Abuse and Neglect/ Psychosocial Outcome Severity Guide

Presenters:

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10/13/2022

Objectives

- Understand the regulatory changes to Abuse, Neglect, Reporting (F600 and F609)
- Understand how the new guidance will affect reporting requirements
- Understand how the surveyors will review this area(s) for compliance

Changes to F600 – F610

Flag	Tag Subject	Key Changes to Regulation or Interpretive Guidelines	Significant Change/Technical Correction
F600	Abuse/Neglect	Removed language from sexual abuse. Included additional guidance related to neglect.	Significant
F602	Misapprop/Exploit	Minor changes to update references to Appendix P	Technical
F603	Involuntary Seclusion	Minor changes to update references to Appendix P	Technical
F604	Physical Restraints	Clarification of when a bed rail meets the definition of a physical restraint	Significant
F605	Chemical Restraints	Minor changes to update references to Appendix P	Technical
F606	Not Employ Staff w/ Adverse Action	Revised intent to match the regulation text	Technical
F607	Abuse Policies	Added guidance for coordination with QAPI and provisions the former 608	Significant
F608	Reporting of Suspected Crimes	Deleted – Guidance is at F607/F609	Significant
F609	Reporting Alleged Violations	Revised definitions & guidance related to the timing of reports, added language related to what facilities must report, added provisions from the former F608	Significant

F600 Abuse

- All resident-to-resident altercations do not result in abuse. All incidents must be investigated.
- Removed the language: “Residents without the capacity to consent to sexual activity may not engage in sexual activity.”
- Added language: “The facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity.”

F600 Neglect Definition

- Indifference or disregard for resident care, comfort or safety, resulting in or may result in, physical harm, pain, mental anguish or emotional distress.
- Noncompliance at Quality of Care does not always result in Neglect at F600.

Changes to F607, F608 and F609

- F607 will be used for citations related to the failure to develop and implement written policies and procedures;
    - Policies
        - Protections for abuse to include reporting of suspected crimes
        - QAPI coordination and oversight for prohibiting abuse and neglect
        - Posting conspicuous signage for employee regarding prohibited retaliation against employees reporting a suspected or witnessed crime
- F608 - deleted
- F609 will be used for citations related to the facility's failure to ensure the reporting of suspected crimes and notifying covered individuals of their reporting responsibilities

Key Changes for F609-Reporting of Suspected Crimes

Examples of actions that policies and procedures should address:

- Orienting new staff and assuring that covered individuals are annually notified;
- Identifying barriers and implementing interventions to remove barriers and promote a culture of transparency and reporting;
- Working with law enforcement annually to determine which crimes are reported;
- Assuring that covered individuals can identify what is reportable and providing in-service training; and
- Providing periodic drills.

Key Changes for F609-Reporting of Suspected Crimes

- Surveyors will be investigating to determine the facility's compliance to develop and/or implement policies and procedures for reporting suspected crimes.
- If the covered individual refuses to report, or the surveyor cannot verify that the report was done, the surveyor will consult with his/her supervisor immediately.

F609-Reporting of Alleged Violations

Clarified guidance for alleged violations which must be reported:

- Staff to resident abuse
- Resident to resident altercations.

Resident to Resident Altercations-Mental/Verbal Conflict

Required to Report:

- Threats of violence
- Inappropriate sexual comments that are used in a deliberately threatening manner
- Inappropriate threatening that offend, humiliate, or demean a resident
- Taking and/or distributing demeaning or humiliating photographs or recordings or residents through social media or multimedia messaging

Resident to Resident Altercations-Mental/Verbal Conflict

Not Required to Report:

- Non-targeted outburst
- Residents with certain conditions such as Huntington’s/Tourette’s
- Arguments or disagreements, which do not include any behavior

Resident to Resident Altercations-Sexual Contact

Not Required to Report:

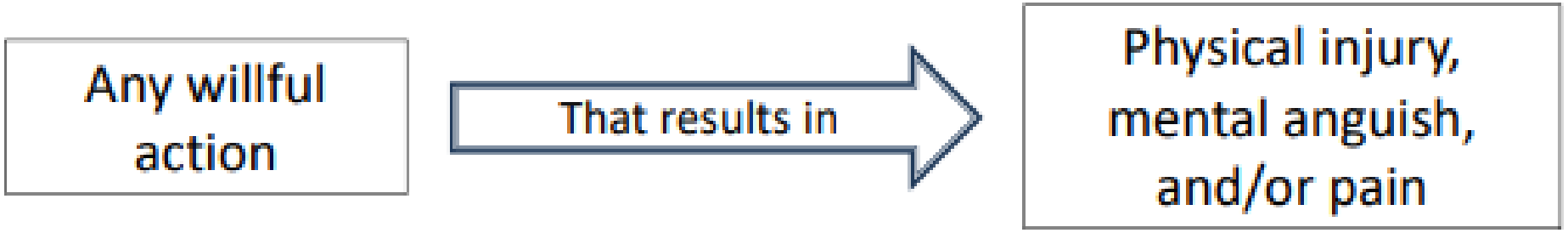
- Consensual sexual contact between residents who have the capacity to consent to sexual activity
- Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or non-verbal cues
- Sexual activity between residents in a relationship, married couples or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal cues.

Resident to Resident Altercations-Sexual Contact

Required to Report

- Touching a resident's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues
- Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown
- Instances where the alleged victim is transferred to a hospital for examination and/or treatment of injuries resulting from possible sexual abuse
- Other unwanted actions for the purpose of sexual arousal or sexual gratification
- Forced observation of masturbation, or pornography
- Forced, coerced or extorted sexual activity
- Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident

Resident to Resident Altercations-Physical



Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

Willful Action

Willful actions include, but are not limited to, the following:

- Hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing, and shoving
- The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm

Physical Injury - Reportable

A physical injury resulting from the willful action including, but not limited to, the following:

- Death
- Injury requiring medical attention beyond first aid (such as a cut requiring suturing or an injury requiring transfer to a hospital for examination and/or treatment)
- Fracture(s), subdural hematoma, concussion
- Bruises
- Facial injury(ies), such as broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks

Mental Anguish - Reportable

Psychosocial outcomes resulting from the willful action including, but not limited to, the following:

- Fear of a person or place or of being left alone or of being in the dark, disturbed sleep, nightmares
- Changes in behavior, including aggressive or disruptive behavior toward a specific person
- Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts

* There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.

Pain - Reportable

Pain resulting from the willful action including, but not limited to, the following:

- Complaints of pain related to the altercation
- Onset of pain evidenced by nonverbal indicators, such as
  - Groaning, crying, screaming
  - Grimacing, clenching of the jaw
  - Resistance to being touched
  - Rubbing/guarding body part

Examples of Non-Reportable Events

- The general examples of physical altercations below illustrate possible cases that would likely **NOT** need to be reported, as long as it is not a willful action that results in physical injury, mental anguish, or pain. Every case is fact specific and all facts, circumstances and conditions involving the event/occurrence would need to be examined.
- A resident lightly taps another resident to stop an irritating behavior or get attention, with no resulting physical injury, mental anguish, or pain.
- A resident who is slow, impedes the pathway of another resident, such as in the dining room, the other resident nudges the resident out of the way to get to his/her table faster, but there is no harm to the victim.
- A resident who swats at another resident who is trying to take some food off his/her plate, and no physical injury, mental anguish, or pain has occurred.

Reportable Events Related to Potential Neglect

Examples of events to be reported include, but are not limited to, the following:

- Failure to meet payroll or pay supplier bills resulting in residents not receiving goods or services, such as
  - Insufficient staff (including the night shift and weekends) resulting in the lack of provision for resident's care needs (e.g., residents who need continuous skilled nursing care or supervision, residents with cognitive deficits requiring continuous supervision); or
  - Lack of essential supplies or equipment such as incontinence supplies, wound care supplies, or oxygen equipment or adaptive equipment according to the needs of the resident(s); or
  - Lack of sufficient amounts of food to meet the residents' nutritional needs.
- Staff repeatedly ignoring residents' needs for assistance with activities of daily living, resulting in residents remaining in bed when they want to be up and repeatedly missing activities; or residents being left in fecal material or urine.
- Failure to oversee the management of pain for a resident resulting in a resident not receiving required medications or treatments, leading to prolonged excruciating pain.
- Failure to implement and monitor care planned interventions, resulting in repeated failures to provide necessary care and services to prevent the development a new avoidable pressure ulcer that develops into a Stage 3 or 4 pressure ulcer.

Psychosocial Outcome Severity Guide and Citations at F600-Abuse

Key Changes

- Psychosocial Outcome Severity Guide
- Appendix PP, Tag F600-Deficiency Categorization

New Definitions

- "**Fear**" is defined as an unpleasant often strong emotion caused by anticipation or awareness of danger.
- "**Psychosocial"** refers to the combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness.
- The **"reasonable person concept"** refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome that a deficiency may have had on a reasonable person in the resident's position.

Investigating psychosocial outcomes

In the revised Psychosocial Outcome Severity Guide, CMS directs surveyors how to investigate psychosocial outcomes to the resident.

- Surveyors obtain evidence through observation, interview and record review of the impacted resident.
- collect information regarding the resident's verbal and non-verbal responses.
- If a psychosocial outcome is identified, surveyors will compare the resident's behavior and mood before and after the noncompliance, and any identified history of similar incidents.

When a surveyor cannot conduct an interview with the resident for any reason, or there are no apparent or documented changes to behavior;

- the surveyor will attempt to interview other individuals who are familiar with the resident's routine or lifestyle, such as the resident's representative or family, direct care staff, resident's clinician, or the ombudsman.
- If no such changes are apparent or documented, the surveyor will consider the response a **reasonable person** would exhibit considering the triggering event.

When will the Reasonable Person Concept be applied?

- There are no apparent or documented changes to the resident's behavior.
- When a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome.
- When a resident's reaction is markedly different with the level of reaction a reasonable person in the resident's position would have to the deficient practice.

How will this be applied to the investigation process?

Complaint Investigations

- Prep Complaint/Self Report – review facility reports that can be investigated and include in sample.
- Contact complainant and Ombudsman
- Entrance
- Request Census/Staff Roster/Access to Electronic Records
- Start observations
- Interview Residents and Staff
- Interview family (if applicable)
- Review records and policies to confirm information received through interview.
- Interview management
- Surveyor will need to determine if:
  - abuse occurred
  - facility took action to prevent/protect residents from abuse/further abuse
  - S/S level will need to be determined
- Continue investigation if more information is needed until compliance determination can be made.

Long-term Care Survey Process – Recertifications

- Prep/Complaint - Indicate whether the facility has a **history** of **abuse** allegations, **patterns of abuse**, or **citations** since the prior standard survey.
- Survey teams would review complaints and FRI's that have been reported since the last recertification survey during offsite prep.
- Any identified abuse concern from the initial pool process.
- Sample Process
- Investigation – same as for complaint investigation
- Nursing Homes | CMS - Pathways

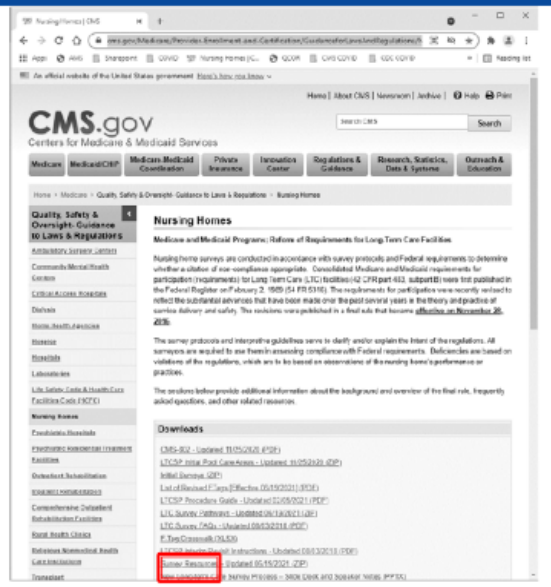
Resources

[Nursing Homes | CMS]

- Appendix PP
- Pathways
- [Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide | CMS]

Where to Find the Psychosocial Outcome Severity Guide

- File location: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes under Survey Resources



Thank you!

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Update to Complaints and Incidents

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10/13/2022

Objectives

- Understand the regulatory changes to F609 per Chapter 5 SOM
- Understand how the changes will affect the reporting process
- Understand changes to the triage process

Facility Reported Incidents

Nursing homes send the following types of incidents to the State Survey Agency:

- All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property;
- The results of all facility investigations involving alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property; and
- Reasonable suspicions of crimes against nursing home residents.

Facility Reported Incidents – Initial Report

The facility must provide in its report sufficient information to describe the alleged violation and indicate how residents are being protected [See §483.12(c)(3)- F609 -Reporting of Alleged Violations]. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report, so that state agencies can initiate action necessary to oversee the protection of nursing home residents. See Exhibit 358 for a sample form for initial reporting.

Exhibit 358 - Sample Form for Facility Reported Incidents (cms.gov)

Current NHIR report is being revised to reflect the changes to the initial report which will include:

- Date/Time/Name when staff became aware of the incident
- Date/Time NHA was notified of the incident and by whom.
- Current location of the alleged victim (such as discharged-where to?, hospitalized)

Initial Report -Continued

- Alleged Perpetrator - specific title/position
- Contact info for the AP
- Who made the allegation and relationship to the alleged victim
- Were other agencies notified. If so, identify the date/time and to whom it was reported such as LTCO, law enforcement or any other agency. Agencies could include, medical examiner, board of nursing, and board of medical practice.
- Description of change in resident's behavior, different from normal baseline related to psychosocial changes
- Witnesses – identify their position/title

Initial Report - Continued

Provide all steps taken immediately to ensure resident(s) are protected. Such steps could include:

- Immediate assessment of the alleged victim and provision of medical treatment as necessary;
    - Evaluation of whether the alleged victim feels safe and if he/she does not feel safe, taking immediate steps to protect the resident, such as a room relocation and/or increased supervision;
- Immediate notification to the alleged perpetrator's (if a resident) and/or the alleged victim's physician and the resident representative when there is injury, a significant change in condition or status, and/or a need to alter treatment significantly;
    - If the alleged perpetrator is facility staff, removal of the alleged perpetrator's access to the alleged victim and other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents;
    - If the alleged perpetrator is a resident or visitor, removal of the alleged perpetrator's access to the alleged victim and, as appropriate, other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents;
- Other measures the facility is taking to prevent further potential abuse, neglect, exploitation, and misappropriation of resident property

Reporting Suspicion of Crimes

NOTE:

If the SA receives information that a suspected crime may have occurred in a facility and there is indication that it has not been reported or the SA cannot verify that a report was made to law enforcement, then the SA forwards the information from the initial report immediately to law enforcement.

The SA must follow applicable laws and regulations related to information disclosures, privacy and confidentiality, as it makes referrals.

Notification to Law Enforcement

Notification to law enforcement (LE)

- the name of the entity;
- name of the LE contact person;
- who reported to LE;
- the date/time report was made;
- any copies of the report made to LE (if available);
- what information was conveyed to LE;
- and police report number provided by LE.

Priority Determination

Immediate Jeopardy (IJ)

- In cases where the initial report indicates the following, the SA must initiate an onsite survey within three business days of receipt of the initial report:

  1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident, and

  2) The facility has not implemented adequate protection for all residents, or the SA has not received sufficient evidence to conclude that residents are adequately protected.

- In cases where the initial report indicates the following, the SA must initiate an onsite survey within seven business days of receipt of the initial report:

  1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident, and

  2) The facility has potentially implemented adequate protection for all residents.

Priority Determination - Continued

Non-IJ High

The alleged noncompliance may have caused actual physical and/or psychosocial harm to the resident(s), the SA must initiate an onsite survey within an annual average of 15 business days of receipt of the initial report, not to exceed 18 business days.

Non- IJ Medium

Facility-reported incidents are assigned a "medium" priority if the alleged noncompliance with one or more requirements caused no actual physical and/or psychosocial harm but there is the potential for more than minimal harm to the resident(s) and the facility has not provided an adequate response to the allegation or it is not known whether the facility provided an adequate response. For complaints and facility-reported incidents that are assigned a "medium" priority, the SA must initiate an onsite survey within 45 calendar days of receipt of the initial report.

Non-IJ Low

Intakes are assigned a "low" priority if the alleged noncompliance with one or more requirements may have *no actual harm with a potential for minimal harm. SA must track/trend for potential focus areas during the next onsite survey or initiate a new complaint survey.*

Priority Assignments - Timeframes

In cases where the state agency (SA) has noted a pattern of similar complaints, CMS expects SAs to prioritize complaints at the appropriate level that is warranted. The timeframes in Section 5075 represent maximum timeframes for investigation;

- The SA is not precluded from investigating complaints and facility-reported incidents within a shorter timeframe.

In addition, the SA is not precluded from taking other factors into consideration in its triage decision.

- For example, the SA may identify a trend in allegations that indicates an increased risk of harm to residents, or the SA may receive corroborating information from other complainants regarding the allegation.

See also Section 5310.2 for requirements for nursing home facility-reported incidents.

Maximum Time Frames for Onsite Investigations

5075.9 - Maximum Time Frames Related to the Federal Onsite Investigation of Complaints/Incidents
(Rev.)

	Intake Prioritization			
Provider Type	Immediate Jeopardy (IJ)	Non-IJ High	Non-IJ Medium	Non-IJ Low
Nursing home *complaints*	SA must initiate an onsite survey within *3* business days of receipt *of the initial report.*	SA must initiate an onsite survey within *an annual average of 15 business days of receipt of the initial report, not to exceed 18 business days.*	*SA must initiate an onsite survey within 45 calendar days of receipt of the initial report.*	*SA must track/trend for potential focus areas during the next onsite survey, or initiate a new complaint survey.*
Nursing home incidents	*With inadequate resident protection, SA must initiate an onsite survey within 3 business days of receipt of the initial report.* *With potentially adequate resident protection, SA must initiate an onsite survey within 7 business days of receipt of the initial report.* *See Section 5310.2F.*	*SA must initiate an onsite survey within an annual average of 15 business days of receipt of the initial report, not to exceed 18 business days.*	*With an inadequate facility response, SA must initiate an onsite survey within 45 calendar days of receipt of the initial report.*	*With a potentially adequate facility response, SA must track/trend for potential focus areas during the next onsite survey, or initiate a new complaint survey.*

Resident Protection- Facility Response

Depending on the nature of the allegation, the facility would be expected to take immediate action(s) to ensure the protection of residents. Information provided by the facility may assist the SAs in determining whether there are potentially adequate protections provided to the resident:

Examples of such information include, but are not limited to:

- Monitoring of the alleged victim and other identified residents who are at risk, such as conducting unannounced management visits at different times and shifts;
- Evaluation of whether the alleged victim feels safe and if he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.;
- Providing social services (e.g., emotional support and counseling) to the resident, as needed;
- Immediate assessment of the alleged victim and provision of medical treatment as necessary;
- Provision of goods and/or services that are necessary to avoid serious injury, harm, impairment, or death to a resident;

Resident Protection- Facility Response - Continued

- Immediate notification of the alleged victim's physician and the resident representative, when there is injury or a change in condition or status;
- If the alleged perpetrator is staff-Removal of access by the alleged perpetrator to the alleged victim and other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents other residents;
- If the alleged perpetrator is a resident or visitor-
    - Removal of access by the alleged perpetrator to the alleged victim and, as appropriate, other residents and assurance that ongoing safety and protection is provided for the alleged victim and other residents
- Notification of the alleged violation to other agencies or law enforcement authorities, within timeframes as specified under Federal or State law or regulations; and
- Whether administrative staff, including the administrator, were informed and involved as necessary in the investigation.

Resident Protection- Facility Response - Continued

Below are examples that indicate that a resident(s) may not be protected in the facility:

- The alleged perpetrator continues to have access to the alleged victim and/or other residents;
- Retaliation occurs against a resident who reports an alleged violation;
- A resident who repeatedly fondles other residents is moved to another unit, where he/she continues to exhibit the same behaviors to other residents; and
- A resident with a history of striking a resident is left unsupervised with a resident who has been targeted in the past.

5-day Final Report of Suspected Allegation- 359

For alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, the facility is required to submit a report of the results of the investigation within 5 working days to the State Survey Agency (See 42 C.F.R. §483.12(c)(4), Tag F609 of Appendix PP of the State Operations Manual).

Within five (5) working of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.

It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the initial report. The investigation report should include any updates to information provided in the initial report and the following additional information, which should include, but are not limited to, the following:

Exhibit 359 - Follow-up Investigation Report (cms.gov)

5-day Final Report- Continued

Provide a detailed summary of ALL steps taken to investigate allegation.

- Include interviews with AP, VA, witnesses, supervisor and victim's responsible party.
- Identify any signs of adverse psychosocial reaction.
- Pertinent investigation facts.
- Conclusion – verified, not verified or inconclusive.
- Corrective Actions Taken.
- If systemic actions were identified that require correction, identify the steps that have been taken to address the systems.
- Primary person conducting the investigation.

Thank You!

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Quality Assurance Performance Improvement (QAPI)

Brenda Fischer, RN Regional Operations Manger

10/13/2022

Objectives

- Understand the regulatory changes to QAPI Plan and Program
- Understand how the surveyors will review this area for compliance
- Understand what is included in a QAPI program including feedback, data collection, analysis, monitoring and Performance Improvement Activities/Programs (PIP).

CMS Phase 3 requirements, November 28, 2019

- Phase 3 requirements went into effect November 28, 2019
- CMS planned release interpretive guidance during 2nd quarter 2020, then COVID
- Interpretive guidance released, implement October 24, 2022.

F865 QAPI Program, Plan, Disclosure, Good Faith Attempt

- New requirements in F865 for the Quality Assurance and Performance Improvement (QAPI) plan and program,
- Requirements in F866 have been relocated
- New requirements for the QAPI program, feedback, data collection, analysis and monitoring, and improvement activities
- Expansion of required Quality Assessment and Assurance (QAA) required committee members
- New QAPI training requirements

F865 QAPI Program, Plan, Disclosure, Good Faith Attempt

- §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

- §483.75(a)(l) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but 1s not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

- §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

- §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

F865 QAPI Program, Plan, Disclosure, Good Faith Attempt

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

F865 QAPI Program, Plan, Disclosure, Good Faith Attempt

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(l) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;

§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(S) Corrective actions address gaps in systems, and are evaluated for effectiveness;

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

Investigation & Key Elements for F865

- Surveyors will use the facility task QAPI and QAA review when determining if the facility meets the requirements for, or investigating concerns related to requirements in F865.
- Key Elements of Non-Compliance for F865 have been updated to include the new requirements discussed.

Key Elements of Non-Compliance

The facility did not complete one of the following:

- Maintain documentation and evidence of its ongoing QAPI program;
- Present its QAPI plan to the Federal and/or State surveyors during recertification survey or upon request;
- Present QAPI evidence necessary to demonstrate compliance with these requirements;
- Develop, implement and maintain an effective, comprehensive QAPI program, that addresses the full range of services the facility provides; and
- Ensure governing body oversight of the facility's QAPI program and activities.

F866 QAPI/QAA Data Collection & Monitoring

F866

Note: Regulatory requirements §483.lS(c) and §483.75(c) (l)-(4) have been relocated to F867.

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(l) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

- Identify-Concern areas, resident focus
- Collect- audit tool, observation, interview, testing
- Use data/information for all department
  - Nursing, Dietary, Housekeeping, Maintenance, Laundry, Therapy

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

- Performance indicators: Measurement of data collected
- Methodology: procedures used, defined
- Frequency: weekly, monthly, quarterly
- Monitor: collection of data, keeping record of process
- Evaluation: reviewing data, analysis, did meet goal or purpose project

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

- Define adverse event: Untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses.
- Methods, identify, report, track, investigate and analyze
- How will they use data, prevent adverse events
  - How mitigate these events
    - New process or system, communication and/or teaching

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(e) Program activities.

§483.75(e)(l) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at

§483.70(e). Improvement projects must include **at least annually** a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

F867 Data Collection, Monitoring, Analysis & Improvement

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

Investigation & Key Elements for F867

- Surveyors will use the facility task QAPI and QAA Review along with the interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to requirements in F867.
- The Key Elements of Non-Compliance have been updated to include the new requirements discussed.

F868 QAA Committee

§483.75(g) Quality assessment and assurance.

§483.75(g)(l) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

***

(iv) The infection preventionist.

§483.80{c) [Infection preventionist] participation on quality assessment and assurance committee.

The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.

QAPI & QAA Review (CMS20058)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Quality *Assurance & Performance Improvement (QAPI)* and *Quality Assessment &* Assurance (QAA) Review

This review should occur at the end of the survey, after completion of investigation into all other requirements. However, identification of systemic concerns to be reviewed during the QAPI and QAA review should begin with Offsite Preparation and occur throughout the survey.

Offsite: Make note of concerns identified during offsite preparation, which will be further investigated during the survey (*e.g.* repeat deficiencies, ombudsmen concerns, and complaints/facility-reported incidents). These represent possible systemic issues, which if validated during the survey, should be cited under the relevant outcome tag, and incorporated into the *QAPI and* QAA review for investigation.

Team Meetings: During end of day team meetings, the survey team discusses potential systemic issues or shared concerns for further investigation, or those that have been validated for incorporation into the *QAPI and* QAA review.

- ☐ Were any offsite concerns validated during the survey?
- ☐ Were new systemic*, high-risk, or problem-prone* concerns validated (concerns which will likely be cited at pattern or widespread, substandard quality of care*, or any substantiated or actual incidents of abuse, neglect, exploitation, or misappropriation of resident property)* during the survey?
- ☐ Has more than one surveyor identified and validated the same concern?

Regulation Recap

F865: For concerns related to whether a facility has implemented and maintains a comprehensive QAPI program and plan, disclosure of records and governance and leadership.

F867: For concerns related to how the facility obtains feedback, collects data, monitors adverse events, identifies areas for improvement, prioritizes improvement activities, implements corrective and preventive actions, and conducts performance improvement projects (PIPS).

F868: For concerns related to the composition of the QAA committee, frequency of meetings and reporting to the governing body.

F944 QAPI Training

§483.95(d) Quality assurance and performance improvement.

A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at §483.75.

Training Requirements

Brenda Fischer RN, Regional Operations Manager

10/13/2022

Objectives

- Understand the regulatory changes to Training
- Understand training that is required for staff, including new and existing staff, individuals providing services under contract; and volunteers
- Understand the key changes to the regulation or interpretative guidelines for staff training, and what this includes.

Training

Ftag	Tag Subject	Key Change to Regulation or Interpretive Guidelines	Significant Change or Technical Correction
F940	Training Requirements	Added new guidance for this stem requirement for all training tags	Significant
F941	Communication Training	Added new guidance for communication	Significant
F942	Resident Rights Training	Added new guidance for training related to Resident Rights/Facility Responsibilities	Significant
F944	QAPI Program	QAPI program mandatory training	Significant
F945	Infection Control Training	Added new guidance for training related to Infection Control	Significant
F946	Compliance and Ethics	Annual training requirement for organizations with 5 or more facilities	Significant
F947	In-service Training for Nurse Aids	Added new guidance for training related to Nurse Aides	Significant
F949	Behavioral Health Training	Added new guidance for training related to Behavioral Health	Significant

Key Changes to Training

F940 Training Requirements:

- Facilities must develop, implement, and maintain effective training program for:
  - All new and existing staff;
  - All individuals providing services under contract; and
  - Volunteers
- Facilities must use the Facility Assessment at F838 to determine the amount and types of training necessary.

Key Changes to Training

F941 Communication Training:

- A facility must include effective communications as mandatory training for direct care staff.
- Guidance includes description of:
  - Effective communication
  - Direct care staff

Key Changes to Training

F942 Residents' Rights Training:

- Facilities must develop and implement an ongoing education program on all resident rights and facility responsibilities for caring of residents as outlined in §483.10.
- Education program should:
  - Support current scope and standards of practice.
  - Incorporate learning objectives, performance standards, and evaluation criteria

Key Changes to Training

F944 QAPI training

- §483.95(d) Quality assurance and performance improvement.
- A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at §483.75.

Key Changes to Training

F945 Infection Control Training:

- All facilities must develop, implement and permanently maintain an effective training program for all staff, which includes training on the standards, policies, and procedures for the infection prevention and control program, (as described at §483.80{a)(2)] that is appropriate and effective, as determined by staff need.
- Guidance addressing training on written standards, policies and procedures of the Infection Prevention and Control Program.
- Added probes related to observations, interviews and review of training records.

Key Changes to Training

F946 Compliance and ethics training:

- The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85
  - §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.
  - §483.95(f)(2) Annual training if the operating organization operates five or more facilities.

Key Changes to Training

F947 Nurse Aide Training:

- Required in-service training for nurse aides. In-service training must:
- §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.
- Guidance expanded to reflect that the minimum 12 hour nurse aide training, in addition to ensuring competence, and including dementia and abuse training, must address areas of weakness as determined in nurse aide performance reviews.

Key Changes to Training

F949 Behavioral Health Training:

- Facilities must develop, implement, and maintain an effective training program for all staff, which includes, at a minimum, training on behavioral health care and services (consistent with §483.40) that is appropriate and effective, as determined by staff need and the facility assessment (as specified at §483.70)

Key Changes to Training

F949 Behavioral Health Training: New provision for Phase 3

Training should include competencies/skills necessary to provide:

- Person-centered care reflective of resident's goals for care;
- Interpersonal communication that promotes mental/psychosocial well-being;
- Meaningful activities which promote engagement/positive relationships;
- An environment/atmosphere that is conducive to mental/psychosocial well being;
- Individualized, non-pharmacological approaches to care;
- Care specific to the individual needs of residents diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma, and/or post traumatic stress disorder, or other behavioral health condition; and
- Care specific to the individual needs of residents diagnosed with dementia.

Thank You!

Brenda Fischer, RN Regional Operations Manger

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Quality of Life and Quality of Care, Physician Services, Food and Nutrition, Compliance and Ethics and Physical Environment

Presenter Sarah Grebenc SW | Regional Operations Manager

10/13/2022

Objectives

- Understand the regulatory changes to Quality of Life and Quality of Care, Physician Services, Food and Nutrition, Compliance and Ethics and Physical Environment
- Understand how the guidance/changes will affect the survey process
- Understand how the surveyors will review these areas for compliance

Quality of Life and Quality of Care

F675 Quality of Life

F686 Pressure Ulcers

F687 Foot Care

F689 Accidents/Supervision

F690 Bowel/Bladder Incontinence, Catheter, UTI

F694 Parenteral/IV Fluids

F695 Respiratory/Tracheostomy Care and Suctioning

F697 Pain Management

F700 Bedrails

F675 - Quality of Life

- Technical corrections to address grammar and update references;
- Removed language suggesting automatic citation of F675 at Immediate Jeopardy (IJ) level;
- Added language to direct surveyors to consider impact to resident(s) affected, and to refer to Appendix Q for any concerns which may rise to IJ

F686 – Pressure Ulcers/F687 – Foot Care

- No Phase 3 regulations related to F686 and F687
- Changed guidance to reflect that pressure ulcer risk assessments should occur quarterly (rather than monthly) or whenever there is a change in condition
- Added new language on following proper infection prevention practices for foot care equipment
- Added a reference to the infection prevention and control tag related to foot care.

F689 – Accidents/Supervision

New guidance on electronic cigarettes (e-cigs):

- Added guidance in response to increased use of the devices and questions received from nursing home stakeholders.
- Guidance identifies risks associated with e-cigs:
  - Health effects for the user and others nearby
  - Nicotine overdose by ingestion or skin contact
  - Explosion or fire caused by device battery.

F689 – Accidents/Supervision

- Facilities must oversee the use of these devices and include them in smoking policies.
- Policies should address
  - Unique characteristics and risks of e-cigarettes
  - How use will be supervised.
  - Handling of batteries and refill cartridges.
- Surveyors should consider how facilities:
  - Provide for resident safety;
  - Balance safety with resident right to use the device; and
  - Protect residents who do not want to be exposed to second-hand aerosol.

F689 – Accidents/Supervision

- New guidance has been added to address safety for residents with substance use disorder.
- Care planning interventions should address risk for a resident leaving to satisfy an addiction to alcohol or illegal or prescription drugs.
- Facilities are responsible for identifying and assessing a resident's risk for leaving and developing interventions to address the risk.
- A resident who leaves the facility with facility knowledge of the departure, despite facility efforts to explain the risks of leaving earlier than planned, would likely be against medical advice.

F689 – Accidents/Supervision

- Documentation in the medical record should show that facility staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA.
- Documentation should also identify the time the facility became aware of the resident leaving the facility.
- A resident who leaves the facility without staff knowledge of the departure would be considered an elopement.

F689 – Accidents/Supervision

For residents with a history of substance use:

- Facility staff should assess residents for the risk for illicit substance use in the facility and have knowledge of signs and symptoms of possible substance use.
- Facility staff should be prepared to address emergencies related to substance use by maintaining knowledge of administering opioid reversal agents like naloxone, initiating CPR as appropriate, and contacting emergency medical services as soon as possible.
- Surveyors should be aware that the occurrence of an overdose does not necessarily mean that noncompliance exists. If evidence shows a facility took steps to increase its monitoring of a resident, and despite this effort, the resident overdosed between checks, then noncompliance with 483.25(d) may not be present.

F690 – Bowel/Bladder Incontinence, Catheter, UTI

- No Phase 3 regulations
- This regulatory tag is specific to bowel incontinence, not bowel management
- Clarified that any issues related to bowel management, such as constipation or impaction should be referred to F684
- Technical correction – corrects the Urinary Tract Infection parameter to 10 to the fifth power rather than 105

F694 – Parenteral/IV Fluids

- Added guidance on frequency of assessment of an IV catheter including factors which affect the frequency such as:
  - Ability of resident to report symptoms
  - Type of infusion—is it an irritant or vesicant?
  - Location of IV; and
  - Facility policy.
- New language on infection control practices when accessing or using IV .
- Clarified the need to document continued need for IV catheter.

F695 – Respiratory/Tracheostomy Care and Suctioning

- No Phase 3 regulations, only guidance clarification.
- Clarified that mechanical ventilation guidance only applies to facilities who choose to offer this service.

F697 – Pain Management

- Added language regarding use of opioids within the current opioid crisis and to align with the efforts of other government agencies.
- Recommend use of CDC resources on use of opioids for chronic pain.
- Facilities should assess residents for history of past addiction and related treatment and employ strategies to address pain for residents with history of opioid use disorder.
- Guidance describes side effects of opioids and addresses prevention of opioid overdoses by administering naloxone.

F700 - Bedrails

- The guidance for bedrails has been clarified to include the “use” of bedrails in addition to installation.
- Added links to resources and guidance related to appropriate alternatives to bedrails
- Clarified that there is no requirement that bedrails be removed or disabled when not in use
- Added guidance that if bedrails are determined to be inappropriate for a resident, if left on the bed in the down position, raising the rail would be considered noncompliance

F700 - Bedrails

- Any use of bedrails must meet the requirements to:
  - assess the resident,
  - obtain consent,
  - evaluate appropriateness and
  - routinely provide maintenance of the bed and bed rail.

F700 - Bedrails

- When no alternative exists for bed rails the medical record must include:
  - Purpose of bedrail and notation that no appropriate alternative exists
  - An assessment of the resident and the bedrail for entrapment risk
  - An assessment of the risks versus benefits which must be reviewed with the resident and resident representative with informed consent given.

F712 Physician Services

- Column 1 was divided into two columns and orders added to column three

Table 1: Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Re-certifications when Permitted by the State

	Initial Comprehensive Visit	*Admission Orders*	Other Required Visits *& Orders^*	Other Medically Necessary Visits & Orders+	Certification/ Recertification±
SNFs					
PA, NP & CNS employed by the facility	May not perform	*May not provide*	May perform alternate visits *and sign*	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform	*May not provide*	May perform alternate visits *and sign*	May perform and sign	May sign *as permitted under State laws.*
NFs					
PA, NP, & CNS employed by the facility	May not perform	*May not provide*	May not perform *or sign*	May perform and sign	Not applicable
PA, NP, & CNS not a facility employee	May perform	May provide*	May perform and sign	May perform and sign	Not applicable

F812 Food and Nutrition

Ftag	Tag Subject	Key Change to Regulation or Interpretive Guidelines	Significant Change or Technical Correction
F812	Food Procurement, Store/Prepare/Serve - Sanitary	Guidance reorganized for clarification; Added language related to culture change dining practices	Significant

F812 Food and Nutrition

- F812 Food Procurement, Store/Prepare/Serve - Sanitary:

  Additions included -

  - Separation of food distribution and food service
  - Clarification of the definition for *Food Distribution*
  - Definition for *Food Service*
  - Details on staff hair restraint use
  - Details on staff glove use

F895 Compliance and Ethics

To ensure that facilities have in operation an effective compliance and ethics program that uses internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements to deter criminal, civil and administrative violations and promote quality of care for nursing home residents.

F895 Compliance and Ethics

1. Implementing written policies, procedures and standards of conduct
2. Designation of a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Enforcing standards through well-publicized disciplinary guideline.
6. Conducting internal monitoring and auditing
7. Responding promptly to detected violations and corrective action

F895 Compliance and Ethics

High-level personnel - an individual(s) who has substantial control over the operating organization or who has a substantial role in the making of policy within the operating organization.

Operating organization - the individual(s) or entity that operates a facility

Requirements for All Facilities

- §483.85(c) Required components for all facilities.
  The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:

Requirements for All Facilities

- §483.85(c)(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act. and promote quality of care.
- §483.85(c)(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.
- §483.85(c)(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures.

Requirements for All Facilities

- §483.85(c)(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.

- §483.85(c)(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.

- §483.85(c)(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures.

- §483.85(c)(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program.

Requirements for All Facilities

- §483.85(c)(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.
- §483.85(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:
- §483.85(d)(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f).

Requirements for All Facilities

- §483.85(d)(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer.
- §483.85(d)(3) Designated compliance liaisons located at each of the operating organization's facilities.

Requirements for All Facilities

- §483.85(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.

Surveyor Considerations

- When investigating concerns related to a criminal, civil and administrative violation in the facility, surveyors should review the facility's written standards, policies and procedures for the compliance and ethics program and interview high-level personnel, who are designated to oversee the program and staff.

Surveyor Considerations

- The guidance also contains probes in F895 to consider during investigation and when making compliance determinations. Examples include:
  - When reports or reasonable suspicions of violations are identified, did the organization take prompt action to respond to the violations and prevent further occurrences?
  - Does the operating organization review the program annually and as needed, and in response to organization, facility and/or regulatory changes?

Surveyor Considerations

Interview high-level personnel designated to oversee the organization's compliance and ethics program about their involvement in the program to determine:

- how the facility uses monitoring and auditing systems to detect criminal, civil, and administrative violations by staff;
- if they are aware of the potential violation under investigation and what was their response.

Ask staff if:

- they are aware of the facility's compliance and ethics program;
- there is a method for staff to anonymously report suspected violations;
- they are confident in reporting compliance matters without fear of retaliation.

If the operating organization has five or more facilities, have a compliance officer and a facility-based compliance liaison been designated.

Potential Tags for Additional Consideration

If a negative or potentially negative resident outcome is determined to be related to the facility's failure to meet compliance and ethics requirements, it should also be investigated under the appropriate quality of care or other relevant requirement.

For concerns related to systems of care and management practices, written policies and procedures for feedback, data collection systems, monitoring, analyzing and acting on available data to make improvements, see Quality Assurance and Performance Improvement (QAPI) requirements in §483.75.

F919 Physical Environment

§483.90(g) F919 Resident Call System.

The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from–

- *§483.90(g)(1) Each resident's bedside*; and
- *§483.90(g)(2) Toilet and bathing facilities*.

F919 Physical Environment

The system must be accessible to residents:

- While in their bed or
- other sleeping accommodations within the resident's room.

- **The system must be accessible at each:**
  - Toilet, Bath, Shower
    - The system should be accessible to residents lying on the floor

F919 Physical Environment

Residents and their representatives' interviews:

- Do you have access to your call light at all times while in your room, bathroom or shower?
- Has the call system needed repair recently?
- What did the facility do if the call system was not working?
- Were any needed repairs made timely?
- Does the facility have a process to routinely ensure the call system for residents is operational?
- During a loss of power will the resident call system be operational or is an alternate means of communicating with the staff put into place?

Thank You!

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Behavioral Health Services/Trauma informed Care

Presenter: Kathy Lucas, RN Regional Operations Manager

10/13/2022

Objectives

- Understand the regulatory changes to Behavioral Health Services/Trauma Informed care
- Understand what areas in the regulation address these changes
- Understand some of the potential elements of noncompliance where concerns in these areas may be cited.

F699 Trauma-Informed Care

***§483.25(m)**: The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.*

Regulatory Grouping-Trauma-Informed Care

483.25 Quality of Care	
F684	*Quality of Care
F685	*Treatment/Devices to Maintain Hearing/Vision
F686	*Treatment/Svcs to Prevent/Heal Pressure Ulcers
F687	*Foot Care
F688	*Increase/Prevent Decrease in ROM/Mobility
F689	*Free of Accident Hazards/Supervision/Devices
F690	*Bowel/Bladder Incontinence, Catheter, UTI
F691	*Colostomy, Urostomy, or Ileostomy Care
F692	*Nutrition/Hydration Status Maintenance
F693	*Tube Feeding Management/Restore Eating Skills
F694	*Parenteral/IV Fluids
F695	*Respiratory/Tracheostomy care and Suctioning
F696	*Prostheses
F697	*Pain Management
F698	*Dialysis
F699	*{PHASE-3} Trauma Informed Care
F700	*Bedrails

F699 Trauma-Informed Care

Intent: To ensure facilities deliver care and services which:

- Meet professional standards.
- Use approaches which are culturally-competent;
- Account for residents' experiences and preferences;
- Address the needs of trauma survivors by minimizing triggers

F699 Trauma Informed Care

Trauma	Trauma-Informed Care
• Results from an event, series of events, or set of circumstances • Physically or emotionally harmful or life threatening • Has lasting adverse effects on an individual's functioning, and mental, physical, social, emotional, or spiritual well-being	• An approach to delivering care that involves: • Understanding, recognizing and responding to the effects of all types of trauma; • Recognizing the widespread impact and signs and symptoms of trauma in residents; and • Avoiding re-traumatization

F699 Trauma Informed Care

Facilities must identify triggers which may re-traumatize residents with a history of trauma.

"A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening."

Trauma Informed Care -Elements of Noncompliance

Facility failed to do one of the following:

- Identify cultural preferences of residents who are trauma survivors.
- Identify a resident’s past history of trauma.
- Identify triggers which cause re-traumatization.
- Use approaches that are culturally competent and/or are trauma-informed.

Comprehensive Care Plans

§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must –

(b)(3)(iii) Be culturally-competent and trauma-informed

Regulatory Grouping-Comprehensive Care Plans

483.21	Comprehensive Resident Centered Care Plans
F655	Baseline Care Plan
F656	Develop/Implement Comprehensive Care Plan
F657	Care Plan Timing and Revision
F658	Services Provided Meet Professional Standards
F659	Qualified Persons
F660	Discharge Planning Process
F661	Discharge Summary

F656 Comprehensive Care Plans

Intent:

To ensure each resident's person-centered comprehensive care plan includes approaches that address the resident's cultural preferences and reflects trauma-informed care when appropriate.

F656 Comprehensive Care Plans

When reviewing a resident's care plan, the surveyor should determine if the care plan:

- Describes the resident's cultural preferences, values and practices;
- Includes approaches to meet the resident's cultural needs and preferences; and
- For residents with a history of trauma, if the care plan describes interventions accounting for the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization.

F656 Comprehensive Care Plans

To address trauma and cultural preferences, facilities should:

- Collaborate with survivors, family, friends, and other health care professionals to obtain history of trauma
- Identify triggers which may re-traumatize the resident and develop interventions to decrease or mitigate exposure to triggers
- It is important for facility staff to understand the cultural preferences of the individual and how they impact the delivery of care

Revisions to Behavioral Health Services

Behavioral Health Services

Ftag	Tag Subject	Key Change to Regulation or Interpretive Guidelines	Significant Change or Technical Correction
F740	Behavioral Health Services	Removed reference to Appendix P and added reference to Psychosocial Outcome Severity Guide; Added language related to mental health and substance use disorders throughout guidance.	Significant
F741	Sufficient/Competent Staff-Behav Health Needs	Removed reference to Appendix P and added reference to Psychosocial Outcome Severity Guide; Minor change to correct reference to F679; Added language related to history of trauma and/or post-traumatic stress disorder throughout guidance; Added language related to mental health and substance use disorders throughout guidance.	Significant
F742	Treatment/Services for Mental/Psychosocial concerns	Removed reference to Appendix P and added reference to Psychosocial Outcome Severity Guide	Technical
F743	No Pattern of Behavioral Difficulties Unless Unavoidable	Removed reference to Appendix P and added reference to Psychosocial Outcome Severity Guide	Technical
F744	Treatment/Service for Dementia	Removed reference to Appendix P and added reference to Psychosocial Outcome Severity Guide	Technical

Regulatory Grouping-Behavioral Health Services

483.40	Behavioral Health Services
F740	Behavioral Health Services
F741	Sufficient/Competent Staff-Behav Health Needs
F742	*Treatment/Svc for Mental/Psychosocial Concerns
F743	*No Pattern of Behavioral Difficulties Unless Unavoidable
F744	*Treatment /Service for Dementia
F745	*Provision of Medically Related Social Services

Revisions/F740

Changes to F740 Behavioral Health Services

- Reference to the PASARR specific to Mental disorders-
  - If the resident does not qualify for specialized services under PASARR, but requires more intensive behavioral health services (e.g., individual counseling), the facility must demonstrate reasonable attempts to provide for and/or arrange for such services.
  - Clarification on use of behavioral contracts which cannot conflict with resident rights

Key Elements of Noncompliance F740

Facility failed to

- Obtain needed services for behavioral needs.
- Learn the resident's history in order to identify appropriate interventions
- Develop/revise person centered care plans/interventions based on assessed behavioral needs

Revisions/F741

F741 Sufficient/Competent staff. Added the following language:

Intent:

- The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans….
- This includes residents with mental disorders, psychosocial disorders, or substance use disorders *(SUDs*), *and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment*.

Revisions/F741

F741 Sufficient/Competent staff. Added the following language:

- Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
- PTSD occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD

Revisions/F741

F741 Sufficient/Competent staff. Added the following language:

- Substance Use Disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.
- Information pertaining to the use of the facility assessment for behavioral health care needs
- Additional examples of non-pharmacological interventions
- A new severity level 2 example under the Deficiency Categorization section pertaining to care planning

Key Elements of Noncompliance F741

Facility failed to:

- Identify the signs and symptoms of substance use in a resident with SUD;
- Provide care, in accordance with the individualized care plan, that meets the needs of residents with mental disorders, substance use disorders, a history of past trauma, and other behavioral health needs;
- Provide sufficient staff who have the knowledge, training, competencies, and
- skills sets to address behavioral health care needs;
- Demonstrate reasonable attempts to secure professional behavioral health services, when needed;
- Utilize and implement non-pharmacological approaches to care, based upon the comprehensive assessment and plan of care, and in accordance with the resident's abilities, customary daily routine, life-long patterns, interests, preferences, and choices;

Thank You

Presenter(s) Kathy Lucas

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483.10- Resident Rights

Presenter LeAnn Huseth, RN | Regional Operations Supervisor

10/13/2022

Objectives

- Understand the regulatory changes to 483.10, Resident Rights.
- Understand how the new guidance will affect the survey process.
- Understand how the surveyors will review this area for compliance.

Resident Rights

Ftag	Tag Subject	Key Changes to Regulation and/or Interpretive Guidelines	Significant Change or Technical Correction
F557	Respect, Dignity/Right to have Personal Property	Added language related to mental health and substance use disorders throughout guidance	Significant
F561	Self Determination	Reinsertion of "facility policy on resident smoking" language which was inadvertently removed.	Significant
F563	Right to Receive/Deny Visitors	Added language related to mental health and substance use disorders throughout guidance; Added language related to visitation during infectious outbreaks or pandemics	Significant
F578	Request/Refuse/ Discontinue Treatment; Formulate Adv Dir	Corrected tag reference under Key Elements of Noncompliance	Technical
F582	Medicare/ Medicaid Coverage/ Liability Notice	Revisions based upon new Skilled Nursing Facility Advance Beneficiary Notices (SNFABN)	Significant

Resident Rights

- F557 Respect, Dignity/Right to have Personal Property
- Addition of guidance related to
  - Staff searches
  - Signs, symptoms, and triggers of possible substance use
  - Referral to law enforcement
  - References to F689 and F740

Resident Rights

- F561 Self-Determination
- Re-insertion of previous guidance inadvertently deleted
- Prohibition of smoking
  - Change of policy from smoking to non-smoking
  - Current residents affected by policy change

Resident Rights

- F563 Right to Receive/Deny Visitors
- Addition of guidance related to:
  - Denying access to visitors who have a history of bringing illegal substances into the facility
  - Visitation during communicable disease outbreaks
  - Signs, symptoms, and triggers of possible substance use after interaction with visitors
  - Referral to law enforcement
  - Staff searches
  - References to F689 and F740

Resident Rights

- F582 Medicaid/Medicare Coverage/Liability Notice
- Revisions based on changes to Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (Form CMS-10055)
- Clarification provided for -
  - Notice of Medicare Non-coverage (Form CMS-10123)
    - Notification that Part-A coverage is ending
  - Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (Form CMS-10055)
    - Transfer of financial liability to the beneficiary
    - Separate and unrelated from the admission and discharge requirements

Thank You!

Presenter LeAnn Huseth

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483.80 Infection Control

Presenter: Karen Aldinger | RN, Regional Operations Supervisor

10/13/2022

Objectives

- Understand the regulatory changes to Infection Control
- Understand how the changes will affect the survey process
- Understand how the surveyors will review this area for compliance

Regulatory Grouping

Regulatory Group: Infection Control

- F880: Infection Prevention and Control
- F881: Antibiotic Stewardship Program
- F882: Infection Preventionist
- F883: Influenza and Pneumococcal
- F868: QAA Committee

F880 Water Management

Water Management- Legionella

Facilities must be able to demonstrate its measures to minimize the risk of *Legionella* and other opportunistic waterborne pathogen outbreaks in building water systems.

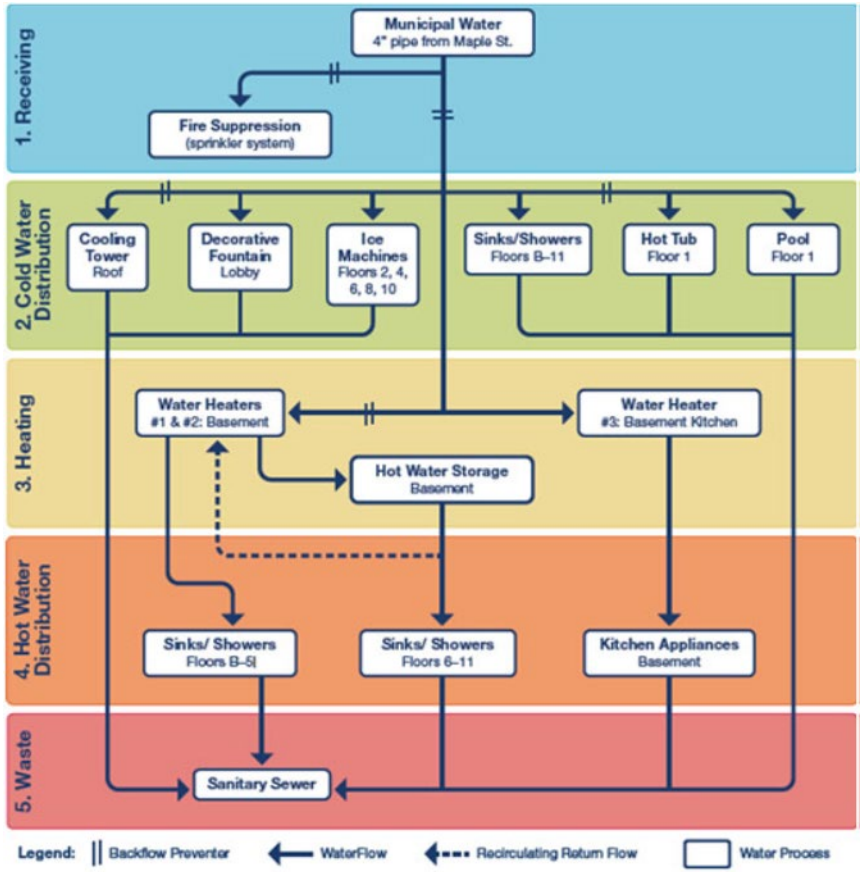
An example of such is a documented water management program.

F880-Water Management

A facility must use nationally accepted standards (e.g., ASHRAE, CDC, EPA) to minimize the risk of waterborne pathogens.

F880-Water Management

An assessment of the building water system to identify where opportunistic waterborne pathogens could grow and spread.



F880-Water Management

Interview and document review:

- Were there any diagnosed cases of legionellosis in residents since the last recertification survey?
- If there was a case of legionellosis identified:
    - Did the facility implement adequate prevention and control measures prior to and once the issue was identified?

Legionnaires' disease is a reportable infection (aka Legionella, Legionellosis).

F880

MDRO Colonization and Infection guidance

Contact precautions are used for residents infected or colonized with MDROs in the following situations:

- When a resident has wounds, secretions, or excretions that are unable to be covered or contained; and
- On units or in facilities where, despite attempts to control the spread of the MDRO, ongoing transmission is occurring.

F881 Antibiotic Stewardship Program

- Revised requirement to provide feedback to prescribing practitioners
- If there are concerns with the antibiotic stewardship program
  - Surveyors will include at least one resident in the sample to determine if they are being prescribed antibiotics unnecessarily (F757) and if there were any negative outcomes or an adverse drug event

F882 Infection Preventionist Qualifications/Role

- Must be member on quality assessment and assurance committee
- The IP is responsible for assessing, developing, implementing, monitoring, and managing the IPCP.
- The IP must work at least part-time at the facility.

F882 Infection Preventionist Qualifications/Role

- Must be member on quality assessment and assurance committee
- The IP is responsible for assessing, developing, implementing, monitoring, and managing the IPCP.
- The IP must work at least part-time at the facility.

F882- IP Professional Training

Professionally trained in:

- Nursing
- Medical technology
- Microbiology
- Epidemiology
- Other related field

F882- IP Specialized Training

The IP must have completed specialized training in infection prevention and control.

Infection Prevention Training | LTCF | CDC

The Nursing Home Infection Preventionist Training course is designed for individuals responsible for infection prevention and control (IPC) programs in nursing homes.

IP Participation on the QAA Committee

- §483.80 (c) IP participation on the Quality Assessment and Assurance committee.
- Cite at F868.

F883 Influenza and Pneumococcal Immunizations

Removed the outdated language related to the Advisory Committee on immunization Practices (ACIP) recommendations for the 13-valent Pneumococcal conjugate vaccine (PCV13) in those ≥65 years

New Pneumococcal Vaccine Recommendations

- **Adults aged ≥65 years.** Adults aged ≥65 years who have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of PPSV23 (Table 1).

- **Adults aged 19–64 years with certain underlying medical conditions or other risk factors.** Adults aged 19–64 years with certain underlying medical conditions or other risk factors who have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of PPSV23.

PneumoRecs VaxAdvisor (cdc.gov)

Recommended Adult Immunization Schedule (cdc.gov)

Thank You!

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651-201-3794

483.15 Admission, Transfer Discharge and Arbitration

Judy Loecken SW and Lisa Krebs, RN- Regional Operations Supervisor

10/13/2022

Objectives

- Understand the regulatory changes to Admission, Transfer, Discharge rights
- Understand how the [new guidance/changes] will affect the survey process
- Understand how the surveyors will review this area for compliance

Admission, Transfer, and Discharge Rights

- No new changes related to Phase 3 regulatory requirements.
- Changes were made to F622, F623, and F626 guidance in response to stakeholder feedback and questions

Key changes for F622- Transfer & Discharge

Guidance clarified for situations involving:

Situation: Resident is admitted for short term rehab under Medicare. The resident completes rehab but is not ready to leave. If the facility proceeds with discharge, it is considered a facility-initiated discharge.

Discharge cannot be based solely on payment source.

Key Changes for F622—Transfer & Discharge Requirements

When Medicare ends but the resident still needs long-term care, the Facility should offer the resident the ability to remain:

- Pay privately
- Should provide necessary assistance to apply for Medicaid

Key Changes for F622-Transfer & Discharge Requirements

Assist resident to apply for Medicaid and explain:

- If denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and
- If found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.
- Residents cannot be discharged for nonpayment while Medicaid is pending, or if found eligible for Medicaid.

Key Changes for F622 Emergent transfers

Transfers to acute care is considered facility-initiated transfer, not a discharge because the resident's return is generally expected.

- Initiation of discharge while resident in hospital must be based on resident's current condition when resident seeks return to facility.
- Discharge criteria at §483.15(c)(i) must be met. Resident has the right to return to the facility pending an appeal. Unless would endanger other residents.
- Facility must document the danger if they allowed the resident to return.
- Residents who are sent to acute care setting for routine treatment/planned procedures must also be allowed to return.

Key changes F622: examples of Immediate Jeopardy

Examples of Severity Level 4 Non-compliance: Immediate Jeopardy to Resident Health or Safety

- Facility initiated a discharge on the basis that the resident's health had improved, however, the resident and her family disagreed and filed an appeal. The facility did not allow the resident to remain in the facility while the appeal was pending and dropped her off at her daughter's home. The resident's daughter previously stated she could not care for her mother at her home where needed medical equipment and wound care was not available. The resident developed sepsis from inadequate wound management and remains hospitalized post-amputation of the infected limb.
- A facility initiated a discharge based on the facility's inability to meet a resident's needs. However, upon complaint investigation, it was determined by interview and record review that, while the resident was depressed and had challenging behavior requiring staff attention, he did not have needs which could not be met in that facility, and there was evidence that the facility was caring for other residents with similar challenging behaviors. The resident was discharged to the street and found by a passerby in the street, rolled up in a tarp, and in a health condition requiring immediate medical attention.

Key changes F622: examples of Harm Level

Examples of Severity Level 3 Noncompliance: Actual Harm that is not IJ

- A facility initiated a resident's discharge after the resident attempted to hit a staff member during morning care over several days. The facility discharged the resident claiming the resident was a danger to others. Upon investigation of a complaint, it was determined the facility had been failing to provide the resident with pain medication prior to morning care in accordance with the care plan. Evidence also showed the resident had never attempted to hit staff when pain was managed according to the care plan, therefore the resident was not actually a danger to others. There was also no documentation of the facility's attempts to meet the resident's needs or what services the new receiving facility had in order to meet the resident's needs. During an interview with the resident, the surveyor found the resident was not happy in the new facility and was no longer participating in activities or therapy, resulting in a significant decreased ability to perform ADLs.

Key Changes to F623—Notice Requirements Before Transfer/Discharge

Notice of Transfer or Discharge and Ombudsman Notification

- For facility-initiated transfers or discharges of a resident, ***prior*** *to the transfer or discharge* the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

Documentation of notification changed from

- The medical record must contain evidence that the notice was sent to the Ombudsman

To

➢ The *facility* must *maintain* evidence that the notice was sent to the Ombudsman

Key Changes to F623—Facility Initiated Transfers and Discharges

OLD LANGUAGE

- Does not identify timeline

- *In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman.*

***Emergency Transfers**…notice of transfer must be provided to the resident and resident representative as soon as practicable, according to…..*

NEW LANGUAGE

- Clarifies the timeline

*In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative **before the discharge**, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman*

***Emergency Transfers**…notice of transfer must be provided to the resident and resident representative as soon as practicable **before the transfer**, according to..the ombudsman notice must meet the notice content.*

Key Changes to F623-Content of the Notice

- ✓ *The specific reason for the transfer or discharge, including the basis per §483.15(c)(1)(i)(A)-(F);*
- ✓ *The effective date of the transfer or discharge;*
- ✓ *The location to which the resident is to be transferred or discharged;*
- ✓ *An explanation of the right to appeal to the State;*
- ✓ *The name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests;*
- ✓ *Information on how to request an appeal hearing;*
- ✓ *Information on obtaining assistance in completing and submitting the appeal hearing request; and*
- ✓ *The name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman.*

*The facility's notice must include **all of** the following **at the time notice is provided***

- ✓ *The **specific** reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F);*
- ✓ *The effective date of the transfer or discharge;*
- ✓ *The **specific** location to which the resident is to be transferred or discharged;*
- ✓ *An explanation of the right to appeal the **transfer or discharge** to the State;*
- ✓ *The name, address (mail and email), and telephone number of the State entity which receives **such** appeal hearing request;*
- ✓ *Information on how to **obtain** an appeal **form**;*
- ✓ *Information on obtaining assistance in completing and submitting the appeal hearing request; and*
- ✓ *The name, address (**mailing and email**), and phone number of the representative of the Office of the State Long-Term Care ombudsman*

Key Changes to F623, Timing of the Notice

Generally, this notice must be provided at least 30 days prior to the transfer or discharge. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because

- *The resident's welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or*
- *The health or safety of others in the facility is endangered.*
- *In these cases, the notice must be provided as soon as practicable and notice to the ombudsman in these situations can be sent when practicable, such as a list of residents on a monthly basis.*

Generally, this notice must be provided at least 30 days prior to the transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because:

- *The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;*
- *The resident's health improves sufficiently to allow a more immediate transfer or discharge;*
- *An immediate transfer or discharge is required by the resident's urgent medical needs; or*
- *A resident has not resided in the facility for 30 days.*
- *In these exceptional cases, the notice must be provided to the* ***resident, resident's representative if appropriate****, and LTC ombudsman* ***as soon as practicable before the transfer or discharge.***

Key Changes to F623, Changes to The Notice

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. For significant changes, such as a change in the destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date, in order to provide 30 day advance notification.

If information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. For significant changes, such as a change in the ***transfer or discharge*** *destination, a new notice must be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30 day advance notification and* ***permit adequate time for discharge planning****.*

Key Changes to F626-Permitting Residents to Return to Facility

Clarified the requirement to permit residents to return after hospitalization or therapeutic leave applies to all residents regardless of payment source.

The facility policies must provide that residents who seek to return to the facility within the bed-hold period defined in the State plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period or when state law does not provide for bed-holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident:

- Still requires the services provided by the facility; and
- Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.

The policies must also provide that if the facility determines that a resident cannot return, the facility must comply with the requirements of paragraph at 42 CFR 483.15(c) as they apply to facility-initiated discharges.

Key Changes to F626-Permitting Residents to Return to Facility

Summary of Investigative Procedures:

For when facility does not permit return due to lack of available bed or inability to meet resident's needs. Surveyor should investigate:

- Whether the facility held the resident's bed in accordance with policies
- If the resident's stay outside the facility exceeded the bed-hold period,
- Whether there was an available bed at the time the resident sought return
- If there was not an available bed at the time of return should determine whether or not the resident was allowed to return based on the first available bed in semi-private room.

For when facility does not permit return due to inability to meet resident's needs, Surveyors should

- Investigate why the resident's needs cannot be met
- Review admissions to determine if resident with similar care needs have been permitted to remain.

Key Changes to F626-Permitting Residents to Return to Facility

Composite Distinct Part

When a resident is returning to a composite distinct part, he/she must be allowed to return to an available bed in the particular location of the composite distinct part in which he/she resided previously, or the next available bed in that location.

F622, F623, F626—Against Medical Advice Discharges (AMA)

Language added to F622, F623, and F626 identifies in some instances AMA could be a facility-initiated discharge in which the facility is required to be in compliance with transfer/discharge, and abuse/neglect/exploitation.

Situations in which residents sign out of the facility or leave Against Medical Advice (AMA) should be thoroughly investigated to determine if the discharge is facility-or resident-initiated. If evidence reveals that a resident or resident representative was forced, pressured, or intimidated into leaving AMA, the discharge would be considered a facility-initiated discharge, requiring further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F623. See additional guidance on AMA discharges at F660 and guidance on Abuse, Neglect and Exploitation at F600.

Arbitration- F847 and F848

Presenters: Judy Loecken and Lisa Krebs | Regional Operations Supervisors

10/13/2022

Objectives

- Understand the regulatory tags for F847 and F848
- Understand how the new regulations will affect the survey process
- Understand how the surveyors will review this area for compliance

F847

F847 Entering Into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement…

F847 Cont.

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). . .

Definitions

- **Arbitration**: a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments.
- **Binding Arbitration Agreement (Arbitration Agreement or Agreement)**: a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds.

Definitions Continued

- **Pre-dispute binding arbitration agreement (pre-dispute arbitration agreement or pre-dispute agreement):** A binding agreement to resolve a future unknown dispute with an arbitrator prior to any issue or dispute arising.
- **Post-dispute binding arbitration agreement (post-dispute arbitration agreement, or post-dispute agreement):** A binding agreement signed after the circumstances of the dispute have occurred to resolve the dispute with an arbitrator.
- **Dispute:** A disagreement, controversy, or claim amongst parties where one party claims to have been harmed.
- **Judicial Proceedings**: any action by a judge (i.e., trials, hearings, petitions, or other matters) formally before the court.

F847 Intent

- To ensure residents/representative are informed of the nature an implications of any proposed binding arbitration agreement, to inform their decision on whether or not to enter into such agreements.
- To ensure resident/representatives right to make informed decisions.

F847 Surveyor process

Surveyors will verify with facility whether arbitration agreements are used to resolve disputes. If so, F847 will be investigated through interviews with residents/representatives, resident and family councils, ombudsman, facility staff and record review.

- Surveyors should determine how the facility ensures residents or their representatives understood the terms of the binding arbitration agreement, and how this understanding is acknowledged.
- Surveyors should thoroughly investigate the basis for transfer or discharge for any resident who has refused to enter into a binding arbitration agreement, and has been, or will be subsequently transferred or discharged.
- Surveyors should verify through interview that the resident or his or her representative were not discouraged in any way from contacting federal, state, or local officials, which includes and is not limited to surveyors and ombudsmen, when entering into a binding arbitration agreement.

F847 Key Elements Of Noncompliance

To cite deficient practice at F847, the surveyors' investigation will generally show: **The facility failed to:**

- Explain the terms of the agreement to the resident or his or her representative in a form and manner (including language) that he or she understands; and/or
- Inform the resident or his or her representative they are not required to enter into a binding arbitration agreement as a condition of admission, or as a condition to continue to receive care at the facility; or
- Inform the resident or representative they have the right to rescind or terminate the agreement within 30 calendar days of signing.

The agreement itself:

Contains language that prohibits discourages the resident or his or her representative from communicating with federal, state, or local officials, including:

- Federal and state surveyors, and/or
- Other federal or state health department employees, and/or
- Representative of the Office of the State Long-Term Care Ombudsman; or
- Fails to contain language which clearly informs the resident or their representative they are not required to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at the facility.

F848 Regulation

F848 Arbitrator/Venue Selection and Retention of Agreements §483.70(n) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. . .

§483.70(n)(2) The facility must ensure that . . .

(iii)The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and

(iv)The agreement provides for the selection of a venue that is convenient to both parties…

§483.70(n)(6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee.

Definitions

- **Arbitrator**: A third party who resolves a dispute between others by arbitration and pursuant to an arbitration agreement. Arbitrators are decision makers, with procedures set by the arbitration agreement and state law, except they may not be required to follow federal or state rules of evidence and their decisions may not be reviewable by a court absent extraordinary circumstances.

- **Convenient Venue**: A location in which to carry out arbitration proceedings which should be agreed upon and suitable to both parties.

- **Neutral Arbitrator**: An impartial, or unbiased third-party decision maker, contracted with, and agreed to by both parties to resolve their dispute.

F848 Intent

- To provide a neutral and fair arbitration process and the venue is convenient to both parties.
- The retention requirement enables CMS to fully evaluate quality of care complaints that are addressed arbitration and assess the overall impact of these agreements on the safety and quality of care provided in long-term care facilities.

F848 Surveyor Procedures

- Surveyors to focus on the record retention requirement
- Surveyors should verify with the facility whether arbitration agreements are used to resolve disputes. If so, determine compliance with F848 through interview of sampled residents, resident representatives, resident council/family council (if one exists), Long-Term Care Ombudsman, facility staff; and record review

F848 Key Elements of Noncompliance

To cite deficient practice at F848, the surveyor's investigation will generally show that the facility failed

- Ensure that the arbitration agreement specifically provides for the selection of a neutral arbitrator; or
- Ensure that the arbitration agreement specifically provides for the selection of a venue that is convenient

For disputes resolved by arbitration, the facility failed to:

- Retain a copy of the signed agreement for binding arbitration and the arbitrator's final decision (for disputes resolved by arbitration) after the facility and a resident or their representative resolve a dispute through arbitration for five (5) years or
- Refuse to make the signed agreement or final decision available for inspections upon request by CMS or its designee

Thank You!

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Potential Inaccurate Diagnosis and/or Assessment

Nicole Osterloh, RN | Federal Operations Supervisor

10/13/2022

Objectives

- Understand the regulatory changes to inaccurate diagnosis and/or assessment
- Understand how the new guidance/changes will affect the survey process
- Understand how the surveyors will review this area for compliance.

Areas of Discussion

F641 Accuracy of Assessments

F658- Comprehensive Care Plans

F758- Unnecessary Psychotropic Meds/PRN meds

F641 Accuracy of Assessments

The assessment must accurately reflect the resident's status to ensure each resident receives an assessment, reflective of their status at the time of the assessment and performed by staff qualified to assess relevant care areas.

- "Accuracy of Assessment" means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify their strengths to maintain or improve their medical status, functional abilities, and psychosocial status using the appropriate RAI (i.e. comprehensive, quarterly, etc.)

- Facilities are responsible for ensuring that all participants in the assessment process have the knowledge to complete an accurate assessment. Ex: a nutritional assessment portion should be performed by the RD or equivalent.

- The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident with involvement of physicians, nurses, rehab, activities, social workers, dietitians, and other professionals who are knowledgeable about the resident's status, needs, strengths, and areas of decline.

F641 cont.

- **The assessment must represent an accurate picture of the resident's status during the observation period of the MDS** (also known as the Look-back period or the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD)). *Be aware that different items on the MDS have different Observation Periods.*

- **When the MDS is completed, only those occurrences during the observation period will be captured on the assessment.** In other words, if it did not occur during the observation period, it is not coded on the MDS.

- ***Note**: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, surveyors will determine if non-compliance exists for the facility's completion of an accurate assessment and may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.*

F641 cont.

Surveyors will identify if:

1. Each portion of the MDS assessment accurately reflects the resident's status as of the Assessment Reference Date (ARD).
2. If there is evidence the health professionals who assessed the resident had the skills and qualifications to conduct the assessment.

F658- Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.

“Professional standards of quality” means that care and services are provided according to accepted standards of clinical practice.

F658 Cont.

NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the **clinical assessment process is more fluid and should be ongoing.** The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident's needs between required RAI **assessments should be addressed at §483.35 Nursing Services**, F726 (competency and skills to identify and address a change in condition**), and the relevant outcome tag**, such as §483.12 Abuse, §483.24 Quality of Life, §483.25 Quality of Care, and/or §483.40 Behavioral Health.

F658 cont.

If a negative or potentially negative resident outcome is determined to be related to the facility's failure to meet professional standards and the team determines a deficiency has occurred, it **should also be cited under the appropriate quality of care or other relevant requirement.**

For example, if a resident develops a pressure injury because the facility's nursing staff failed to provide care in accordance with professional standards of quality**, the team should cite the deficiency at both F658 and F686 (Skin Integrity).**

F758- Free from Unnecessary Psychotropic Meds/PRN

A psychotropic drug is any drug that affects brain activities associated with mental processes and behaviors. These drugs include but are not limited to, drugs in the following categories:

(i) Anti-psychotic;

(ii) Anti-depressant;

(iii) Anti-anxiety; and

(iv) Hypnotic

F758 cont.

Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
- Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
- **PRN orders for psychotropic drugs are limited to 14 days.** Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
- **PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication**.

F758 cont.

- The intent of these requirements is to ensure:
- each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being;
- the facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and
- PRN orders for psychotropic medications are only used when necessary and PRN use is limited.

F758 cont.

Added definitions:

- “Dose” is the total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the daily dose.
- “Duplicate therapy” refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking.
- “Excessive dose” means the total amount of any medication (including duplicate therapy) given at one time or over a period of time that is greater than the amount recommended by the manufacturer’s label, package insert, and accepted standards of practice for a resident’s age and condition.

F758 cont.

Why is this regulation significant?

Proper medication selection and prescribing (including dose, duration, and type of medication(s)) may help stabilize or improve a resident's outcome, quality of life and functional capacity. Any medication or combination of medications—or the use of a medication without adequate indications, in excessive dose, for an excessive duration, or without adequate monitoring—may increase the risk of a broad range of adverse consequences such as medication interactions, depression, confusion, immobility, falls, hip fractures, and death.

While assuring that only those medications required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications are important considerations for all residents. Therefore, as part of all medication management (especially psychotropic medications), **it is important for the IDT to implement non-pharmacological approaches designed to meet the individual needs of each resident.**

F758 cont.

The resident's medical record should have evidence of documentation and communication to the entire team of the basic elements of the care process and the resident's goals and preferences.

The regulations associated with medication management include consideration of:

- Indication and clinical need for medication
- Dose (including duplicate therapy);
- Duration;
- Adequate monitoring for efficacy and adverse consequences; and
- Preventing, identifying, and responding to adverse consequences.

F758 cont.

- Regarding psychotropic medications, the regulations additionally require:
- Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition;
- Implementing GDR and other non-pharmacologic interventions for residents who receive psychotropic medications, unless contraindicated; and
- Limiting the timeframe for PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner.
- Limiting PRN antipsychotic medications, to 14 days and not entering a new order without first evaluating the resident. NOTE: The required evaluation of a resident before writing a new PRN order for an antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed.

F758 cont.

Situations to consider:

Admission (or Readmission) – Some residents may be admitted on medications for an undocumented chronic condition or without a clear indication as to why a medication was begun or should be continued. It is expected the attending physician, pharmacist, and staff subsequently **determine if continuing the medication is justified by evaluating the resident's** clinical condition, risks, existing medication regimen, preferences, goals, and related factors.

Multiple prescribers – Regardless of who the prescribers are, the continuation of a medication needs to be evaluated to determine if the medication is still warranted in the context of the resident's other medications and comorbidities**. Medications prescribed by a specialist or begun in another care setting, such as the hospital, need to have a clinically pertinent documented rationale in the resident's medical record.**

F758 cont.

The risk for adverse consequences increases with both the number of medications being taken regularly and with medications from specific pharmacological classes, such as anticoagulants, diuretics, psychotropic medications, anti-infectives, and anticonvulsants. **Use of a tool, such as the CMS Adverse Drug Event Trigger Tool, may assist in identifying resident risk factors and triggers for adverse drug events as well as in determining whether a facility has systems and processes in place to minimize risk factors and mitigate harm to residents.** The tool is available on the CMS Nursing Home QAPI website, Adverse Drug Event Trigger Tool (cms.gov)

F758 cont.

NEW: ***Additionally, as part of a facility's QAPI program****, a facility may track its use of certain classes of medications, such as antipsychotics, through reports from the long-term care pharmacist which could identify trends and reduce adverse events.*

The regulations and guidance concerning psychotropic medications are not intended to supplant the judgment of a physician or prescribing practitioner in consultation with facility staff, the resident and his/her rep and in accordance with appropriate standards of practice. Rather, the regulations and guidance are intended to ensure psychotropic medications are **used only when the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition.**

F758 cont.

What does that mean for facilities?

The resident's medical record must show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed.

An evaluation of the resident by the IDT helps to identify his/her needs, goals, comorbidities, and prognosis to determine factors that are affecting signs, symptoms, and test results. This evaluation process is important when selecting initial medications and/or non-pharmacological approaches and when deciding whether to modify or discontinue a current medication.

Ensuring a physician or ordering prescriber has directly examined the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed.

Thank You!

Nicole Osterloh

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Pharmacy Services- *§483.45*

Pete Cole, RN | Regional Operation Supervisor

10/13/2022

Objectives

- Review the affected regulations for this category
- Understand the new guidance changes to *§483.45*
- Understand how the new guidance changes will affect the survey process
- Understand how surveyors will review this area for compliance
- Understand examples of non-compliance

What is New?

- No changes in *requirements* for F755, 757 and 758
- New changes to *guidance* for F755, 757 and 758

Summary of Key Changes

Ftag number	Tag Subject	Change to Interpretive Guidance	Significant change Or Technical Correction
F755	Pharmacy Services	Clarified language related to disposal of Fentanyl patches	Significant
F757	Drug regimen is free from unnecessary drugs	Added language related to antibiotic stewardship and F881	Significant
F758	Free from Unnecessary Psychotropic medications/ PRN use	Clarification of other classes of drugs not listed in the regulation and how they are affected by the psychotropic medication requirements.	Significant

F755 - Review

Requirements under F755

- Provide routine and emergency drugs and biologicals to residents or obtain them under an agreement.
- Have procedures for the provision of pharmaceutical services that meet the needs of each resident.
- Employ or obtain the services of a licensed pharmacist who provides consultation on the provision of pharmacy services in the facility.
- Establish a system to enable the accurate reconciliation of all controlled drugs.
- Ensure that drug records are in order and that an account of all controlled drugs is maintained and reconciled periodically.

F755 Review

Facilities need to ensure their policies address:

- Acquisition
- Receiving
- Dispensing
- Administration – including authorized personnel
- ***Disposal of medications***

Revised Guidance to F755

- Nursing homes may use drug disposal systems if those systems can be demonstrated to prevent diversion and accidental exposure
- Disposal of fentanyl patches in unsecured trash or sharps containers would be non-compliance.
- The EPA does not ban flushing pharmaceuticals unless they are hazardous
- Fentanyl patches are not classified as hazardous

Flushing Fentanyl Patches per MPCA Guidelines

- Fentanyl patches may be assumed non-hazardous in Minnesota.
- Generators within cities provided sewer service by the Metropolitan Council Environmental Services (MCES) may sewer fentanyl patches for disposal. This includes the 7-county metro area.
- Generators outside of the 7-county metro area who are not served by MCES must contact their sewage provider before sewering fentanyl patches.
- If a facility chooses not to flush Fentanyl patches, it needs to show that the chosen method of disposal is secure and prevents diversion.

F755 Example of Noncompliance

- A resident has Fentanyl patches discontinued. The Fentanyl patches are cut up and disposed of in a sharps container in a locked medication room.

F757 Review

F757 is essentially the unnecessary medications deficiency for all medications (excluding psych medications – F758).

An unnecessary medication is any medication used…

- In excessive dose (including duplicate drug therapy); or
- For excessive duration; or
- Without adequate monitoring; or
- Without adequate indications for its use; or
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued.

Changes to Guidance for F757 and F758

- A “Note” has been added to F757 and F758
- If the surveyor finds unnecessary antibiotic use the note directs the surveyor to consider non-compliance with F881 – Antibiotic Stewardship Program.
- The unnecessary antibiotic use could indicate non-compliance with the antibiotic stewardship program

F758 Review

F758 Summary

- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
- Residents who use psychotropic drugs receive gradual dose reductions (GDRs), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue the medication.

F758 Review

Summary of F758 Requirements

- Residents do not receive PRN ***psychotropic drugs*** unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record
- PRN orders for ***psychotropic drugs*** are limited to 14 days. If the order needs to be extended, the physician should document their rationale in the medical record and indicate the duration
- PRN orders for ***antipsychotic drugs*** are limited to 14 days. Orders cannot be renewed unless the physician evaluates the resident for continued appropriateness of the medication

F758 Review

- Phase 2 guidance in November 2017 expanded the category of antipsychotics to also regulate the use of psychotropic medications
- Psychotropic medications include; antipsychotics, anti-depressants, anti-anxiety medications and hypnotics
- This was done to address the concern regarding the decrease in antipsychotic medications driving an increase in psychotropic medication use.

Additional Guidance for F758 – Other Medications

- New guidance describes other medications which may affect brain activity – These may be clinically indicated but can also have adverse consequences.
- The use of these “other medications” comes under the psychotropic medication requirements if the documented use appears to be substitution for a psychotropic medication instead of for it’s approved indication.
- An example is a seizure medication being given to a resident with no history of seizures and the medical record indicates the medication is given for agitation.

Additional Guidance for F758 – Gradual Dose Reductions

- Additional language was added to the gradual dose reduction section:
  - Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence.
  - In addition, resources were added to provide information on gradual dose reductions.

Additional Guidance for F758 – Potential for Psychosocial Harm

- Added language to direct surveyors to evaluate if a resident experience psychosocial harm related to side effects of a medications.
- Did side effects such as sedation, lethargy, agitation, mental status changes, or behavior changes do any of the following;
  - Affect resident's abilities to perform activities of daily living or interactions with others.
  - Cause the resident to withdraw or decline
  - Cause diminished ability to think or concentrate

F758 Example of Noncompliance

- A resident is prescribed amoxicillin 500 mg every 12 hours for 7 days. No urine culture was ordered prior to starting the antibiotic therapy.
- Consideration of citation under F881 Antibiotic Stewardship Program. Surveyor would evaluate for further non-compliance with F881.

F758 Example of Noncompliance

- Resident is started on Depakote 250 mg twice daily in 2020 with no documentation of rationale for the extended time period, no specific duration and no gradual dose reduction attempted. Resident has no documentation of a seizure disorder in the resident's medical record however the medical record indicates the medication is being administered for agitation.

Thank You!

Pete Cole

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Payroll Based Journal/Nursing Services

Becky Haberle, RN | HFE II Federal Training Team

10/13/2022

Objectives

- Understand the regulatory changes to nursing services and the Payroll Based Journal
- Understand how the new guidance/changes will affect the survey process
- Understand how the surveyors will review this area for compliance

Nursing Services 483.35

F tag	Tag Subject	Key Change to Regulation or Interpretive Guidelines
F725	§483.35(a) Sufficient Staff	Added new guidance for the Procedure, Probes, and Deficiency Categorization Examples
F727	§483.35(b) Registered nurse.	Added new guidance for the Procedure, Probes, and Deficiency Categorization
F729	§483.35(d)(4) Registry verification.	Added new guidance for Procedure
F732	§483.35(g) Nurse Staffing Information	Added Procedures and Probes

Administration 483.70

F tag	Tag Subject	Key Change to Regulation or Interpretive Guidelines
F851	§ 483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format	Guidance and Key Elements of Noncompliance

Sufficient and Competent Nursing Staff Review

Survey staff will utilize CMS Sufficient Staffing Pathway

The staffing task is now divided into Part 1 and Part 2

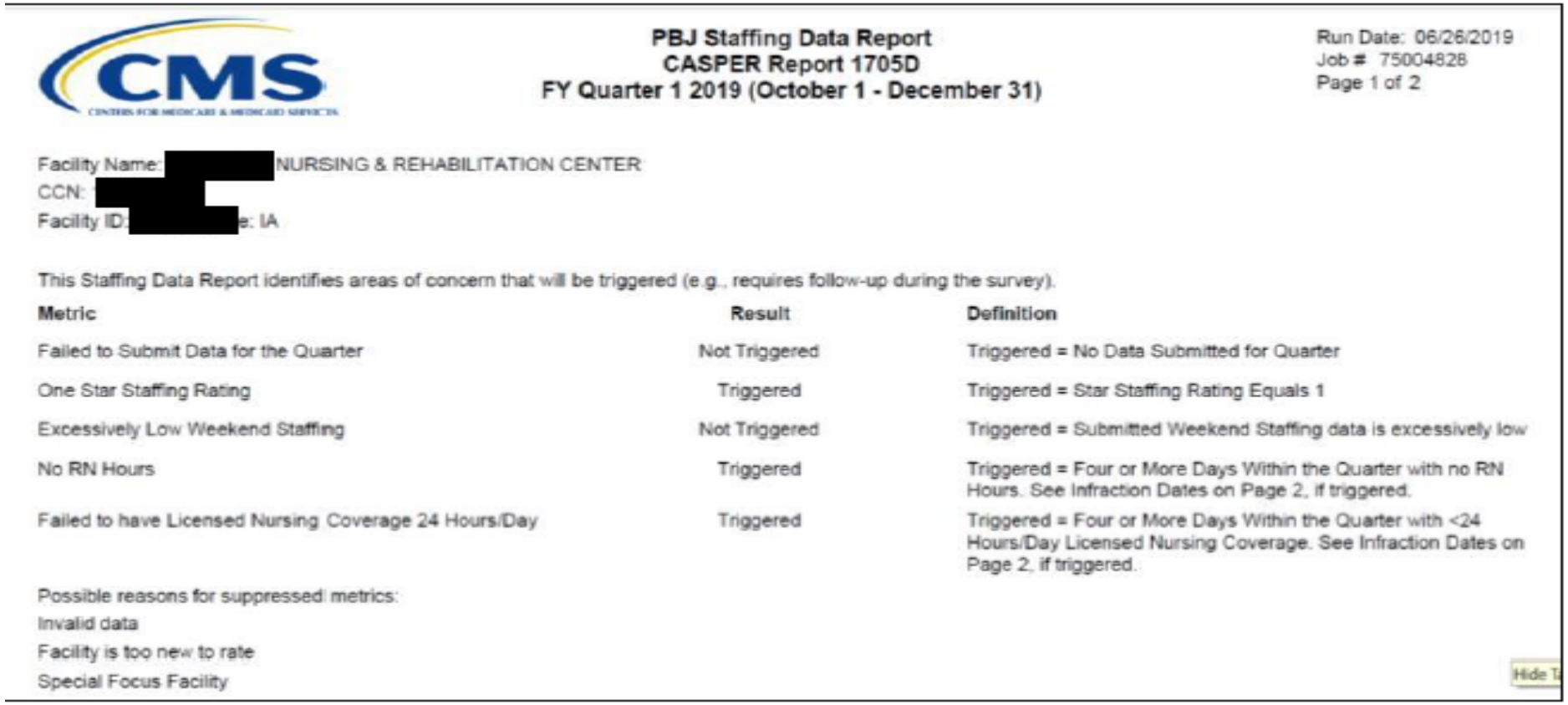
- Part one- Required to be completed by all survey members- information regarding staffing obtained by observation, interview and record review.
- Part Two- To be completed by surveyor assigned as the lead investigator for staffing
  - Review PBJ Report
  - Review the staffing schedule – past month and any identified time from the PBJ report
  - NA training/competency evaluation program- only when concerns are identified

The updated pathway is scheduled to be released on October 24, 2022

F851 Payroll –Based Journal

- §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.
- §483.70(q)(1) Direct Care Staff.
- §483.70(q)(2) Submission requirements.
- §483.70(q)(3) Distinguishing employee from agency and contract staff.
- §483.70(q)(4) Data format.
- §483.70(q)(5) Submission schedule.

PBJ Report



PBJ Staffing Data Report
CASPER Report 1705D
FY Quarter 1 2019 (October 1 - December 31)

Run Date: 06/26/2019
Job # 75004828
Page 1 of 2

Facility Name: [redacted] NURSING & REHABILITATION CENTER
CCN: [redacted]
Facility ID: [redacted] e: IA

This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey).

Metric	Result	Definition
Failed to Submit Data for the Quarter	Not Triggered	Triggered = No Data Submitted for Quarter
One Star Staffing Rating	Triggered	Triggered = Star Staffing Rating Equals 1
Excessively Low Weekend Staffing	Not Triggered	Triggered = Submitted Weekend Staffing data is excessively low
No RN Hours	Triggered	Triggered = Four or More Days Within the Quarter with no RN Hours. See Infraction Dates on Page 2, if triggered.
Failed to have Licensed Nursing Coverage 24 Hours/Day	Triggered	Triggered = Four or More Days Within the Quarter with <24 Hours/Day Licensed Nursing Coverage. See Infraction Dates on Page 2, if triggered.

Possible reasons for suppressed metrics:
Invalid data
Facility is too new to rate
Special Focus Facility

Hide T

PBJ Report

PBJ Staffing Data Report
CASPER Report 1705D
FY Quarter 1 2019 (October 1 - December 31)

Run Date: 06/26/2019
Job # 75004828

Facility Name: [redacted] NURSING & REHABILITATION CENTER
CCN: [redacted]
Facility ID: [redacted] IA

Metric	Infraction Dates
No RN Hours	10/06 (SA); 10/07 (SU); 10/13 (SA); 10/20 (SA); 10/21 (SU); 10/27 (SA); 10/28 (SU)
	11/03 (SA); 11/18 (SU)
	12/01 (SA); 12/22 (SA); 12/23 (SU)
Failed to have Licensed Nursing Coverage 24 Hours/Day	10/27 (SA); 10/28 (SU)
	11/18 (SU)
	12/22 (SA)

PBJ Resources

- CMS PHB Policy Manual
- CMS PBJ Policy Manual FAQ
- CMS Staffing Data Submissions PBJ Website
- CMS Five Star Quality System Technical Uses Guide
- Questions regarding PBJ Policy can be sent to NHStaffing@cms.hhs.gov

F725 Nursing Services

- §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a) Sufficient Staff.

- §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

- (i) Except when waived under paragraph (e) of this section, licensed nurses; and

- (ii)Other nursing personnel, including but not limited to nurse aides.

- §483.35(a)(2) Except when waived under paragraph [(e)] of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

F727 Registered Nurse

- **§483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.**
- **§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.**
- **§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.**
- **DEFINITIONS §483.35(b) "Full-time" is defined as working *40* or more hours a week.**

F729 Registration verification

- §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—
- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or
- (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.
- §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.
- §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

F732 Staff Posting

Data requirements: The facility must post the following information on a daily basis:

- Facility name
- The current Date
- Total number of actual hours worked by the RN, LPN and NA
- Resident Census

Posting requirements:

- Post at the beginning of each shift
- Data must be posted in a clear readable format
- In a prominent place radially accessible to residents and visitors.
- Aviable upon request
- Maintain the post staffing data for 18 months

No changes in facility expectation, added surveyor procedures and probes.

Support

- Review your Staffing Plan- Appendix Z 004 and 026
- LTC Battle Plan Team is still open for support please reach out to them:
- For COVID Outbreak call: 833-454-0149
- health.COVID.SEOC-LTC.staffing.response@state.mn.us
- Aladtec Non-Outbreak Application

Thank You!

Becky Haberle

Becky.haberle@state.mn.us

Survey Process

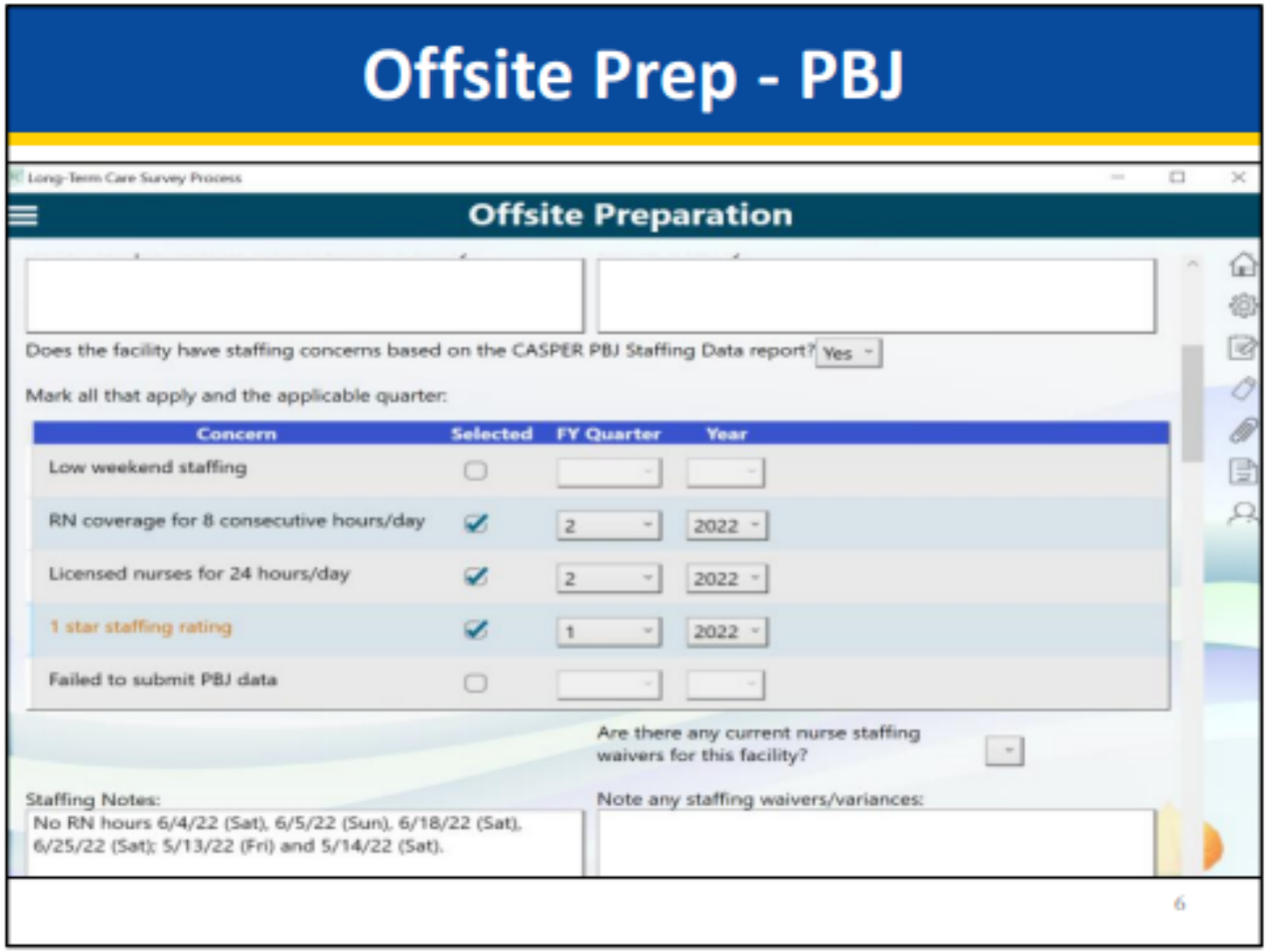
Theresa Gullingsrud, RN | HFE II Federal Training Team

10/13/2022

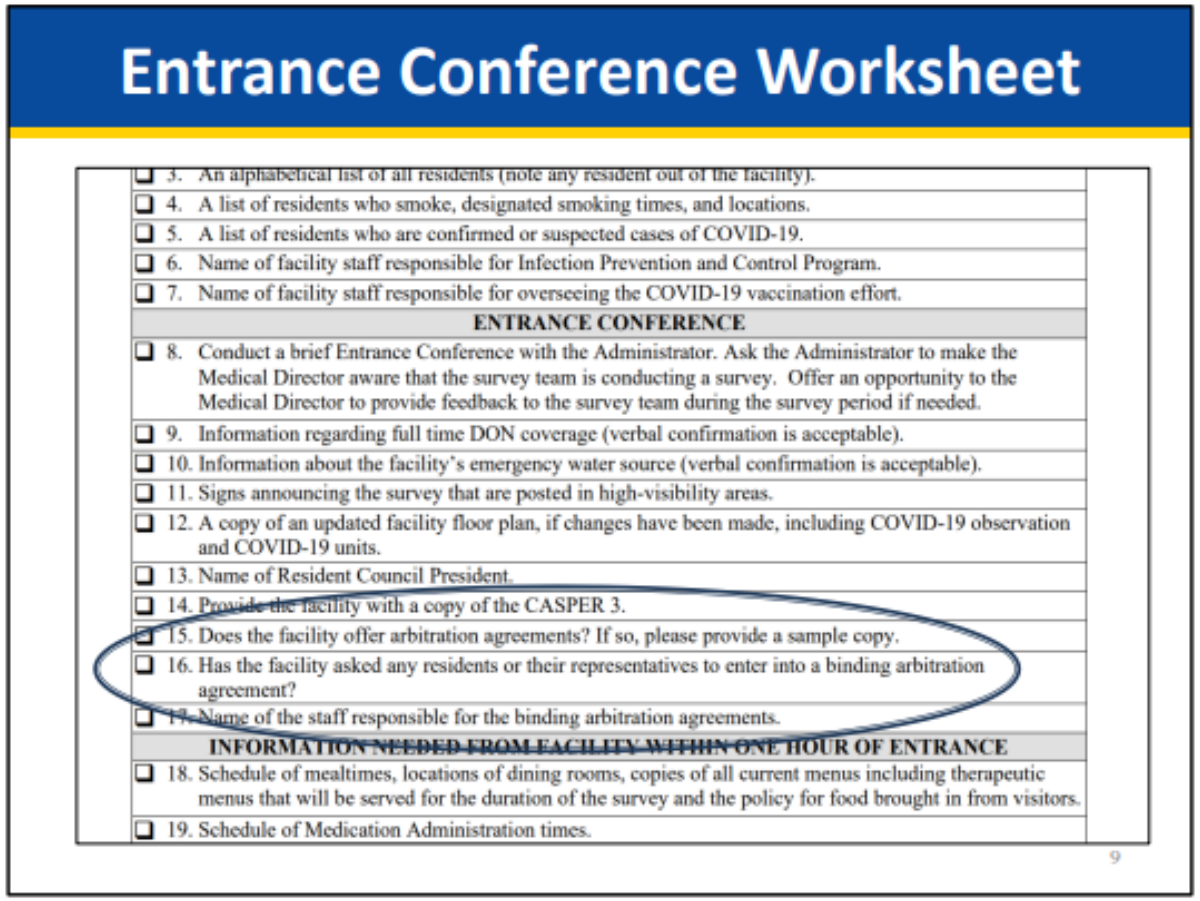
Objectives

- Understand how the new guidance/changes will affect the Long-Term Care Survey Process (LTCSP)
- Identify what pathways were updated for investigation guidance.

Offsite Prep



Entrance

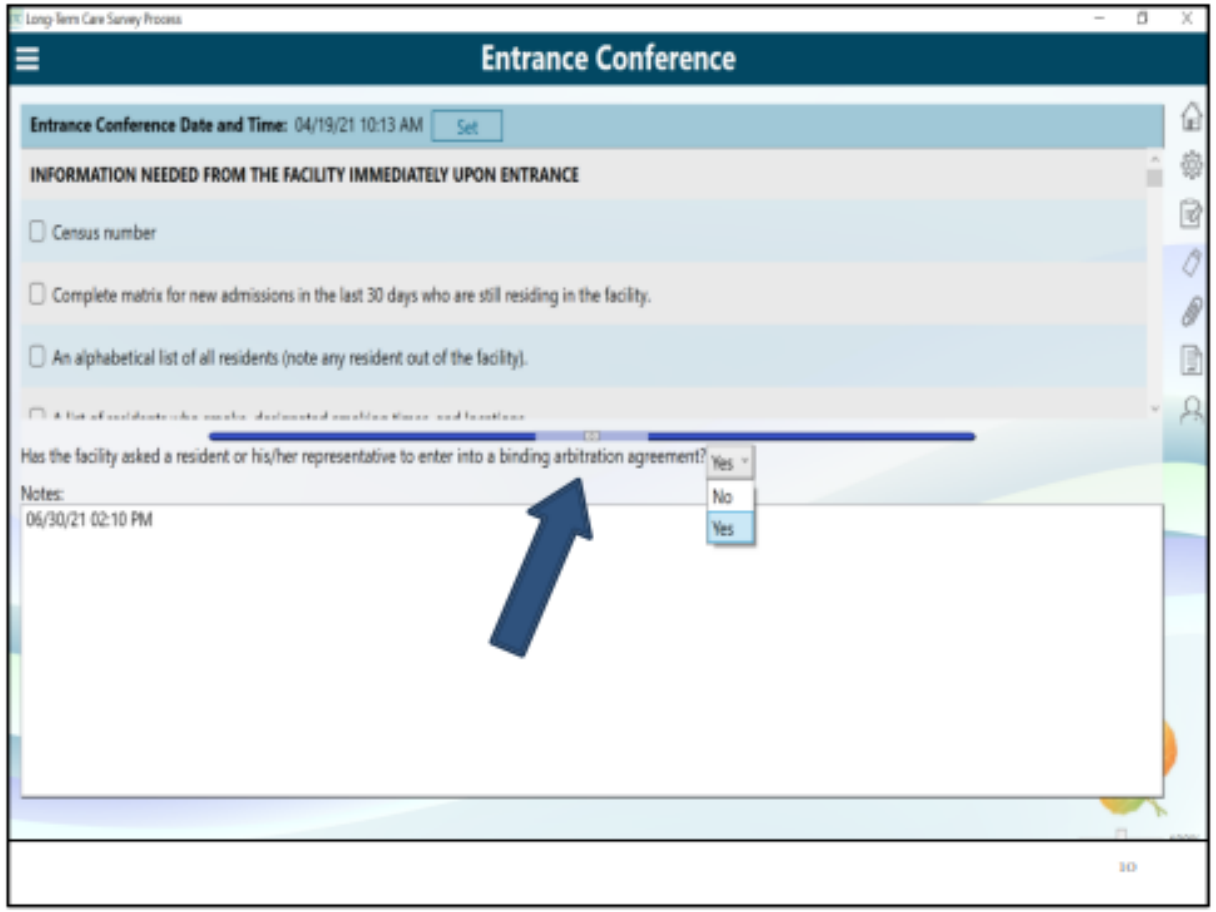


Entrance Conference Worksheet

❑	3. An alphabetical list of all residents (note any resident out of the facility).
❑	4. A list of residents who smoke, designated smoking times, and locations.
❑	5. A list of residents who are confirmed or suspected cases of COVID-19.
❑	6. Name of facility staff responsible for Infection Prevention and Control Program.
❑	7. Name of facility staff responsible for overseeing the COVID-19 vaccination effort.
	ENTRANCE CONFERENCE
❑	8. Conduct a brief Entrance Conference with the Administrator. Ask the Administrator to make the Medical Director aware that the survey team is conducting a survey. Offer an opportunity to the Medical Director to provide feedback to the survey team during the survey period if needed.
❑	9. Information regarding full time DON coverage (verbal confirmation is acceptable).
❑	10. Information about the facility's emergency water source (verbal confirmation is acceptable).
❑	11. Signs announcing the survey that are posted in high-visibility areas.
❑	12. A copy of an updated facility floor plan, if changes have been made, including COVID-19 observation and COVID-19 units.
❑	13. Name of Resident Council President.
❑	14. Provide the facility with a copy of the CASPER 3.
❑	15. Does the facility offer arbitration agreements? If so, please provide a sample copy.
❑	16. Has the facility asked any residents or their representatives to enter into a binding arbitration agreement?
❑	17. Name of the staff responsible for the binding arbitration agreements.
	INFORMATION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
❑	18. Schedule of mealtimes, locations of dining rooms, copies of all current menus including therapeutic menus that will be served for the duration of the survey and the policy for food brought in from visitors.
❑	19. Schedule of Medication Administration times.

9

Entrance


Long Term Care Survey Process
Entrance Conference
Entrance Conference Date and Time: 04/19/21 10:13 AM
Set
INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
Census number
Complete matrix for new admissions in the last 30 days who are still residing in the facility.
An alphabetical list of all residents (note any resident out of the facility).
Has the facility asked a resident or his/her representative to enter into a binding arbitration agreement?
Yes
No
Yes
Notes:
06/30/21 02:10 PM
10

Initial Pool

MDS indicators changes:

- Catheter
- Depression
- Low-risk B&B
- Pain
- Wandering
- Infection priority

New MDS indicators:

- PTSD
- Schizophrenia
- Antibiotics

Initial Pool

New Probes

- Accommodation of needs
- Mood & Behavior
- New antibiotic use area
- Smoking
- Schizophrenia item in record review for the new indicator

Staffing information is pulled forward and available from Offsite prep throughout the initial pool areas.

Sample Selection

- Significant redesign to resolve some ongoing issues and enhance functionality to promote increased efficiency and accuracy and ensure a thorough sample selection that meets the requirements.
- Closed record sample selection: The system will not prioritize unplanned, facility-initiated discharges before selecting a discharged resident who had a planned, resident-initiated discharge.
- For the Unnecessary Medication review – the system selects a resident who is receiving an anticoagulant, insulin, and an antipsychotic with Alzheimer's or dementia if available. The system will now sample a resident who is 65 or older and is receiving an antipsychotic and has a new dx of schizophrenia after admission, if available.
- The team is also now permitted to remove residents from a sampled area if the team agrees an area is oversampled and the team isn't ruling out SQC.

Investigations

Minor Pathway revisions:

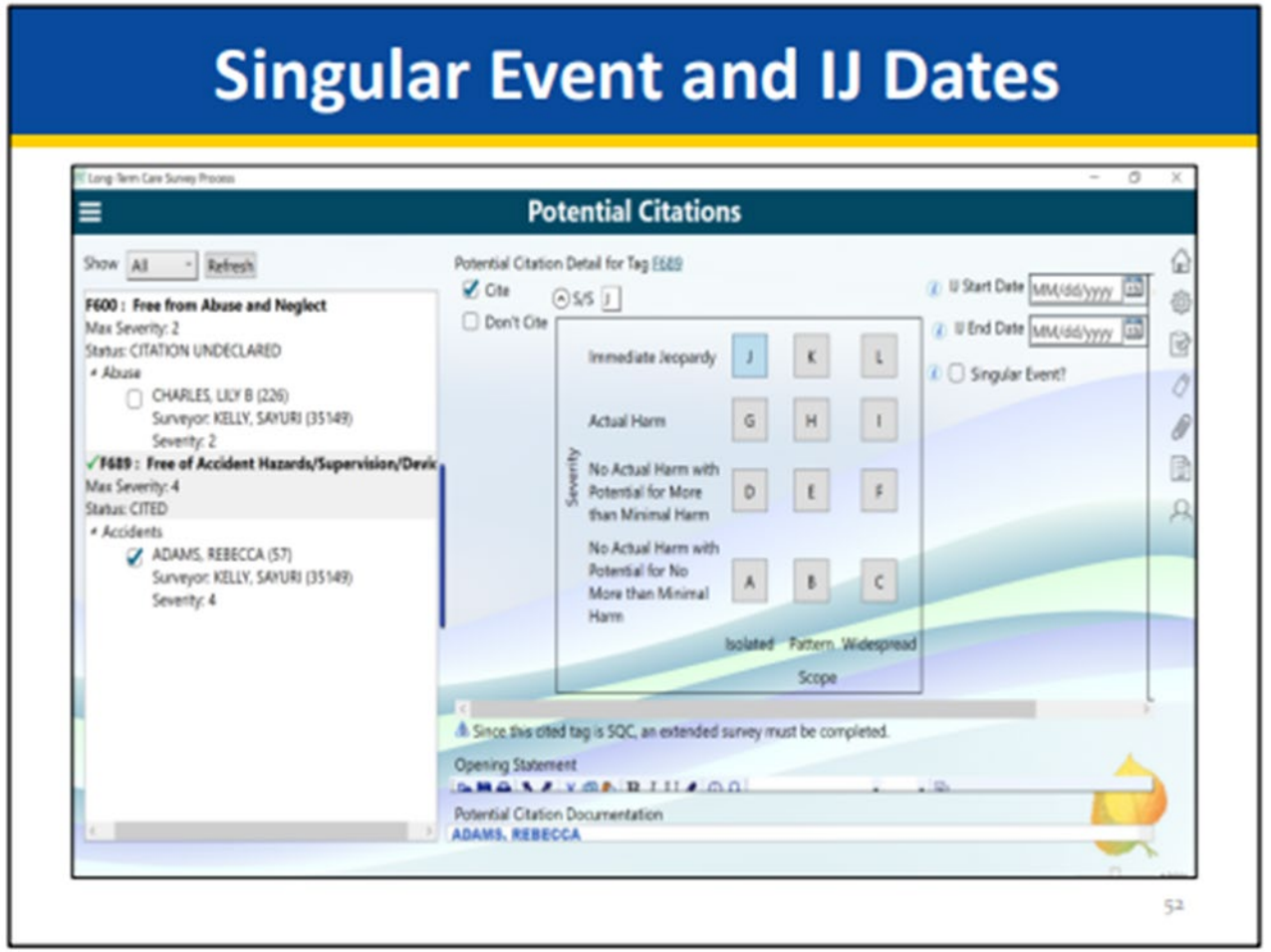
- **Med storage**
- **Dining**
- **Kitchen**
- **Resident council**
- **Environment**
- **Personal Funds**
- **Beneficiary Notification**
- Urinary Cath
- Dental
- Pain
- Accidents
- Hospitalization
- Unnecessary meds
- Abuse/Neglect

Major Pathway Revisions:

- **Extended**
- Dementia
- **Sufficient Staffing**
- Behavioral-Emotional
- Discharge
- **QAPI**
- **Infection Control**
- **Arbitration (new)**

- **Mandatory Facility Tasks**
- **Triggered Facility Tasks**

Potential Citations



Thank You!

Theresa Gullingsrud

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Resources

QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide. Attachments and advanced pathways:

https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/revised-long-term-care-surveyor-guidance-revisions-surveyor-guidance-phases-2-3-arbitration

Resources

- CMS Nursing Home Website- Surveyor Resources: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes
- QSEP https://qsep.cms.gov/welcome.aspx

Thank You