; Standard Tags - Agency's Option:** Surveyors conduct a follow-up survey (within 45-days from exit date) to assess implementation of provider's POC & abatement of cited condition-level deficiencies

Most Common Citations

RHC Citations are Federal Only

Conditions for Certification are located at 42 CFR Part 419, Subpart A

Staffing and Staff Responsibilities

J 123 – Policies are developed with the advice of a group of professional personnel that includes one or more physician(s) and one or more physician assistant or nurse practitioner. At least one member is not a member of the clinic staff … These policies are reviewed at least biennially

Most Common Citations

Physical Plant and Environment

- **J 040** – Physical Environment Condition-level tag.
- **J 041** – The clinic is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provisions of direct services.
- **J 042** – Maintenance: The clinic has a preventative maintenance program to ensure that all essential mechanical, electrical and patient-care equipment is maintained in safe operating condition
- **J 043** – Drugs and biologicals are appropriately stored
- **J 044** – The premises are clean and orderly. Includes infection prevention measures

Most Common Citations

Organizational Structure

- **J 101** – Staffing and Staff Responsibilities

Periodically reviews patient records – Clinical record review completed by physician(s) and mid-level clinicians **Patient Health Records**

- **J 152** – Records Systems

Program Evaluation

- **J 161** – The clinic carries out, or arranges for, a biennial evaluation of its total program.

Utilization of services - # of patients and volume of services

Representative of active and closed records

Biennial review of clinic's health care policies (along with tag 123)

Most Common Citations – Emergency Preparedness

Implemented in November 2019 for 17 provider types.

For RHCs, Emergency Preparedness regulations are surveyed as part of all recertification surveys

Emergency Preparedness Program Shared Elements (all provider types):

- Risk Assessment and Planning – Develop emergency plan on documented facility-based and community–based risk assessments, using an all-hazards approach, focus on capacities and capabilities, update every 2 years
- Policies and Procedures – Develop P&Ps based on emergency plan, risk assessment, and communication plan, update every 2 years
- Communication Plan – Develop communications plan that meets state and federal standards and coordinates care within facility, across providers, with state/local public health departments and emergency management systems, update every 2 years
- Training and Testing – Develop training & testing programs, P&Ps, conduct drills & exercises, document analysis of drills and exercises

(7) Resources: CMS website downloads; SOM Appendix Z

Most Common Citations – Emergency Preparedness

- **E0037 – EP Training Requirements**: Develop training programs that cover emergency preparedness policies and procedures
  - Initial training to all new and existing staff, individuals providing services under arrangement and volunteers-ALL staff
  - Provide emergency preparedness training at least every 2 years
  - Maintain documentation of all emergency preparedness training

- **E0039 – EP Testing Requirements:** Must conduct exercises to test the emergency plan annually
  - Participate in a full-scale exercise that is community-based every 2 years (if a community-based exercise is unavailable, conduct an individual facility-based functional exercise
  - Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise
  - Analyze the response to and maintain documentation of all drills, tabletop exercises and emergency events

Most Common Citations – Emergency Preparedness

- **E0001– Establishment of the Emergency Program:** The facility must establish and maintain a comprehensive EP program. This is a condition-level deficiency
- **E0004 – Develop EP Plan:** The facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years
- **E0006 – Plan based on All-Hazards Risk Assessment:** Emergency plan must be based on, and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Must include strategies for addressing emergency events identified by the risk assessment.
  - Emerging infectious diseases need to be included as part of the all-hazards approach

Most Common Citations – Emergency Preparedness

- **E0042 – Integrated Health Systems:** If a clinic is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated EP Plan, the clinic may choose to participate in the system's coordinated EP program.
- If a clinic elects to participate in a unified plan, then:

- The clinic must actively participate in the development of the unified plan
- The plan must be developed to take into consideration the clinic's unique circumstances, patient populations and services offered
- Each clinic must be capable of actively using, and is in compliance, of the plan
- The clinic must have documentation of both the community-based and individual facility-based risk assessments using an all-hazards approach
- The clinic must be actively involved in the annual review of the program requirements and any program updates
- Each clinic must maintain individual training records of staff and records all training exercises

FAQs

1. Medical Director on-site
2. Infection Control
3. Physical Environment
4. Medications
5. Personnel Records
6. Specific policies and procedures
7. Emergency Preparedness

FAQ – Medical Director

How much time does the Medical Director need to be on-site?

- While there is no prescribed timeframe, the ‘medical director/physician’ is responsible for the overall medical operation of the center, and the three, overarching duties at 491.8(b)
- §491.8(b) Physician responsibilities. The physician performs the following:
  - Provide medical direction for the clinic’s health care activities and consultation for, and medical supervision of, the health care staff
  - In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the clinic's or center's written policies and the services provided to Federal program patients
  - Periodically reviews the clinic's or center's patient records, provides medical orders, and ***provides medical care services to the patients of the clinic or center***

FAQ – Medical Director (continued)

- CMS does not prescribe the ‘medical director’s’ amount of effort in terms of time; the amount of effort depends on the size and complexity of the clinic, and ultimately the clinic’s policies and procedures
- Surveyors will defer to the clinic’s policy outlining the responsibilities of the medical director and verify the medical director provides patient services on-site
- If there is not a clinician on-site, the clinic can not have patients in the clinic except for non-health related issues, i.e insurance questions. There must be an MD, NP, PA or SW in the clinic.

FAQ – Infection Control

- Sterilizers
- TB surveillance for all health care staff
- Placement of sharps containers
- Cloth pillowcases
- What can be in the waiting area
- CMS guidance is to use the infection control worksheet used by ASCs:
  www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_351.pdf
- Clean and dirty sinks
- No rips, tears or holes in exam table or chair upholstery in patient areas.
- Hand hygiene performed by staff during observations

FAQ – Physical Environment

- Equipment lists are not explicitly required, but preventative maintenance documentation of biomedical equipment is reviewed.
- Log sheets will be reviewed (AEDs, fridge temps, lab equipment, eye wash stations)
- O2 tanks need to be secured, empty tanks separated from full tanks.
- No holes or exposed plaster in walls; countertops clean, no chips or missing chunks of laminate
- Fire extinguishers checked monthly, annual fire inspection
- Floors must be in good shape, no gaps and no carpets in exam rooms
- No uncovered incandescent light bulbs in procedure lamps

FAQ – Medications

- § 491.9(b)(3)(iii) Patient care policies:

  The clinic must have a complete medication policy (one of the 3 required policies that need to be specific for the individual clinic) that describes the STORAGE, HANDLING and ADMINISTRATION of drugs and biologicals

- Acceptable labeling of multi-dose vials
- Storage of controlled substances
- Medication/Vaccine storage
- Drug sample inventory

FAQ – Personnel Records

- Personnel record review can take some time to complete
- The personnel files do not have to be kept on-site at the clinic. Logistics can be worked out.
- Use of a worksheet helps to keep the record review organized. Someone from HR or the clinic can fill out the worksheet, but surveyors will want to verify documentation.
- The minimum reviewed in personnel files: Licensure; DEA certification; required emergency trainings (BLS, ACLS and PALS); TB surveillance; and EP training. The worksheet contains a more complete list.
- The clinic must employ a PA or NP. If a small clinic has only 1 mid-level practitioner that resigns or takes a leave of absence, then the clinic must apply for a staffing waiver.

Clinic Policies/Procedures specific to clinic J124 and J125

- A description of the services the clinic furnishes, directly or through agreement or arrangement
- Guidelines for the medical management of health problems which include the conditions requiring medical consultation/referral; the maintenance of health records; procedures for review and evaluation of services
- Rules for storage, handling and administration of drugs and biologicals

FAQ – Emergency Preparedness

- Clinics must complete, at the minimum, an annual fire drill that includes an after-action report
- If the clinic uses an actual disaster for testing requirements, the clinic must document the EP plan was activated and there should be an after-action
- Training includes all clinic personnel

Additional Tasks of the State Agency (SA)

Administrative

- Name changes
- Administrator changes
- Voluntary terminations
- Address changes
- Addition of services
- Changes of Ownership
- Initial licensure
- Initial certifications
- Waivers

SA Contact Information

Program Information:
All correspondence should go through our general mailbox
mailbox.hclc@odhsoha.oregon.gov
971-673-0540
www.healthoregon.org/hflc

Additional Resources:

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