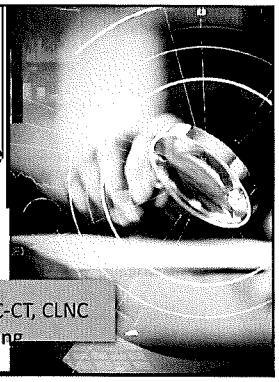
PROACTIVE
MEDICAL REVIEW

Intensive Training on New and Updated CMS Guidance and Implications

KAHCF/KCAL Annual Meeting
November 15, 2022



Presented by: Janine Lehman, RN, RAC-CT, CLNC
Director of Legal Nurse Consulting

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Janine Lehman, RN, RAC-CT, CLNC

Janine is a Registered Nurse with over 30 years experience in long term care, working in all nursing capacities from Nursing Assistant and Charge Nurse, to MDS Coordinator, Staff Development Coordinator, ADON and DON. She is MDS Certified through AAPACN and is a Certified Legal Nurse Consultant. Her background includes serving as a Corporate Nurse Consultant, and the Director of Clinical Services for a multi-facility, multi-level of care organization. Janine serves as a founding member of the Kentucky RUG Task Force Committee and has served on the Case Mix Appeals Panel and IDR Panel as a provider representative, as well as serving on the Kentucky Medicaid Technical Advisory Committee.

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Objectives

1. Review the Phase 2 and 3 new and updated RoP guidance that surveyors are using to identify non-compliance.
2. Guide participants through what areas of the guidance are new or have been revised, how surveyors drill down to determine compliance, actions providers should take to ensure compliance.
3. We will review the American Health Care Association's and other resources to help Kentucky navigate this topic.

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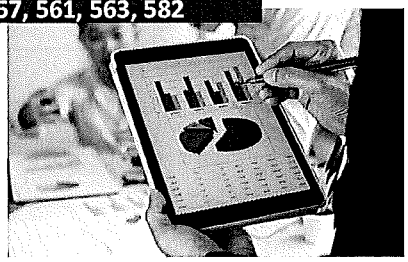
Resident Rights F557, 561, 563, 582



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F557 §483.10(e) Respect and Dignity Procedures

- Must obtain consent from resident or resident's representative for staff searches of resident's body or personal possessions.
- Staff should have knowledge of signs, symptoms, and triggers of possible substance use
- Refer cases of illegal substance brought into facility by visitors to local law enforcement
- Surveyors will refer to F689-Accidents for concerns related to identification of risk & supervision to prevent accidental overdoses & F740-Behavioral Health Services for concerns related to behavioral health services.

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F561 §483.10(f) Self-determination Guidance

- If you change your policy to prohibit smoking (including electronic cigarettes), must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents.
- The smoking area may be an outside area provided that residents remain safe.
- Residents admitted after the facility changes its policy must be informed of this policy at admission.
- For further explanation of safety concerns, refer to §483.25(d), F689.
- For information on smoking policies, refer to §483.90(i)(5), F926.

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F563 Right to Receive/Deny Visitors Guidance

- Policy & procedures for reasonable clinical and safety restrictions to protect residents and staff may now include denying access or providing supervised visitation to individuals with history of bringing illegal substances into facility

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F563 Right to Receive/Deny Visitors Visitation Considerations During a Communicable Disease Outbreak

- May need to modify visitation practices when infection outbreaks occur to align with current CMS/CDC guidance
- Residents on transmission-based precautions can still receive visitors
- Visitors should be educated on potential risks & necessary precautions that must be followed
- Visitors must adhere to principles of infection prevention
- Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life

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F563 Right to Receive/Deny Visitors Visitation & Illegal Substance Use

- Staff should have knowledge of signs, symptoms, & triggers of possible illegal substance use
- If resident exhibits signs & symptoms of possible substance use after interaction with visitors, facility may ask resident whether or not they possess or have used an illegal substance
- If facility determine illegal substances have been brought into facility by visitor, referral should be made to local law enforcement & additional monitoring & supervision may need to be provided to protect residents
- Facility staff should not conduct searches of a resident or their personal belongings, unless the resident or resident representative agrees to a voluntary search and understands the reason for the search

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Action Plan for Compliance

- Update policy & procedures
- Staff training

√ Visitation
√ Substance Use
√ Smoking
√ Resident Privacy
√ Medicaid/Medicare Coverage notices

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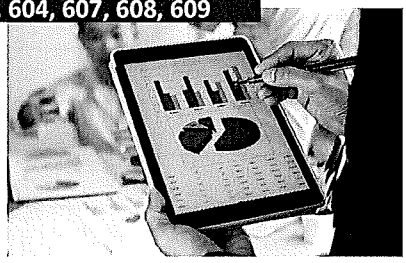
Abuse, Neglect, & Exploitation F600, 604, 607, 608, 609



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F600 §483.12 Freedom from Abuse Resident to Resident Abuse of Any Type

- Surveyors should not assure that every resident-to-resident altercation results in abuse
- Must determine if incident meets definition of abuse
- Abuse -- "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology" (Appendix PP Page 2)
- Infrequent arguments or disagreements during course of normal social interactions would not constitute abuse

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F600 §483.12 Freedom from Abuse Capacity and Consent

- 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.

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F600 §483.12 Freedom from Abuse Determination of Past Non-Compliance

- Prior to citing a deficiency as past-noncompliance, surveyors should investigate each instance thoroughly to determine if the facility took all the appropriate actions to correct the noncompliance, and determine the date on which the facility had returned to substantial compliance
- If abuse is identified, you must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately.
- Taking immediate action to correct any issues can reduce the risk of further harm continuing or occurring to other residents, thereby potentially preventing the scope and severity of the deficiency from increasing.
- Failure to take steps could result in findings of current noncompliance and increased enforcement action

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F600 §483.12 Freedom from Abuse Neglect

- Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress
- Occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but fails to provide them to the resident(s), that results in, or may result in, physical harm, pain, mental anguish, or emotional distress.
- Includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress
- Not every deficiency at Resident Rights, Quality of Care, or Quality of Life will result in finding of neglect

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F600 §483.12 Freedom from Abuse Investigative Procedures

- If Tag F600 is cited for abuse, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567:
- "Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from [Type(s) of abuse: mental abuse/verbal abuse/physical abuse/sexual abuse/deprivation of goods and services] by [Perpetrator type: staff/a resident/a visitor]...."
- If Tag F600 is cited for neglect, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567:
- "Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from neglect...."
- See new examples added for abuse citations on pages 21-24 of abuse changes handout

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F604 Right to be Free from Physical Restraints New Guidance Regarding Bed Rails

- A bed rail is considered to be a restraint if the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently

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Abuse Related Definitions New Definitions Added

- Covered Individual – anyone who is an owner, operator, employee, manager, agent or contractor of the facility
- Crime – defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law
- Law Enforcement – the full range of potential responders to elder abuse, neglect, and exploitation including police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners
- Serious Bodily Injury – an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse
- Criminal Sexual Abuse – In the case of "criminal sexual abuse" which is defined in section 2011(19)(B) of the Act, serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act
- Willful – individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F607 Develop/Implement Abuse Policies Guidance

- F608 Reporting Reasonable Suspicion of Crime Deleted
- F607 for citations related to failing to develop/implement written policies & procedures related to posting conspicuous notice of employee rights & prohibiting & preventing retaliation
- Deficient practice statement: Based on [observations/interviews/record review], the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act...
- F609 for citations related to failing to ensure reporting of suspected crimes & notifying individuals of their reporting responsibilities

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F607 Develop/Implement Abuse Policies Guidance

- For concerns related to not developing and/or implementing policies and procedures related to screening procedures prior to employment, a finding of noncompliance will be considered at F607, not F606.
- For concerns related to employing or engaging an individual, either directly or under contract, who was found guilty by a court of law of abuse, neglect, misappropriation of property, exploitation or mistreatment, or had a finding entered into the State nurse aide registry or has a disciplinary action in effect against his/her professional license concerning abuse, neglect, mistreatment of residents or misappropriation of resident property, a finding of noncompliance will be cited at F606.

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F607 Develop/Implement Abuse Policies Reporting/Response

- Abuse policy & procedures should address:
- Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint;
- Prohibiting retaliation against an employee who reports a suspicion of a crime

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F607 Develop/Implement Abuse Policies Coordination with QAPI

- Abuse policy & procedures should address:
- How staff will communicate and coordinate situations of abuse/neglect with QAPI program
- Physical or sexual abuse cases always require corrective actions & tracking by QAA committee

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F609 Reporting of Alleged Violations New Requirement

- §483.12(b) The facility must develop and implement written policies and procedures that:
- §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.
- (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.
- (A)Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.
- (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

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F609 Reporting of Alleged Violations Guidance

- Once an individual suspects that a crime has been committed, facility staff should exercise caution when handling materials that may be used for evidence or for a criminal investigation.
- Facilities should reference applicable State and local laws regarding preserving evidence.
- It has been reported that some investigations were impeded due to washing linens or clothing, destroying documentation, bathing or cleaning the resident before the resident has been examined, or failure to transfer a resident to the emergency room for examination including obtaining a rape kit, if appropriate.

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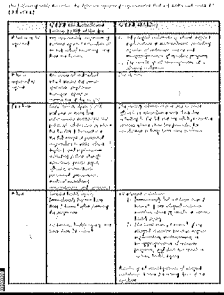
F609 Reporting of Alleged Violations



- There are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to be reasonable suspicion of a crime.
- In these cases, the facility is obligated to report to the administrator, to the state survey agency, and to other officials in accordance with State law (see F609).
- Regardless, covered individuals still have the obligation to report the reasonable suspicion of a crime to the State Survey Agency and local law enforcement.

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F609 Reporting of Alleged Violations Ensuring the Reporting of a Reasonable Suspicion of a Crime

- Policy & procedures should include:
- Identification of who in the facility is considered a covered individual;
- Identification of crimes that must be reported;
- NOTE: Each State and local jurisdiction may vary in what is considered to be a crime and may have different definitions for each type of crime. Facilities should consult with local law enforcement to determine what is considered a crime.
- Identification of what constitutes "serious bodily injury;"
- The timeframe for which the reports must be made; and
- Which entities must be contacted, for example, the State Survey Agency and local law enforcement.

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F609 Reporting of Alleged Violations Ensuring the Reporting of a Reasonable Suspicion of a Crime

- May have policies and procedures where the administrator could coordinate timely reporting to the State Survey Agency and law enforcement on behalf of covered individuals who choose to the report to the administrator.
- Risks to the covered individual for reporting to the administrator could be mitigated if an individual has clear assurance that the administrator is reporting it and submitting a collective report would not cause delays in reporting according to specified timeframes.
- Reports should be documented and the administrator should keep a record of the documentation.
- It remains the responsibility of each covered individual to ensure that his/her individual reporting responsibility is fulfilled, so it is advisable for any multiple-person report to include identification of all individuals making the report.
- You cannot prohibit or circumscribe a covered individual from reporting directly to law enforcement even if you have a coordinated internal system

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F609 Reporting of Alleged Violations Ensuring the Reporting of a Reasonable Suspicion of a Crime

- Include examples of crimes that would be reported in your policy and procedure
  - Murder
  - Manslaughter
  - Rape
  - Assault & battery
  - Sexual abuse
  - Theft/Robbery
  - Drug diversion
  - Identify theft
  - Fraud and forgery

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F609 Reporting of Alleged Violations Ensuring the Reporting of a Reasonable Suspicion of a Crime

- Policy & 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

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F609 Reporting of Alleged Violations Annual Notification of Reporting Obligations to Covered Individuals

- Policy & procedures should address:
  - Who are covered individuals in the facility
  - How covered individuals are notified of the reporting requirements
  - Timeframe requirements for reporting reasonable suspicion of crimes
  - Penalties associated with failure to report
  - Mechanism for documenting that all covered individuals have been notified annually of their reporting obligations

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F609 Reporting of Alleged Violations
Reporting Alleged Violations

- Alleged violations can be observed or reported by staff, resident, family, visitors, another provider, or others
- You must submit reports that are accurate, to best of your knowledge at the time of submission
  - Avoid making reports that are misleading
  - Include sufficient information to describe alleged violation & how residents are being protected

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F609 Reporting of Alleged Violations
Initial Report

- Allegations of abuse or any serious bodily injury must be reported immediately (within 2 hours after allegation is made)
- Allegations of neglect, exploitation, misappropriation of property, or mistreatment with no serious bodily injury must be reported within 24 hours

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Initial Report

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.

1. Facility Information

Facility Name
CMS Certification Number (CCN)
Address
Phone number
Email address

2. Allegation Type

Select all that apply to the reportable incident

Abuse specify whether	Physical	Sexual	Mental/Verbal
Deprivation of Goods and Services by Staff			
Neglect Property Exploitation		Misappropriation of Resident	
Injury of Unknown Source		Suspected Crime	

3. Information about when the Facility became aware of the incident

Date/Time Name of when staff became aware of the incident
Date/Time administrator was notified of the incident and by whom

Sample Form for Initial Reporting – Exhibit 358

- See Handout

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F609 Reporting of Alleged Violations Follow-up Investigation Report

- Within 5 working days of the incident, must provide report with sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified
  - Provide as much information as possible, to best of your knowledge
  - Include any updates to information provided in initial report

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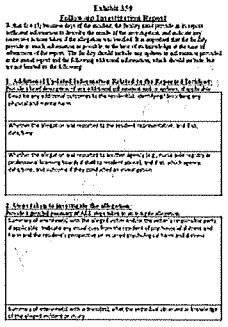
Sample Follow-Up Investigation Report Exhibit 359



- See Handout

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F609 Reporting of Alleged Violations Staff to Resident Abuse

- Must report all allegations/occurrences of all types of staff-to-resident abuse, including:
  - Physical, sexual, mental, & verbal abuse
  - Deprivation of goods & services by staff
  - Involuntary seclusion perpetrated by staff
  - Staff taking or distributing demeaning or humiliating photos or recordings
  - All reports from residents of abuse by staff, regardless of resident's cognition

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F609 Reporting of Alleged Violations
Staff to Resident Abuse

Type of Abuse	Required to Report	Not Required to Report
Mental/Verbal Conflict	• Intimidation • Bullying • Communication that is motivated by an actual or perceived characteristic (i.e., race, color, religion, sex, disability, or sexual orientation that results in mental anguish or social withdrawal) • Threats of violence • Inappropriate sexual comments that are used in an deliberately threatening manner • Inappropriate sexual comments that offend, humiliate, or demean a resident • Taking and/or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging	• Non-targeted outbursts • Residents with certain conditions (e.g., Huntington's/ Tourette's) who exhibit verbalizations • Arguments or disagreements, which do not include any behavior or communication identified in required to report column

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F609 Reporting of Alleged Violations
Staff to Resident Abuse

Type of Abuse	Required to Report	Not Required to Report
Sexual Contact	• Unwanted touching of breasts or perineal area • Sexual activities where one resident indicates the activity is unwanted through verbal or non verbal cues • Sexual activity or fondling where one of resident's capacity to consent is unknown • Sexual assault or battery (ex. Rape, sodomy, coerced nudity) • Instances where alleged victim is transferred to hospital for exam and/or treatment of injuries resulting from possible sexual abuse • Forced observation of masturbation or pornography • Forced, coerced, or extorted sexual activity • Other unwanted actions for purpose of sexual arousal or gratification resulting in degradation or humiliation of another resident	• Consensual sexual contact between residents who have capacity to consent to sexual activity • Affectionate contact such as hand holding, hugging, or kissing with resident who indicates consent to 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

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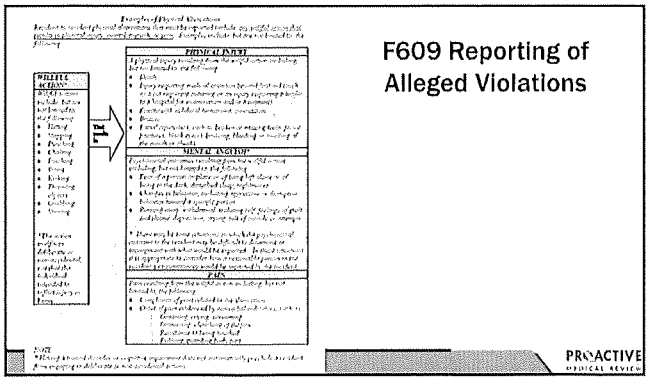

F609 Reporting of Alleged Violations

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F609 Reporting of Alleged Violations
Reporting Suspicious Injuries of Unknown Source

Type of Abuse	Required to Report	Not Required to Report
Injuries of Unknown Source	• Unobserved/Unexplained [illegible]	• Bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect • Injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect • Injuries that were witnessed by staff, where there is no indication of abuse or neglect Note: even if injury is not one that requires a report, facility should adequately assess & monitor resident, notify MD/RP, and document injury & investigation as part of medical record

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F609 Reporting of Alleged Violations
Reportable Events Related to Potential Neglect

- Neglect – the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress
  - Occurs when the facility is aware, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish or emotional distress.
- Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress.
  - 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 position would be impacted by the incident.

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F609 Reporting of Alleged Violations
Reportable Events Related to Potential Neglect

- Examples of events to be reported include, but are not limited to, the following:
  1. Failure to meet payroll or pay supplier bills resulting in residents not receiving goods or services
  2. 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.
  3. 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.
  4. 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.

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F609 Reporting of Alleged Violations Reportable Allegations of Misappropriation of Property & Exploitation

Type of Abuse	Required to Report	Not Required to Report
Misappropriation of resident property & exploitation	• Theft of personal property, including but not limited to jewelry, computer, phone, and other valuable items such as eyeglasses and hearing aids; • Unauthorized/coerced use by staff of resident's personal property; • Theft of money from bank accounts; • Unauthorized or coerced purchases on a resident's credit card; • Unauthorized or coerced purchases from resident's funds; • Staff who accept money from a resident for any reason including when staff have made the resident believe that staff was in a financial crisis or the resident believes that he/she is in a relationship with the staff person; • A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion; and • Missing prescription medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain	• Theft of nominal items with little to no monetary or sentimental value; • Lost items that are not listed under "must be reported

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Action Plan for Compliance

- Update abuse policy & procedures
- Document all actions related to resolving grievances/allegations
- Staff training on reporting requirements
- Policy & Procedure for communication & coordination with QAPI

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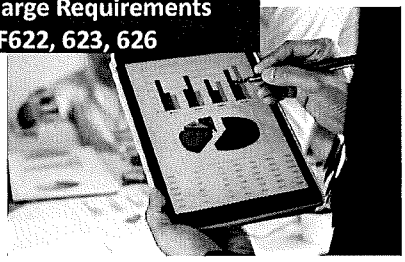
Admission, Transfer, & Discharge Requirements F622, 623, 626



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F622 Transfer & Discharge Requirements Guidance

- If a resident is forced, pressured, or intimidated into leaving AMA, the discharge would be considered a facility-initiated discharge, requiring further investigation to determine compliance with the transfer/discharge requirements
- If a resident admitted for short-term skilled rehab under Medicare communicates that they are not ready to leave facility following rehab & facility proceeds with discharge, it is considered a facility-initiated discharge & may require investigation to ensure discrimination based on payment source has not occurred

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F622 Transfer & Discharge Requirements Guidance

- The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
  - (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
  - (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
  - (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
  - (D)The health of individuals in the facility would otherwise be endangered;
  - (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
  - (F)The facility ceases to operate

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F622 Transfer & Discharge Requirements Nonpayment as Basis for Discharge

- When Medicare ends & resident still needs long-term care, facility should offer option to remain at facility & pay privately or assist resident to apply for Medicaid
  - If denied Medicaid, resident is responsible to pay for all days after Medicare payment ended
  - If eligible for Medicaid, but facility does not have a Medicaid bed, or only participates in Medicare, resident should be discharged to facility with available Medicaid beds if the resident wants stay paid by Medicaid.
- Resident cannot be discharged for nonpayment while Medicaid is pending, or if found eligible

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F622 Transfer & Discharge Requirements Emergency Transfers to Acute Care

- Emergent transfers to acute care are considered facility-initiated transfers, not discharges, as resident's return is generally expected
- If facility initiates a discharge while resident is in hospital following an emergency transfer, must have evidence that resident's status, at the time resident seeks to return to facility, meets criteria for issuing discharge
- Resident has right to return to facility pending appeal of facility-initiated discharge, unless return would endanger health or safety of resident or others in facility.
- In this situation, facility must document danger failure to transfer/discharge would pose.

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F623 Notice Requirements Before Transfer/Discharge & Ombudsman Notification

- For facility-initiated transfers or discharges of a resident, notice of transfer/discharge must be provided to resident & resident representative prior to the transfer or discharge
  - Notice must also be sent to ombudsman
  - The facility must maintain evidence that the notice was sent to the Ombudsman
- When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer.
- Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices at §483.15(c)(5).

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F623 Notice Requirements Before Transfer/Discharge Contents of the Notice

- 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 (such as the name of the new provider or description and/or address if the location is a residence) 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 requests;
  - 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.
  - For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice must include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy for these populations.

PROACTIVE MEDICAL REVIEW

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F623 Notice Requirements Before Transfer/Discharge Timing of the Notice

- 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 affected 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

PROACTIVE MEDICAL REVIEW

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F623 Notice Requirements Before Transfer/Discharge Contents of the Notice

- 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
  - If a change in destination indicates that the original basis for discharge has changed, a new notice is required and additional appeal rights may exist for the resident.
  - This situation may require further investigation to determine whether the facility is in compliance with the Transfer and Discharge requirements at 42 CFR 483.15(c).
- Example: A facility determines it cannot meet a resident's needs and arranges for discharge to another nursing home which can meet the resident's needs. Before the discharge occurs, the receiving facility declines to take the resident and the discharging facility changes the destination to a setting that does not appear to meet the resident's ongoing medical needs. This could indicate that the basis for discharge has changed and would require further investigation.

PROACTIVE MEDICAL REVIEW

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F626 Permitting Residents to Return to Facility Guidance

- Requirement to permit resident 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.

PROACTIVE MEDICAL REVIEW

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F626 Permitting Residents to Return to Facility Composite Distinct Part

- Requirement only applies to facilities with composite distinct parts
- Residents 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

PROACTIVE MEDICAL REVIEW

55

F626 Permitting Residents to Return to Facility Example of Noncompliance

- After transfer to a behavioral health hospital, a facility failed to allow a resident to return to the facility where the resident had lived for several months. The facility then refused to allow the resident to return to the facility when the hospitalization ended, resulting in the resident being transferred from the hospital to a different nursing home 40 minutes away, where he did not know anyone, and where he developed increased anxiety and depression.

PROACTIVE MEDICAL REVIEW

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Action Plan for Compliance

- Review of Transfer/Discharge Policy and/or processes to ensure following are addressed:
  - What to do when skilled services end, but resident is not ready to discharge
  - Facility's responsibility to resident when MCR coverage ends
  - Return to facility following acute care transfers
- Updates to notice of transfer/discharge
  - Specific location where resident is being transferred/discharged to
    - Name of new provider and/or address if discharging to a residence
  - Requirement to provide new notice if destination changes
- Review/update bed hold policies
  - Address allowing all residents, regardless of payer source, to return after hospitalization or leave unless resident meets a discharge requirement
- Examine how you determine that you are unable to meet residents needs when deciding not to allow residents to return to a facility
  - Ensure these determinations are appropriate based on the regulation and ensure documentation coincides with requirements

PROACTIVE MEDICAL REVIEW

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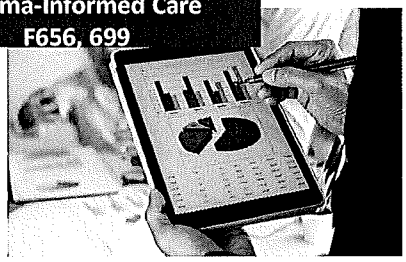
Culturally-Competent & Trauma-Informed Care F656, 699



PROACTIVE MEDICAL REVIEW

58

F656 §483.21(b) Comprehensive Care Plans

- §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
  - (iii) Be culturally-competent and trauma-informed.

PROACTIVE MEDICAL REVIEW

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F656 §483.21(b) Comprehensive Care Plans

- Culture - the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world. Adopted from Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. https://store.samhsa.gov/system/files/sma14-4849.pdf
- Cultural Competency - a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities. US Department of Health and Human Services publication. A Blueprint for Advancing and Sustaining CLAS Policy and Practice at: https://www.thnci.culturalhealth.hhs.gov/clas/blueprint
- 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 ("Trauma." SAMHSA-HRSA Center for Integrated Health Solutions. Substance Abuse and Mental Health Services Administration. 30 Nov 2016. Accessed at: http://www.integration.samhsa.gov/clinical-practice/trauma
- Trauma-informed care- Is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Adapted from: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. https://store.samhsa.gov/system/files/sma14-4884.pdf

PROACTIVE MEDICAL REVIEW

60

F656 §483.21(b) Comprehensive Care Plans

Culturally Competent Care

- Refers to a person's ability to interact effectively with persons of cultures different from his/her own.
- It means being respectful and responsive to the health beliefs, practices and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious or social groups
- Interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity

Trauma-Informed Care

- Implementation of trauma-informed approaches is an essential part of person-centered care.
- Recognizes effects of past trauma on residents and collaborates with the resident, family and friends of the resident to identify and implement individualized interventions.
- Interventions recognize the relationship between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others.

PROACTIVE MEDICAL REVIEW

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Immediate Jeopardy Citation Example

- The facility failed to identify a resident's cultural dietary restrictions related to eating pork. After eating her dinner, upon realization that she had eaten pork, the resident began crying inconsolably and screaming that this was explicitly forbidden in her culture and faith of Islam. The resident remained tearful and inconsolable for several days, and would not eat the food provided by the facility, which resulted in weight loss and serious psychosocial harm.

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Trauma-informed care

- 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.

PROACTIVE MEDICAL REVIEW

63

F699 §483.25(m) Trauma-informed care

Background

- Cultural competency is an important aspect of person-centered care
- Includes language, cultural preferences, and other cultural aspects (thoughts, communication, actions, customs, beliefs, values, & institutions of racial, ethnic, religious, or social groups
- 70% of adults have experienced some type of traumatic event
- Direct correlation between trauma & physical health conditions
- Principles of trauma-informed care must be addressed & applied purposefully

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Trauma-informed care

Assessment

- Facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences.
- This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the **Resident Assessment Instrument** (RAI), **Admission Assessment**, the **history and physical**, the **social history/assessment**, and others.
- There are many psychosocial screening and assessment tools available at the following SAMHSA website: https://www.integration.samhsa.gov/clinical-practice/screening-tools#TRAUMA

PROACTIVE MEDICAL REVIEW

65

F699 §483.25(m) Trauma-informed care

Trauma

- The history and physical assessment can reveal many clues to a resident's history of trauma.
  - Scars and other signs of physical trauma should be explored to determine the cause if the resident is comfortable/agreeable with discussing them.
  - Numerical tattoos may be an indicator of World War II Holocaust survivors.
  - Residents with a history of trauma may have diagnoses such as anxiety, depression, or may have substance abuse issues such as alcoholism, and/or may abuse prescription medications or street drugs.
- Evidence of physical and/or psychological trauma may be identified during a comprehensive social history or assessment by the social worker.

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Trauma-informed care

Triggers

- 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.
- For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization.
- While most triggers are highly individualized, some common triggers may include:
  - Experiencing a lack of privacy or confinement in a crowded or small space;
  - Exposure to loud noises, or bright/flashing lights;
  - Certain sights, such as objects that are associated with those that used to abuse, and/or
  - Sounds, smells, and even physical touch.

PROACTIVE MEDICAL REVIEW

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Promoting Safe Environment

- Keeping common areas, bathrooms, entrances well lit
- Monitoring who is coming in & out of building
- Keeping noise levels low
- Use welcoming language
- Clear access to doors in rooms
- Maintain healthy interpersonal boundaries
- Consistent schedules & routines
- Offering sufficient notice & preparation for changes
- Consistent, open, respectful, compassionate communication
- Cultural awareness

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Trauma-informed care

Examples of trigger-specific interventions include, but are not limited to the following:

Trigger	Intervention
Shower/shower fixtures	Provide alternative methods for bathing such as tubs, sponge bath
Confinement in small/crowded spaces	Offer individual and/or small group activities
Loud noises	Decrease/eliminate exposure to loud noises during holiday celebrations (July 4th, New Year's Eve); and/or decrease volume of, or eliminate overhead paging systems
Removal of clothing	Consideration should be given to methods of assistance given to resident such as: • Consistent staffing/same-sex care giver • Removing clothing slowly • Explanation of what is happening
Exposure to smoke or fire	• Remove from areas where smoking is permitted, or cookouts occur; • Provide alternative meals inside facility

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Culturally Competent

Culture Assessment

- Minimum Data Set (MDS) items in section A address Race, Ethnicity, and Language with which the resident most closely identifies.
  - May indicate further assessment is necessary to determine if there are any cultural preferences which should be honored while the resident is in the facility.
  - Provide demographic race/ethnicity specific health trend information.
  - Identifies whether the resident wants or needs an interpreter and the resident's preferred language.
- Inability to make needs known and to engage in social interaction because of a language barrier can result in isolation, depression, and unmet needs. Language barriers can interfere with accurate assessment.
- Facilities must use their Facility Assessment to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences.
  - Facilitates a facility-wide and department-wide understanding of cultural differences and how to approach the provision of care and services with dignity and respect for that individual.

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Culturally Competent

- The following resources are provided for informational purposes only:
- The National Center for Cultural Competence https://nccc.georgetown.edu
- The National Standards for Culturally and Linguistically appropriate Services in Health and Health Care (developed by the Office of Minority Health in HHS) https://www.thinkculturalhealth.hhs.gov/clas/blueprint
- Office of Minority Health "Think Cultural Health" website https://www.thinkculturalhealth.hhs.gov
- Georgetown University publication: Cultural Competence in Health Care: Is it important for people with chronic conditions https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Culturally Competent

Care Planning to Address Cultural Preferences

- Staff must understand the cultural preferences and how it impacts the delivery of care for the individual.
- Effective communication is critical to be able to identify physical concerns and issues, and for developing a trusting relationship with staff.
- Staff must demonstrate proficiency in communicating with the resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services.
- Care plan should identify the language spoken and what tools are available to communicate, including translators. communication board and/or other systems.
- When communication systems are used, all staff interacting with the resident must know where to locate them, understand how to use them, and consistently implement their use.
- The facility must provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for the resident.

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Culturally Competent

Care Planning to Address Cultural Preferences

- Aspects of cultural preferences which may impact the delivery of care, include:
  - Food preparation and choices;
  - Clothing preferences such as covering hair or exposed skin;
  - Physical contact or provision of care by a person of the opposite sex; or
  - Cultural etiquette, such as avoiding eye contact or not raising the voice.

PROACTIVE MEDICAL REVIEW

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F699 §483.25(m) Culturally Competent

Care Planning to Address Cultural Preferences

- Facilities should also consider
  - Offering activities that are culturally relevant to resident populations within the facility;
  - Group activities with both sexes may not be permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences;
  - Providing reading materials, movies, newspapers in the resident's preferred language may help orient a resident to date, times and events;
  - Allowing the performance of religious rites at end of life to the extent possible; and
  - Certain medications, procedures or treatments may be prohibited

PROACTIVE MEDICAL REVIEW

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Surveyor Investigation of Concerns Re: Culturally Competent and Trauma Informed Care

F656: Comprehensive Care Plan	F699: Trauma Informed Care	F726: Competent Nursing Staff	F742: Treatment for Mental/Psychosocial
• For concerns related to development or implementation of culturally competent and/or trauma-informed care plan interventions;	• For concerns related to outcomes or potential outcomes to the resident related to culturally-competent and/or trauma-informed care;	• For concerns related to the knowledge, competencies, or skill sets of nursing staff to provide culturally competent and trauma informed care or services	• For concerns related to treatment and services for resident with history of trauma and/or history of post-traumatic stress disorder (PTSD)

PROACTIVE MEDICAL REVIEW

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Action Plan for Compliance

- Care Plan Reviews
  - Interventions reflect resident's cultural preferences, values & practices
  - For residents with history of trauma
    - Does care plan describe interventions for care that account for resident's experiences & preferences to eliminate or mitigate triggers
- Screening/Assessment tools
  - History of trauma
  - Cultural Needs
- Policy & Procedures
  - Trauma-Informed Care
  - Cultural Competence
  - Comprehensive Care Plans

PROACTIVE MEDICAL REVIEW

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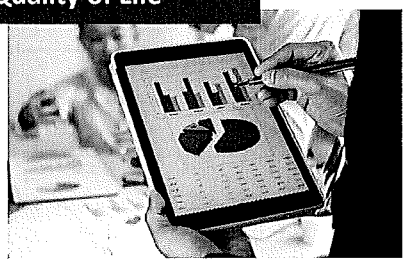
Quality of Life



PROACTIVE MEDICAL REVIEW

77

F679 §483.24(c) Activities

- ADDED GUIDANCE:
- Opportunities for each resident to have a meaningful life may be created by supporting his/her domains of well-being (e.g., security, autonomy, growth, connectedness, identity, joy and meaning) as identified by the Eden Alternative philosophy of care.
- More information may be found at: http://www.edenalt.org/about-the-eden-alternative/theeden-alternative-domains-of-well-being
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PROACTIVE MEDICAL REVIEW

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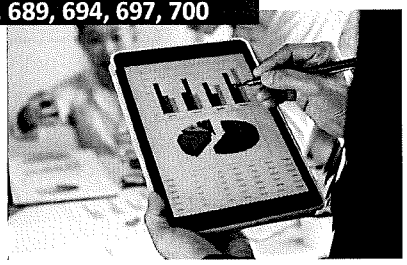
Quality of Care
F687, 689, 694, 697, 700



PROACTIVE MEDICAL REVIEW

79

F686 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.

Pressure Ulcer Risk Assessment:

- Clarifies that the risk assessment should occur:
  - Upon admission
  - Weekly for the first 4 weeks
  - Quarterly (this was changed from monthly based on current standard of practice)
  - When a change in Condition Occurs

PROACTIVE MEDICAL REVIEW

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F687 §483.25(b)(2) Foot care

- Clarifies the need to apply proper infection prevention and control practices for foot care equipment as follows
  - Facility staff must separate used or contaminated foot care equipment from clean equipment.
  - Reusable medical devices (e.g., scalers, electronic nail file, and surgical instruments) that are used on one resident must be cleaned and reprocessed (disinfection or sterilization) for use according to manufacturer's instructions prior to use on another resident.
  - Recommendations for the cleaning, disinfection, and sterilization of medical devices are available in CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html)
- NOTE:, "staff" includes employees, the medical director, podiatrists, consultants, contractors, and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.

PROACTIVE MEDICAL REVIEW

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F689 §483.25(d) Accidents

Updates Guidance to 2 key areas:

- The use of electronic cigarettes (e-cigarettes), including the need for facilities to oversee use and to address them in smoking policies,
  - how staff will supervise resident use of e-cigarettes
  - how batteries and refill cartridges will be handled, and
  - how the facility will keep residents safe, including protecting residents who want to avoid exposure to second-hand aerosol.
- Safety for residents with a substance use disorder, including
  - Documentation requirements if the resident leaves the facility and the facility knows about the departure.
  - Requires the facility to assess the resident's risk for using illicit substances in the facility,
  - Train staff on the signs and symptoms of possible substance use, and
  - Train staff to be prepared to address related emergencies

PROACTIVE MEDICAL REVIEW

82

F694 §483.25(h) Parenteral Fluids

- Policy & procedures should address:
  - Use of appropriate antiseptic to scrub IV ports, needless connectors, & hubs prior to access or use
  - Frequency of assessment of IV catheter to assess the insertion site for signs and symptoms of infection or inflammation (i.e., at least daily or with each use).
- Frequency may depend upon such factors as the:
  - Ability of resident to report symptoms of pain, redness, etc.
  - Type of infusion—is it an irritant or vesicant?
  - Location of IV catheter—is it inserted in an area of flexion; and
  - Facility policy based on long-term care pharmacy IV policies and procedures.
- Assessment of continued need for the catheter if not being used for IV fluids or medications.

PROACTIVE MEDICAL REVIEW

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F697 §483.25(k) Pain Management

- Use of Opioids for Pain Management
  - Added definitions for medication-assisted treatment and opioid use disorder;
  - Provides strategies and resources for the use of opioids for pain management;
  - Instructs facilities to assess for a history of addiction or past or ongoing treatment for opioid use disorder and to evaluate for potential drug diversion if a resident reports or has signs of increased pain; and
  - Describes opioid side effects and the need for facilities to have a written policy addressing opioid overdoses

PROACTIVE MEDICAL REVIEW

84

F700 §483.25(n) Bed Rails

- When no appropriate alternative is identified, the medical record documentation must include the following:
  - Purpose of the bedrail and notation that no alternative was identified
  - An entrapment risk assessment of the resident, bedrail and mattress
  - Assessment of risks vs benefits that were reviewed with the resident or resident representative, who must give informed consent prior to use.

PROACTIVE MEDICAL REVIEW

85

F700 §483.25(n) Bed Rails

- Information that the facility should provide to the resident, or resident representative for informed consent include:
  - What assessed medical needs would be addressed by the use of bed rails;
  - The resident's benefits from the use of bed rails and the likelihood of these benefits;
  - The resident's risks from the use of bed rails and how these risks will be mitigated; and
  - Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.
- The information should be presented to the resident or the resident representative, so that it can be understood and that consent can be given voluntarily, free from coercion.

PROACTIVE MEDICAL REVIEW

86

F700 §483.25(n) Bed Rails

- Process for determining whether beds are appropriate & safe for each resident
- For pre-installed rails, must determine whether or not disabling the rail poses a risk for resident
- Follow manufacturers' recommendations regarding disabling or tying down rails

PROACTIVE MEDICAL REVIEW

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Action Plan for Compliance

- Policy & Procedure Review/Updates
  - Foot Care – Infection Control Requirements
  - Use of electronic cigarettes
  - Care of residents with substance use disorders
  - IV Therapy
  - Pain Management
  - Opioid Overdose
  - Bed Rails
- Assessments
  - Ability to safely handle e-cigarette devices
  - Risk for substance use
  - Bed Rails
- Education/Competency Assessments
  - Maintaining separation of clean & contaminated podiatry equipment
  - Recognizing signs & symptoms of substance use
  - Addressing emergencies r/t substance use
  - IV Therapy
  - Monitoring for side effects of opioids

PROACTIVE MEDICAL REVIEW

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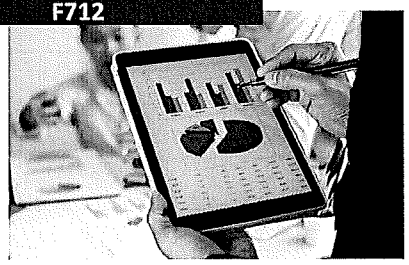
Physician Services F712



PROACTIVE MEDICAL REVIEW

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F712 §483.30(c) Frequency of physician visits

UPDATED GUIDANCE: 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

PROACTIVE MEDICAL REVIEW

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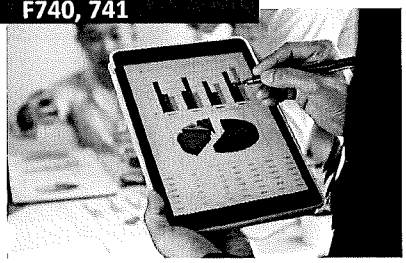
Behavioral Health F740, 741



PROACTIVE MEDICAL REVIEW

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§483.40 Behavioral health services

- Definitions of mental disorder, substance use disorder and PTSD updated as follows:
- "Mental disorder" is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion **regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.** Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.
- "Substance use disorder" ("SUD") 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.**
- "Post-traumatic stress disorder" 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.

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

- The behavioral health care needs of those with a SUD or other serious mental disorder should be part of the facility assessment
- Facility should determine if they have the capacity, services, and staff skills to meet the requirements as discussed in F741.

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

- Individualized Assessment & Person-Centered Planning
  - Care plan must address individualized needs related to mental disorder or substance use disorders (SUDs)
  - Behavioral contracts may be used to address behaviors
  - Residents living with mental health and SUDs may require different activities than other nursing home residents. Facilities must ensure that activities are provided to meet the needs of their residents

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

Use of Behavioral Contracts

- Some facilities may use behavioral contracts as part of the individualized care plan to address behaviors which could endanger the resident, other residents and staff.
- Behavioral contracts may be a method for encouraging residents to follow their plan of care.
  - In some circumstances, using them to impose a system of rewards and/or punishments could be construed as meeting the definition of abuse which includes the willful infliction of punishment and/or the deprivation of goods and services
- Behavioral contracts should only be used for residents who have the capacity to understand them.

PROACTIVE MEDICAL REVIEW

95

F740 §483.40 Behavioral health services

- Steps the facility may take if substance use is suspected, may include:
  - Increased monitoring and supervision in the facility
  - Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff
  - Voluntary drug testing
  - Voluntary inspections
  - Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

Behavioral Contracts

- Refusal to accept or non-adherence to the terms of a behavioral contract cannot be the sole basis for a denial of admission, a transfer or discharge.
- A facility may only transfer or discharge a resident for one of the reasons listed in F622, §483.15(c)(1)(I)(A)-(F).
- Non-adherence to the contract should be treated like any care plan intervention that needs attention or needs to be altered to meet the needs of the resident.
- The IDT should work with the resident and resident representative to revise the care plan and contract.

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

Depression

- Depression (major depressive disorder or clinical depression) is a common and serious mood disorder.
- Symptoms may include fatigue, sleep and appetite disturbances, agitation, and expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation.
- Depression is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.
- Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established

PROACTIVE MEDICAL REVIEW

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F740 §483.40 Behavioral health services

Schizophrenia

- Schizophrenia must be diagnosed by a qualified practitioner, using evidence-based criteria and professional standards, such as the Diagnostic and Statistical Manual of Mental Disorders - Fifth edition (DSM-5), and documented in the resident's medical record.
- It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
- Symptoms of Schizophrenia include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and diminished expression or initiative.
  - Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts.
  - Hallucinations include a person hearing voices, seeing things, or smelling things others can't perceive.

PROACTIVE MEDICAL REVIEW

99

F740 §483.40 Behavioral health services

Bipolar Disorder

- Bipolar disorder is a mental disorder that causes dramatic shifts in a person's mood or energy and may affect the ability to think clearly.
- People with bipolar experience high and low moods—known as mania and depression—which differ from the typical ups-and downs most people experience.
- Symptoms and their severity can vary.
  - A person with bipolar disorder may have distinct manic or depressed states but may also have extended periods—sometimes years—without symptoms.
  - A person can also experience both extremes simultaneously or in rapid sequence.

PROACTIVE MEDICAL REVIEW

100

F741 Sufficient/Competent Staff-Behavioral Health Needs

- The skills and competencies needed to care for residents should be identified through the facility assessment.
- Facility assessment must include an evaluation of the overall number of facility staff needed to ensure that a sufficient number of qualified staff to meet each resident's needs.
- The assessment should include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice.
  - This includes any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care identified.
- Once the necessary skills and competencies are identified, staff must be aware of those disease processes and disorders (e.g. SUDs) that are relevant to each resident to enhance the resident's psychological and emotional well-being
- The IDT should be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress and/or re-traumatization.

PROACTIVE MEDICAL REVIEW

101

F741 Sufficient/Competent Staff-Behavioral Health Needs

Non-pharmacological interventions

- Examples of individualized, non-pharmacological interventions to help meet behavioral health needs of all ages may include, but are not limited to:
  - Assisting the resident outdoors in the sunshine and fresh air
  - Providing access to pets or animals for the resident who enjoys
  - Assisting the resident to participate in activities that support their spiritual needs;
  - Assisting with the opportunity for meditation and associated physical activity
  - Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;
  - Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing
  - Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible
  - Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy; and
  - Providing support with skills related to verbal de-escalation, coping skills, and stress management

PROACTIVE MEDICAL REVIEW

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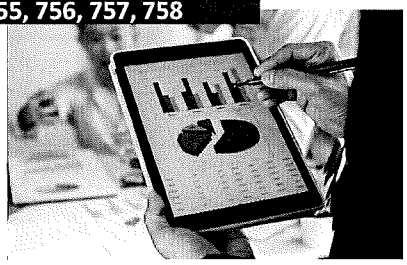
Action Plan for Compliance

- Policy & Procedure Review/Updates
  - Facility Assessment – Addresses behavioral health needs
  - PASARR
  - Behavioral Contracts
  - Substance Use
- Care Plan/Assessments
  - Address mental disorders & history of substance use
- Education/Competency Assessments
  - Caring for residents with behavioral health or substance use disorders

PROACTIVE MEDICAL REVIEW

103

Pharmacy Services F755, 756, 757, 758



PROACTIVE MEDICAL REVIEW

104

F755 §483.45 Pharmacy Services

Key Changes:

Tag	Tag Subject	Key Change to Regulation or Interpretive Guidelines	Significant Change or Technical Correction
F755	Pharmacy Services	Clarified language related to disposal of Fentanyl patches	Significant
F757	Drug Regimen is Free from Unneccessary 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; Added language on potential misdiagnoses, such as schizophrenia, in order to prescribe antipsychotics.	Significant

PROACTIVE MEDICAL REVIEW

105

F755 Pharmacy Services

Revised guidance on disposal of used Fentanyl patches

- The FDA instructions to fold used patch and flush down the toilet may not be appropriate in the nursing home setting
- The EPA does not currently ban flushing of pharmaceuticals not considered hazardous, which includes Fentanyl patch but state and local laws may restrict this flushing
- Nursing homes may use drug disposal systems with evidence that the system minimizes accidental exposure and diversion
- Disposal of fentanyl patches in a trash can in a resident room, common areas or in a sharps container is not compliant as these methods do not prevent accidental exposure or diversion

PROACTIVE MEDICAL REVIEW

106

F758 Psychotropic Drugs

Unnecessary Psychotropic/PRN Use

- Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented.
- Risks associated with psychotropic medications still exist regardless of the indication for their use (e.g., nausea, insomnia, itching), therefore the requirements pertaining to psychotropic medications in §483.45(e) apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety and hypnotic) listed in §483.45(c)(3) without exception.
- In addition, if the documented use of a medication appears to be a substitution for another psychotropic medication rather than for the approved indication
  - Example: The use of Depakote when given to a resident with no history of seizure to treat agitation should be consistent with the psychotropic medication requirements

PROACTIVE MEDICAL REVIEW

107

F758 Psychotropic Drugs

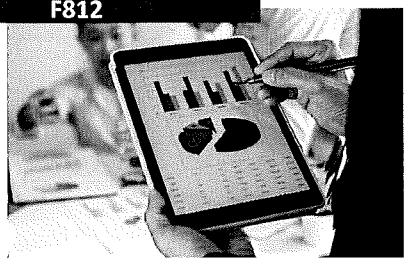
Antipsychotic Medications and Misdiagnosis

- Concerns related to inappropriate prescribing of psychotropic medications may require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.
- 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, please refer to the following regulations:
    - §483.21(b)(3)(i), F658, to determine if the practitioner's diagnostic practices meet professional standards.
    - §483.20(g), F641 to determine if the facility completed an assessment which accurately reflects the resident's status

PROACTIVE MEDICAL REVIEW

108

Food and Nutrition F812



PROACTIVE MEDICAL REVIEW

109

F812 §483.60(i) Food safety requirements

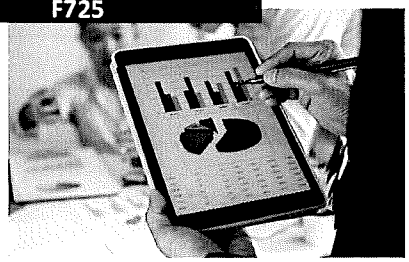
UPDATED GUIDANCE

- Food preparation or service area problems/risks to avoid include, but are not limited to:
  - Holding foods in danger zone temperatures which are between 41 degrees F and 135 degrees F;
  - Using the steam table to heat food;
  - Serving meals on soiled dishware and with soiled utensils;
  - Handling food with bare hands or improperly handling equipment and utensils;
  - Staff distributing meals without first properly washing their hands; and
  - Serving food to residents after collecting soiled plates and food waste, without proper hand washing

PROACTIVE MEDICAL REVIEW

110

Nursing Staffing F725



PROACTIVE MEDICAL REVIEW

111

F725 Nursing Staffing Updated Guidance

- If a facility does not meet State regulations for minimum staffing, surveyors will cite at Administration, F836, §483.70(b).
- Even if a facility meets the State's staffing regulations, that is not, by itself, sufficient to demonstrate that the facility has sufficient staff to care for its residents.
- Compliance with State staffing standards is not necessarily determinative of compliance with Federal staffing standards that require a sufficient number of staff to meet all of the residents' basic and individualized care needs.
- A facility may meet a state's minimum staffing ratio requirement, and still need more staff to meet the needs of its residents.
- Additionally, the facility is required to provide licensed nursing staff 24 hours a day, 7 days a week.

PROACTIVE MEDICAL REVIEW

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F725 Nursing Staffing Updated Guidance

- Must submit staffing data through PBJ system
- PBJ data can be obtained through CASPER PBJ Staffing Data Report
- Surveyors will utilize the PBJ Staffing Data Report in CASPER to identify concerns with staffing.
- The Long Term Care Survey Process (LTCSP) software application will alert the surveyors of specific dates that require further investigation related to staffing.
- Surveyors are expected to verify infraction dates indicated on the PBJ staffing data report.
- If concerns are identified on this report, as well as from other sources, surveyors will refer to the critical element pathway of Sufficient and Competent Staffing, and the probes noted in Appendix PP

PROACTIVE MEDICAL REVIEW

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F725 Additions to Surveyor Probes

- Are the numbers of licensed staff sufficient such that those staff members have enough time to provide direct services to residents as well as to assist and monitor all of the aides they are responsible for supervising?
- Are there any indications of inappropriate use of devices or practices to manage residents' behaviors or activities that may suggest facility staff are using these devices or practices to compensate for lack of sufficient staff? Examples include high numbers and/or inappropriate use of position-change alarms, positioning residents in chairs that limit their movement, or residents who are subdued or sedated?
- Does the facility have adequate staff to monitor residents at risk for wandering?
- Does the facility have licensed nursing staff 24 hours a day?

PROACTIVE MEDICAL REVIEW

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F725 Additions to Surveyor Probes

- If the surveyor is made aware of the absences of licensed nursing staff in a 24 hour period he/she will:
- Interview direct care staff;
  - Are you ever made aware of the absence of licensed nursing staff during your shift?
  - When was the last time that licensed staff was not available during your
  - How often does this occur?
  - How does this impact residents in the facility?
  - Are you aware of any residents that missed medications or treatments due to no available licensed nurse?
  - Who do you notify in the event of an emergency and there is no licensed nurses available?
- Interview the Director of Nursing or Administrator;
  - When was the last time that licensed nursing staff were not available on a shift?
  - How often does the facility not have licensed nursing staff at all times?
  - What is the facility's policy when there is not a licensed nurse available in a 24 hour period?
  - How does the facility provide care to residents that require a licensed nurse if one is not available to work?
  - How does this impact residents in the facility?

PROACTIVE MEDICAL REVIEW

115

Immediate Jeopardy Examples

- A resident had complained of chest pain and shortness of breath after eating their evening meal. The nursing assistant stated they would inform the licensed nurse. The nursing assistant was informed there would be no licensed nurse available onsite. At 10:00 p.m. the resident was found unresponsive with minimal respirations. Because there was no licensed nurse on duty at that time, the nursing assistant called 911 and the resident was sent to the emergency room.
- The survey team was made aware the facility had 4 days in the previous quarter of PBJ submission when there were no licensed nurses in the facility for all 24 hours of each day. After a thorough investigation, the team determined the absences of a licensed nurse in the facility created the likelihood for serious injury, harm, impairment or death for all residents.

PROACTIVE MEDICAL REVIEW

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Actual Harm Example

- A resident was admitted to the facility with a recently repaired hip fracture and required assistance with ambulation. The resident used the calling device to request assistance to the bathroom. After several minutes no help arrived, so the resident attempted to ambulate with a walker to the bathroom without assistance. The resident subsequently fell and was found by nursing assistants. The resident was assisted back to bed by the nursing assistants and complained of pain in the area of the recently repaired hip fracture. There was no licensed nurse on duty to assess the resident for any injuries or provide medication for pain. The next morning the resident complained of increased pain in the area of the repaired hip fracture. After assessment by the day shift licensed nurse the resident was sent to the hospital. The resident was admitted and required surgery to repair the re-fractured hip

PROACTIVE MEDICAL REVIEW

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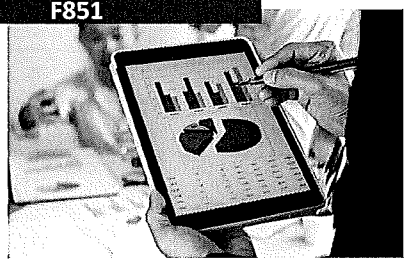
Action Plan for Compliance

- Review staffing policy & procedures for consistency with updated guidance
- Review process for how sufficient staffing is determined for facility
  - Facility Assessment
  - Resident Population & Acuity Levels
  - Specialized Services Provided
  - Unique needs and/or layout of facility
- Process for ensuring PBJ data is accurate & submitted timely

PROACTIVE MEDICAL REVIEW

118

Payroll Based Journal F851



PROACTIVE MEDICAL REVIEW

119

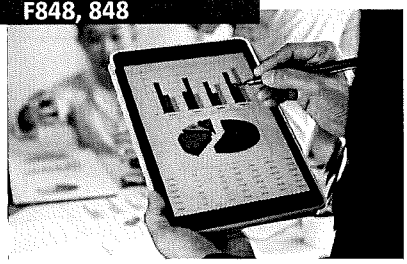
F851 Payroll-Based Journal

- Surveyors can obtain PBJ data from CASPER report to determine if facility submitted required staffing information based on payroll data in a uniform format.
- Failure to submit PBJ data as required will be reflected on CASPER report & will result in a deficiency citation
- If concerns are identified based on the CASPER report, or from any other source, surveyors will refer to the critical element pathway "Sufficient and Competent Staffing."

PROACTIVE MEDICAL REVIEW

120

Arbitration F848, 848



PROACTIVE MEDICAL REVIEW

121

F847 Entering Into Binding Arbitration Agreements

- Used to resolve disputes between facilities and residents
- Parties give up their right to have claims heard in court
- Results typically not disclosed to public
- Decisions are generally final & binding
- Use of binding arbitration agreement must be voluntary & must be clearly communicated to resident or their representative as optional & not required as a condition of admission or continued stay
- Agreement must be explained so that resident/res rep understands the terms of the agreement
  - Include explanation that resident may be giving up right to have dispute decided in a court proceeding
- Must provide 30 days after signing to fully review & potentially rescind any agreement that was not understood at time of admission

PROACTIVE MEDICAL REVIEW

122

F848 Arbitrator/Venue Selection & Retention of 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

PROACTIVE MEDICAL REVIEW

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F848 Interpretive Guidance- Selection of Arbitrator

- Must make reasonable efforts to ensure that any arbitration agreement entered into with a resident/RP provides for the selection of an arbitrator who is impartial, unbiased, & without the appearance of a conflict of interest.
- May put forward suggestions for the use of specific arbitrators for residents/RPs to select, but they are not obligated to use arbitrator suggested by facility & may suggest an alternative arbitrator of their choosing
- Must make a reasonable attempt to come to agreement with resident/RP on selection of a neutral arbitrator & provide a fair process for selection of arbitrator
- Avoid even the appearance of bias, partiality, or a conflict of interest, & should promptly disclose to the resident/RP the extent of any relationship which exists with an arbitrator or arbitration services company, including how often the facility has contracted with the arbitrator or arbitration service, and when the arbitrator or arbitration service has ruled for or against the facility

PROACTIVE MEDICAL REVIEW

124

F848 Interpretive Guidance - Selection of Venue & Retention of Agreements

- Must allow selection of venue that is suitable in meeting needs of both resident/RP & the facility
- Venue should be agreed upon by both parties
- Must maintain copy of signed binding arbitration agreement and final decision for 5 years following resolution of arbitrated dispute
  - Records must be made available to surveyors upon request

PROACTIVE MEDICAL REVIEW

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Action Plan for Compliance

- Review policy & procedures
- Review language of agreement
- Review process for communication with residents/RP
- Staff training on new guidance for those responsible for reviewing agreement with residents/RPs
  - Return demonstration of clear explanation of arbitration agreement that meets standards
- Resource: Health Cap Risk Management Arbitration Agreement Toolkit https://riskmanagement.healthcapusa.com/manuals-toolkits

PROACTIVE MEDICAL REVIEW

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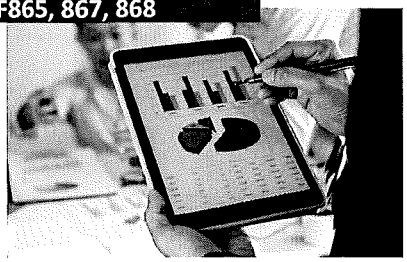
QAPI
F865, 867, 868



PROACTIVE MEDICAL REVIEW

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F865 §483.75 QAPI Program

Program & Documentation

- Must maintain & be able to provide documentation & evidence of your ongoing QAPI program upon request by surveyors
- Systems & reports demonstrating identification, reporting, investigation, analysis & prevention of adverse events
- Data collection & analysis at regular intervals
- Documentation demonstrating development, implementation, & evaluation of corrective actions or performance improvement activities

PROACTIVE MEDICAL REVIEW

128

F865 §483.75 QAPI Program

Program Design & Scope

- Address all systems of care & management practices
- Include clinical care, quality of life & resident choice
- Utilize the best available evidence to define measure indicators of quality & facility goals that reflect processes of care & facility operations that have been shown to be predictive of desired outcomes for residents
- Reflect the complexities, unique care & services that the facility provides

PROACTIVE MEDICAL REVIEW

129

F865 §483.75 QAPI Program

Governance & Leadership

- Governing body must ensure QAPI Program:
  - Is defined, implemented & ongoing
  - Addresses identified priorities
  - Is sustained through transitions in leadership & staffing
  - Has adequate resources, including staff time, equipment, & technical training as needed
  - Uses performance indicator data, resident & staff input, & other information to identify & prioritize problems & opportunities
  - Implements corrective actions to address gaps in systems & evaluates actions for effectiveness
  - Establishes clear expectations around safety, quality, rights, choice & respect

PROACTIVE MEDICAL REVIEW

130

F865 §483.75 QAPI Program

- Examples of when disclosure may be necessary to determine compliance:
  - If the facility's infection control data indicates that staff may not have responded in a timely & effective manner to address an outbreak of a communicable disease, the facility must allow the surveyor to review & copy QAA committee minutes & related documentation so that the surveyor is capable of evaluating the facility's QAPI/QAA compliance.
  - If the surveyor's staff interviews & record reviews reveal the facility has a past history of failing to follow care instructions & recommendations from clinical specialists when residents obtain specialty care outside the facility, the facility must allow the surveyor to review & copy QAPI/QAA documentation.
    - Under these circumstances, review of the QAPI/QAA documentation is necessary to evaluate whether the QAA Committee identified a problem with failure to follow care instructions & recommendations from outside specialists &, if it did, whether the QAA Committee adequately addressed the problem

PROACTIVE MEDICAL REVIEW

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F865 §483.75 QAPI Program

Sanctions & Good Faith Attempts

- To establish that the facility's QAA committee has made a good faith attempt to correct an identified quality deficiency, a facility must do more than just subjectively assert it has made a good faith attempt
  - The facility's actions, taken as a whole, must evidence a good faith attempt to identify & correct quality deficiencies.
  - Surveyors will determine where facility is within the correction process
  - Refusal to disclose QAPI information necessary to demonstrate your compliance will lead to F865 citation

PROACTIVE MEDICAL REVIEW

132

F865 §483.75 QAPI Program

Key Elements of Non-Compliance

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

PROACTIVE MEDICAL REVIEW

133

F867 §483.75 QAPI/QAA Improvement Activities

Feedback

- One of many data sources which provide valuable information the facility must incorporate into an effective QAPI program
- Obtained from staff, residents, resident representatives, as well as other sources
- Used to identify problems that are high-risk, high-volume, or problem prone, as well as opportunities for improvement
- Must establish & implement written policies & procedures for feedback

PROACTIVE MEDICAL REVIEW

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F867 §483.75 QAPI/QAA Improvement Activities

Data Collection Systems & Monitoring

- Must collect & monitor data reflecting your performance, including adverse events
- Policy & procedures must address how data will be identified, & frequency & methodology for collecting & using data for all departments
- Determine what data you will collect to represent your high-risk, high-volume, or problem prone care areas
- Data collection methodology should be consistent, reproducible, & accurate to produce valid & reliable data
- Not all data must be collected at same frequency
- Should develop schedule for routine data collection

PROACTIVE MEDICAL REVIEW

135

F867 §483.75 QAPI/QAA Improvement Activities

Performance Indicators

- Must have policy & procedures for developing, monitoring, & evaluating performance indicators, including how & with what frequency
- Performance indicators enable the QAA committee to establish performance thresholds & goals, identify deviations in performance, & evaluate progress

PROACTIVE MEDICAL REVIEW

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F867 §483.75 QAPI/QAA Improvement Activities

Systematic Analysis & Action

- Must have systems in place for implementing corrective actions, measuring success, & tracking performance
- Policy & procedures must address:
  - How you will use systemic approaches to assist in determining underlying causes of problems impacting larger systems
  - How you will develop corrective actions to effect change at the systems level
  - How you will monitor the effectiveness of performance improvement activities to ensure improvements are sustained

PROACTIVE MEDICAL REVIEW

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F867 §483.75 QAPI/QAA Improvement Activities

Medical Errors & Adverse Events

- Must track medical errors & adverse events
- When adverse event or medical error occurs:
  - Analyze the cause of the error/event
  - Implement corrective actions to prevent future events
  - Conduct monitoring to ensure desired outcomes achieved & sustained
- Educating staff, residents, resident representatives and family members on medical errors and adverse events, such as what to look for and preventive measures, are important factors in reducing and preventing medical errors and adverse resident events

PROACTIVE MEDICAL REVIEW

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F867 §483.75 QAPI/QAA Improvement Activities

Performance Improvement Projects (PIPs)

- Must conduct distinct PIPs, based on scope & complexity of your services & available resources
- Required to perform at least one PIP annually that focuses on high-risk or problem-prone areas
- Action plans to address quality deficiencies & improve performance may be implemented in a variety of ways
- Committee may delegate implementation of action plans to various staff or outside consultants

PROACTIVE MEDICAL REVIEW

139

F868 §483.75 QAA Committee

New Phase 3 Requirement

- §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 & assurance committee & report to the committee on the IPCP on a regular basis.
  - "Regular basis": for the purpose of the infection preventionist reporting requirement, reporting should occur at the same frequency as the QAA committee meetings.
  - "Infection Preventionist (IP)": Term used for the person(s) designated by the facility to be responsible for the infection prevention & control program. (Please refer to F882 for further information on the IP.)

PROACTIVE MEDICAL REVIEW

140

F868 §483.75 QAA Committee

Infection Preventionist Participation on Quality Assessment and Assurance (QAA) Committee

- IP should attend each QAA meeting
- Areas to report on may include:
  - Process & outcome surveillance
  - Outbreaks & control measures
  - Occupational health communicable disease illnesses
  - Antibiotic Stewardship Program antibiotic use & resistance data

PROACTIVE MEDICAL REVIEW

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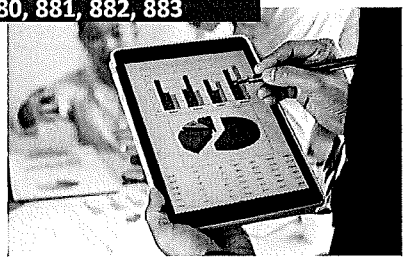
Surveyor Investigation of Concerns Related to QAPI

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt	F867 QAPI/QAA Improvement Activities	F868 QAA Committee
• For concerns related to whether a facility has implemented & maintains a comprehensive QAPI program & plan, disclosure of records & governance & leadership	• For concerns related to how the facility obtains feedback, collects data, monitors adverse events, identifies areas for improvement, prioritizes following: improvement activities, implements corrective & preventive actions, & conducts performance improvement projects	• For concerns related to the composition of the QAA committee, frequency of meetings & reporting to the governing body.

PROACTIVE MEDICAL REVIEW

142

Infection Control F880, 881, 882, 883



PROACTIVE MEDICAL REVIEW

143

F880 Infection Prevention & Control

Definitions

- C. difficile Infection (CDI)-An infection from a bacterium that causes colitis, an inflammation of the colon, causing diarrhea
- Handwashing- washing hands with soap & water
- Legionellosis- Refers to two clinically and epidemiologically distinct illnesses caused by Legionella bacteria:
- Legionnaires' disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and
- Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches)
- Multidrug-resistant organisms (MDROs) - Microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent, these pathogens are frequently resistant to most available antimicrobial agents.

PROACTIVE MEDICAL REVIEW

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F880 Infection Prevention & Control

Infection Prevention & Control Guidance

- Provided as example that screening may be passive through use of signs alerting family members & visitors with signs/symptoms not to enter
- More active screening may include the completion of a screening tool or questionnaire which elicits information related to recent exposures or current symptoms. That information is reviewed by the facility staff & the visitor is either permitted to visit or is excluded
- IPCP must cover all residents, staff, **contractors, consultants,** volunteers, visitors, others **who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions**

PROACTIVE MEDICAL REVIEW

145

F880 Infection Prevention & Control

Infection Control Policies & Procedures

- Added that IPCP policies & procedures must
  - Define & explain standard precautions & their application during resident care activities.
  - Define transmission-based precautions (i.e., contact precautions, droplet precautions, airborne precautions) & explain how & when they should be utilized, as consistent with accepted national standards
  - Include environmental cleaning & disinfection:
    - Routine cleaning & disinfection of frequently touched or visibly soiled surfaces in common areas, resident rooms, & at the time of discharge (note: Privacy curtains should be changed when visibly dirty & should be laundered or disinfected with an EPA registered disinfectant)
    - Routine cleaning & disinfection of resident care equipment including equipment shared among residents (e.g., blood pressure cuffs, rehabilitation therapy equipment, blood glucose meters, etc.).

PROACTIVE MEDICAL REVIEW

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F880 Infection Prevention & Control

Transmission-based Precautions

- 3 categories of transmission-based precautions
  - Contact precautions
  - Droplet precautions
  - Airborne precautions
- Used when route(s) of transmission not completely interrupted using standard precautions alone
- For some diseases with multiple routes of transmission, more than one category may be required
- Used in addition to standard precautions
- Type of PPE & precautions used depends on the potential for exposure, route of transmission, & infectious organism/pathogen
- Should initiate transmission-based precautions for a constellation of new symptoms consistent with a communicable disease
  - Empirically initiated transmission-based precautions may be adjusted or discontinued when additional clinical information becomes available (e.g., confirmatory laboratory results).
- Residents on transmission-based precautions should remain in their rooms except for medically necessary care

PROACTIVE MEDICAL REVIEW

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F880 Infection Prevention & Control

Blood Glucose Meters

- If the facility failed to clean and disinfect **blood glucose meters** per device and **disinfectant** manufacturer's instructions for use, they are used for more than one resident, and **there is a resident with a known bloodborne pathogen** in the facility, surveyors must cite **noncompliance under** this tag and utilize the guidelines in Appendix Q **for determining** immediate jeopardy. **Furthermore, the SA must notify the appropriate local/state public health authority of this practice. Other instances of deficiencies may meet the definition of immediate jeopardy; utilize guidelines in Appendix Q to make this determination.**
- Additional information related to point-of-care testing may be found in CDC's Infection Prevention during Blood Glucose Monitoring and Insulin Administration website at https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html

PROACTIVE MEDICAL REVIEW

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F881 Antibiotic Stewardship Program

Guidance

- Monitor/review response to antibiotics & lab results when available, to determine if antibiotic is still indicated or adjustments should be made
- Provide feedback to prescribing practitioners regarding antibiotic resistance data to improve prescribing practices & resident outcomes
- Antibiotic orders must include indication, dose, & duration
- For surveyor concerns regarding antibiotic stewardship program, surveyors must include at least one resident on an antibiotic in the resident sample to assess whether the resident(s) is being prescribed antibiotic(s) unnecessarily & whether they were any negative outcomes such as adverse drug event

PROACTIVE MEDICAL REVIEW

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F882 Infection Preventionist (IP)

Responsibility for the Infection Prevention and Control Program (including the Antibiotic Stewardship Program)

- Must designate one or more individuals as the IP who is responsible for assessing, developing, implementing, monitoring, & managing the IPCP
- While the IP is responsible for the IPCP, other staff play important roles in infection prevention & control as well as antibiotic stewardship
- While an ASP is a team effort, the IP is responsible for ensuring the program meets the requirements for ASPs
- IP should review & approve infection prevention & control training topics & content, as well as ensure facility staff are trained on the IPCP. However, the IP is not required to perform the IPCP training, since some facilities may have designated staff development personnel

PROACTIVE MEDICAL REVIEW

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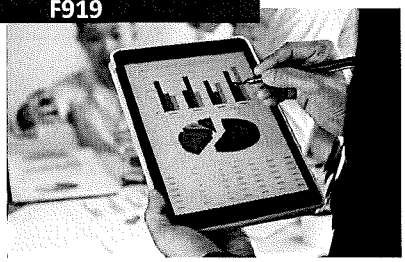
Physical Environment F919



PROACTIVE MEDICAL REVIEW

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F919 Resident Call System

§483.90(g) Resident Call System Requirement

- 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.**

PROACTIVE MEDICAL REVIEW

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F919 Resident Call System

Guidance

- The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.
- The call system must be accessible to the resident at each toilet and bath or shower facility.
- The call system should be accessible to a resident lying on the floor.

PROACTIVE MEDICAL REVIEW

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F910 Resident Room & F911 Bedroom Number of Residents

Recommendations for Resident Rooms

- CMS is urging providers to consider making changes to their physical environment to allow for a maximum of double occupancy in each room.
- They encourage facilities to explore ways in which they can allow for more single occupancy rooms for residents.
- There are several advantages to limiting rooms to double or single occupancy, including:
  1. Allowing for more resident privacy for daily activities such as dressing and visiting with friends and family (§483.10(h)).
  2. Encourages a homelike environment (§483.10(i)).
  3. Improving infection control and prevention by reducing the risks associated with multiple residents in the same room and making it easier to isolate or quarantine residents who are infectious.

PROACTIVE MEDICAL REVIEW

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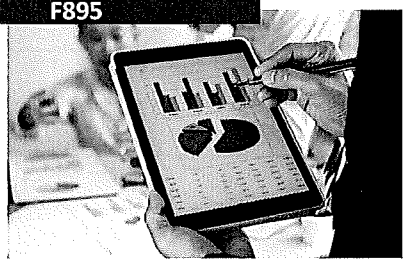
Compliance & Ethics F895



PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- Background
- The OIG guidance from 2000 recommended seven elements which should be included in an effective, comprehensive compliance and ethics program that are:
  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 guidelines
  6. Conducting internal monitoring and auditing
  7. Responding promptly to detected violations and corrective action

OIG Supplemental Compliance Program Guidance for Nursing Facilities (2008):
https://oig.hhs.gov/compliance/compliance-guidance/index.asp

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program Background- Common Risk Areas

Common Risk Areas

- Sufficient staffing
- Comprehensive care plans
- Medication management
- Infection prevention
- Appropriate use of psychotropic medications
- Abuse/Neglect
- Safety

Additional Risk Areas

- Resident rights
- Fraud prevention
- Billing & cost reporting
- Employee screening
- Resident assessment accuracy
- Creation & retention of records
- Falsification & modification of documentation
- Conflicts of interest
- Kickbacks
- Inducements
- Self-referrals

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- Written Standards, Policies, & Procedures
- Must have written standards, policies and procedures for compliance and ethics program, which include at a minimum:
  - Designation of an appropriate compliance and ethics program contact to whom an individual can report suspected violations;
  - An alternate method of reporting suspected violations anonymously without fear of retribution;
  - Disciplinary standards that describe the consequences for committing violations for the entire staff.

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- High-Level Personnel Oversight
- Must assign specific individuals within the high-level personnel of the organization with the overall responsibility of overseeing adherence to the compliance and ethics program's standards, policies, and procedures
  - High-level personnel means individuals who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.
    - Director
    - Executive officers
    - Board of Director members
    - Individual in charge of major business unit of organization
    - Individual with substantial ownership interest

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- Reasonable Steps to Achieve Program Compliance
- Monitoring & auditing systems to detect violations by any staff
- Publicizing an anonymous reporting system
- Ensuring integrity of reported data
- Consistent Enforcement through Disciplinary Mechanisms
- Establish appropriate disciplinary mechanisms & communicate them to staff

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- Response to Detected Violations
- Ensure all steps identified in program are taken to respond appropriately to violations & prevent further violations
  - Corrective action plan, return of overpayments, report to government or referral to law enforcement
- Integrate information & data collected or which arises from program into QAPI
- Annual Review
- Modify program with changes in laws/requirements
- Use past performance to improve program
- Communicate any program changes to all staff

PROACTIVE MEDICAL REVIEW

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F895 483.85 Compliance and Ethics Program

- Additional Requirements for Organizations with 5 or More Facilities
  1. Mandatory Annual Training
  2. Designated Compliance Officer
     - Compliance & ethics program is major responsibility
     - Should have sufficient time & resources to fulfill role
     - Communicates with governing body without coercion or intimidation
  3. Designated Compliance Liaison
     - Must be located at facility
     - Responsible for assisting compliance officer with his/her duties at facility level

PROACTIVE MEDICAL REVIEW

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Compliance & Ethics Resources

- Measuring Compliance Program Effectiveness: A Resource Guide. HCCA-OIG Compliance Effectiveness Roundtable. Roundtable Meeting: January 17, 2017 | Washington, DC Available at:
  - https://assets.hcca-info.org/Portals/0/PDFs/Resources/ResourceOverview/oig-hcca-roundtable.pdf?ver=2017-03-28-062709-153
- Health Care Compliance Association (HCCA). Healthcare Compliance Guides. Available at:
  - https://www.hcca-info.org/publications/healthcare_compliance_guides

PROACTIVE MEDICAL REVIEW

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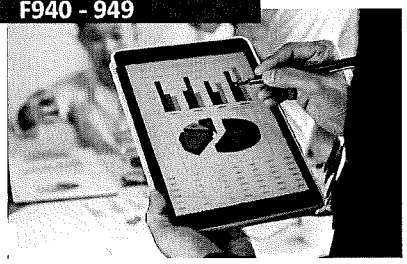
Training Requirements F940 - 949



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F940 §483.95 Training Requirements

- **A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e).**

Guidance

- Must develop, implement, & maintain an effective training program for all staff
  - Includes all direct & indirect care staff, contracted staff, & volunteers
- Determine training needs based on your facility assessment
- Competencies & skill sets for all staff must be consistent with their expected roles
- Must keep record of trainings
- Training requirements must be met prior to staff & volunteers independently providing services to residents, annually, and as necessary based on facility assessment
- No specific training mechanism to meet Training Requirements

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F941 Communication Training Guidance

- Recommended methods of effective communication, include, but are not limited to, the following:
  - Identify yourself and use the resident's name each time you speak with them.
  - Use the proper names for people, places, and objects; avoid saying he, she, it, or they so that the resident can understand.
  - Allow extra time. Many nursing home residents have conditions which require longer information processing time.
  - Avoid distractions, and maintain eye contact, if culturally appropriate. Focus on the resident, make each interaction quality time.
  - Listen carefully to the resident's responses and directly respond to the questions and concerns. Give residents an opportunity to ask questions and express themselves.
  - Sit face to face, residents may have vision and hearing loss, and reading your lips may be crucial. Even if the resident uses a hearing aid, it can be difficult for the resident to understand you because a hearing aid amplifies all sounds, including background noise.
  - Speak slowly, clearly and in a normal tone, and use short, simple words (no medical or slang jargon)
  - Maintain a positive attitude, including a pleasant tone of voice and facial expression. Residents with dementia respond to the feelings you convey more than the actual words.
  - If the communication form is written, simplify the questions, and stick to one topic at a time. Frequently summarize the most important points.
  - Be aware of a resident's body language communications.
  - Eliminate assumptions, make adjustments to the communication method as required during a conversation.
  - Visual aids may be required as communication methods.
  - Repeat back what the person has said to make sure that you understand. Ask for clarification if you aren't sure what the person means.

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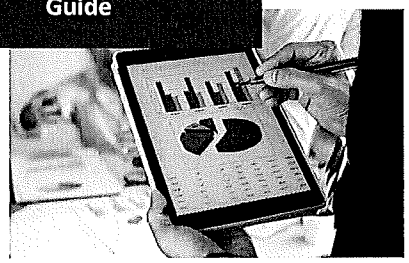
Psychosocial Outcome Severity Guide



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Psychosocial Outcome Severity Guide

- Clarification of Terms
- Fear – 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.
- 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 the deficiency may have had on a reasonable person in the resident's position
- The reasonable person concept described in the Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes
- Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate

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Psychosocial Outcome Severity Guide

- Purpose
- To help surveyors determine severity of psychosocial outcomes resulting from deficient practices, including how to determine the severity of the outcome when the impact on the resident may not be apparent or documented
- Intended to be used in conjunction with the scope & severity grid
- Level of severity of deficiency is based on the highest level of physical or psychosocial outcome
- New example provided:
- When a staff member physically assaults a resident with no resulting physical harm, but the resident only demonstrates indifference to the incident at the time of the survey; however, it is likely that this caused a greater psychosocial outcome. In these cases, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency as it would reflect the highest level of harm or potential for harm.

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Psychosocial Outcome Severity Guide

- Instructions
- To determine severity of psychosocial outcome, surveyors will obtain evidence through observations, interviews, & record reviews
- If a psychosocial outcome is identified, will compare resident's behavior & mood before & after the noncompliance, and any identified history of similar incidents
- If no changes are apparent or documented, will consider the response as a reasonable person in the resident's position would exhibit in light of the triggering event

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Psychosocial Outcome Severity Guide

- Application of the Reasonable Person Concept
- Surveyors will determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position, considering the following:
  - The resident may consider the facility to be his/her home, where there is an expectation that he/she is safe, has privacy, & will be treated with respect & dignity
  - The resident trusts & relies on facility staff to meet his/her needs
  - The resident may be frail & vulnerable
- Surveyor should document resident's actual response & perspective of someone familiar with resident
- Reasonable person concept should be applied & may reveal that resident is likely to, or may potentially suffer a greater psychosocial outcome
- Surveyors should document on 2567 when reasonable person concept is applied to determine psychosocial outcomes for a deficiency

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Psychosocial Outcome Severity Guide

- Severity Level 4 Examples – Immediate Jeopardy
- Anger, agitation, or distress that has caused aggression that can be manifested by self-directed responses or hitting, shoving, biting, scratching others, threatening, screaming, or cursing.
- Crying, moaning, screaming, or combative behavior that is above the resident's baseline.
- Expressions (verbal and/or non-verbal) of avoidable pain that is severe, and more than transient. Pain is considered avoidable when there is a failure to assess, reassess, and/or take steps to manage the resident's pain;
- Fear/anxiety that may be manifested as panic, immobilization, screaming, and/or agitated behavior(s) (e.g., trembling, cowering); avoidance of the situation(s), person(s) or place; preoccupation with fear; resistance to care and/or social interaction; sleeplessness; fear of speaking, and/or verbal expressions of fear.
- Expressions of feelings of hopelessness, worthlessness or guilt (not merely self-reproach or guilt about being sick or needing care);
- Withdrawal from former social patterns, such as isolation from staff, friends and family.

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Psychosocial Outcome Severity Guide

- Severity Level 3 Examples – Actual Harm
- Depressed mood that may be manifested by verbal and nonverbal symptoms such as:
  - Decreased engagement in social activities; apathy; tearfulness; crying; moaning
  - Change of interest or ability to experience or feel pleasure as usual
  - Psychomotor movements (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects);
  - Change in psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering) unrelated to medical diagnosis;
  - Verbal expressions (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), that may be accompanied by a sad tone.
  - Diminished ability to think or concentrate.
  - Expressions (verbal and/or non-verbal) of moderate pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs. Intermittent crying and moaning, or loss in interest for eating. Pain or physical distress has become a central focus of the resident's attention, but it is not severe or overwhelming (as in Severity Level 4).
- Distress (e.g., under stimulation as manifested by fidgeting, restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something), unrelated to medical diagnosis

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Psychosocial Outcome Severity Guide

- Severity Level 2 Examples – No actual harm with potential for more than minimal harm that is not IJ
- Sadness, as reflected in facial expression and/or demeanor, or verbal/vocal disappointment.
- Feelings and/or complaints of discomfort or irritability.
- Complaints of boredom and/or reports that there is nothing to do.

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Psychosocial Outcome Severity Guide

- Severity Level 1 – No actual harm with potential for minimal harm
- Not an option because any facility practice that results in a reduction of psychosocial well-being diminishes resident's quality of life

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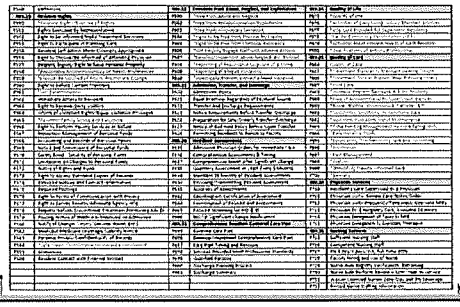
Psychosocial Outcome Severity Guide

Areas with highest risk of psychosocial outcomes



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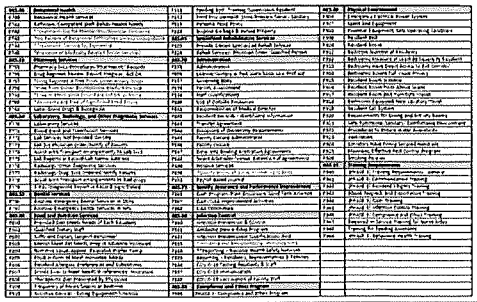
Psychosocial Outcome Severity Guide

Areas with highest risk of psychosocial outcomes



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Psychosocial Outcome Severity Guide

- Because the psychosocial outcome of abuse may not be apparent at the time of the survey, surveyors must apply the reasonable person concept in evaluating the severity of psychosocial outcomes
  - There are situations that are likely to cause psychosocial harm which may take months or years to manifest and have long-term effects on resident
  - Immediate jeopardy or actual harm may be cited when there is not an observed or documented negative psychosocial outcome, or a description of resident impact from those who know the resident

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Psychosocial Outcome Severity Guide F600 Abuse Deficiency Categorization

- Situations involving abuse that are likely to cause serious psychosocial harm:
  - Sexual assault (e.g., rape)
  - Unwanted sexual touching
  - Sexual harassment
  - Any staff to resident physical, sexual, or mental/verbal abuse
  - Staff posting or sharing demeaning or humiliating photographs or videos of nursing home residents
  - When facility staff, as punishment, threaten to take away the resident's rights, privileges, or preferred activities, or withhold care from the resident
  - Any resident-to-resident physical abuse that is likely to result in fear or anxiety

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References

- CMS Nursing Homes Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Downloads https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes
- CMS Appendix PP State Operations Manual https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf

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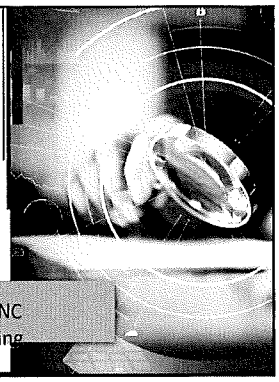
PROACTIVE
MEDICAL REVIEW

Questions?

Thank you!



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Director of Legal Nurse Consulting

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EXHIBIT 358
Sample Form for Facility Reported Incidents

This sample form can be used to ensure the reporting of reasonable suspicion of crimes against a resident or individual receiving care from the facility within prescribed timeframes to the appropriate entities, consistent with Section 1150B of the Act; and all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. The information collected is critical in determining what may be occurring in a facility and the effect(s) that it may have on residents.

Section 1150B(b) of the Social Security Act –
(1) Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.
(2) Timing —If the events that cause the suspicion—
(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and
(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

42 C.F.R. 483.12(c)(1) (F609) - In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

483.12(c)(4) - Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

"**Abuse**," is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of

abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

"**Alleged violation**" is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

"**Crime**": Section 1150B(b)(1) of the Act provides that a "crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

"**Criminal sexual abuse**": In the case of "criminal sexual abuse" which is defined in section 2011(19)(B) of the Act (as added by section 6703(a)(1)(C) of the Affordable Care Act), serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

"**Exploitation**," as defined at §483.5, means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"**Injuries of unknown source**" – An injury should be classified as an "injury of unknown source" when all of the following criteria are met:

- The source of the injury was not observed by any person; and
- The source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

"**Misappropriation of resident property**," as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"**Mistreatment**," as defined at §483.5, is "inappropriate treatment or exploitation of a resident."

"**Neglect**," as defined at §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

"**Serious bodily injury**" means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse (See section 2011(19)(A) of the Act).

"**Sexual abuse**," is defined at §483.5 as "non-consensual sexual contact of any type with a resident."
"**Willful**," is defined at §483.5 in the definition of "abuse," and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

Initial Report

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.

1. Facility Information

Facility Name:
CMS Certification Number (CCN):
Address:
Phone number:
Email address

2. Allegation Type

Select all that apply to the reporting incident.

Abuse specify whether:	Physical	Sexual	Mental/Verbal
Deprivation of Goods and Services by Staff			
Neglect		Misappropriation of Resident Property/Exploitation	
Injury of Unknown Source		Suspected Crime	

3. Information about when the Facility became aware of the incident

Date/Time/Name of when staff became aware of the incident

Date/Time administrator was notified of the incident and by whom

4. Alleged Victim(s)

Please be sure to input the current location of alleged victim at time of filling out this form.

Full Name:	Date of Birth:
Current location of alleged victim:	

5. Alleged Perpetrator(s)

If not a staff member, please insert as much accurate information as possible.

Full Name
Position (if staff)
Contact information, if known
Relationship to the alleged victim

6. Allegation Details

Provide a brief description of the specific allegation, including but not limited to, identifying:

Who made the allegation (unless it was reported anonymously), and their relationship to the alleged victim
What was reported and to whom or which agency/entity
Date and time when the alleged incident occurred
Where the alleged incident occurred

Provide details of any physical harm, pain, or mental anguish to the alleged victim(s), including but not limited to:

Whether serious bodily injury occurred, if known
Describe any type of injury such as a bruise, scratch, laceration, puncture wound, fracture, bleeding, redness on the skin, etc.
Describe any changes in the resident's behavior that indicate something different from the resident's normal baseline such as crying, expressions or displays of fear, cowering, anger, withdrawal, difficulty sleeping, etc.

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.

7. Witness(es)

Full Name:	Position (if staff):
Relationship to alleged victim:	Contact information, if known:

8. Notification to Law Enforcement, if applicable

Was the incident reported to a law enforcement agency? (Yes/No)
If yes, name of the law enforcement agency notified and contact person
Name of reporting individual(s) and position(s)
Date and time (including am/pm) the report was made, report number if available:

9. Notification to Other Agencies

Were other agencies notified?
If YES, which other agency and who at that agency was notified of the allegation (ex: Adult Protective Services, Ombudsman)
Date and Time (include am/pm) the report was made:

10. Submission Report

Name/title of person submitting report
Date/time (am/pm) report was submitted
Contact number and E-mail address of person submitting report for follow up

Exhibit 359
Follow-up Investigation Report

Within five (5) business days 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 report. The facility 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:

1. Additional/Updated Information Related to the Reported Incident:

Provide a brief description of any additional information and/or updates, if applicable.

Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm
Whether the allegation was reported to the resident representative, and if so, date/time
Whether the allegation was reported to another agency (e.g., nurse aide registry or professional licensing boards if staff to resident abuse), and if so, which agency, date/time, and outcome if they conducted an investigation

2. Steps taken to investigate the allegation:

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

Summary of interview(s) with the alleged victim and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress
Summary of interview(s) with witness(es), what the individual observed or knowledge of the alleged incident or injury

Summary of interview(s) with the alleged perpetrator(s) (staff, resident, visitor, contractor, etc.)
Summary of interview(s) with other residents who may have had contact with the alleged perpetrator
Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides
Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident

Provide summary information from the investigation related to the incident from the resident's clinical record, such as relevant portions of the RAI, the resident's care plan, nurses' notes, social services note, lab reports, x-ray reports, physician or other practitioner reports or reports from other disciplines that are related to the incident. If a resident to resident altercation occurred, provide any relevant details that may have caused the alleged perpetrator's behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or BIMS score.

If available within the five business day timeframe, provide summary information of other documents obtained, such as hospital/medical progress notes/orders and discharge summaries, law enforcement reports, and death reports as applicable

3. Conclusion

Provide a brief description of the conclusion of the investigation and indicate if findings were:
[Note: For incidents reported as injuries of unknown source, indicate if the injury resulted from abuse or neglect, based on evidence from the investigation.]

Verified – The allegation was verified by evidence collected during the investigation. Indicate if the allegation was verified by evidence collected during the investigation.
Not Verified – The allegation was refuted by evidence collected during the investigation. Indicate and describe why the allegation was unable to be verified during the investigation.
Inconclusive– The allegation could not be verified or refuted because there was insufficient information to determine whether or not the allegation had occurred. If this was identified as inconclusive, indicate and describe how this was determined.

4. Corrective Action(s) Taken

Provide in detail a summary of all corrective action(s) taken.

Describe any action(s) taken as a result of the investigation or allegation

Describe the plan for oversight of implementation of corrective action, if the allegation is verified.
As a result of a verified finding of abuse, such as physical, sexual or mental abuse, identify counseling or other interventions planned and implemented to assist the resident
If systemic actions (e.g., changes to facility staffing patterns, changes in facility policies, training) were identified that require correction, identify the steps that have been taken to address the systems
If the allegation was reported to law enforcement or another state agency, where applicable and if available, what is the status or provide conclusions of their investigation.

5. Facility investigator

Provide the name of the facility individual who had the primary responsibility for conducting the investigation.

Name of person(s) investigating allegation:

6. Submitted by

Name of administrator/designee:
Date/time of submission:

Contact number and E-mail address for follow up:

Psychosocial Outcome Severity Guide

Clarification of Terms

"Anger" refers to an emotion caused by the frustrated attempts to attain a goal, or in response to hostile or disturbing actions such as insults, injuries, or threats.

"Apathy" refers to a marked indifference to the environment; lack of a response to a situation; lack of interest in or concern for things that others find moving or exciting; absence or suppression of passion, emotion, or excitement.

"Anxiety" refers to the apprehensive anticipation of future danger or misfortune accompanied by a feeling of distress, sadness, or somatic symptoms of tension. Somatic symptoms of tension may include, but are not limited to, restlessness, irritability, hyper- vigilance, an exaggerated startle response, increased muscle tone, and teeth grinding. The focus of anticipated danger may be internal or external.

"Dehumanization" refers to the deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations.

"Depressed mood" (which does not necessarily constitute clinical depression) is indicated by negative statements; self-deprecation; sad facial expressions; crying and tearfulness; withdrawal from activities of interest; and/or reduced social interactions. Some residents such as those with moderate or severe cognitive impairment may be more likely to demonstrate nonverbal symptoms of depression.

"Fear" *is defined as an unpleasant often strong emotion caused by anticipation or awareness of danger*[1].

"Humiliation" refers to a feeling of shame due to being embarrassed, disgraced, or depreciated. Some individuals lose so much self-esteem through humiliation that they become depressed.

*"**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 the deficiency may have had on a reasonable person in the resident's position.*

***NOTE**: The reasonable person concept described in this Guide is merely a tool to assist the survey team's assessment of the severity level of negative psychosocial outcomes.*

[1] https://www.merriam-webster.com/dictionary/fear. Accessed June 17, 2021.

Although the reasonable person concept is used in many areas of the law, the application of common law defenses to the assessment of severity pursuant to this Guide would be inappropriate.

Purpose

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific Ftag, *including how to determine the severity of the outcome when the impact on the resident may not be apparent or documented.* The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Life, Quality of Care) that resulted in, *or may result in,* a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid, but rather it is intended to be used in conjunction with the scope and severity grid to determine the severity of outcomes to each resident involved in a deficiency that has resulted in a psychosocial outcome. The team should select the level of severity for the deficiency based on the highest level of physical or psychosocial outcome. For example, a resident who was slapped by a staff member may experience only a minor physical outcome from the slap but suffer a greater psychosocial outcome, as demonstrated by fear, agitation, and/or *withdrawal. Another example is when a staff member physically assaults a resident with no resulting physical harm, but the resident only demonstrates indifference to the incident at the time of the survey; however, it is likely that this caused a greater psychosocial outcome.* In *these* cases, the severity level based on the psychosocial outcome would be used as the level of severity for the deficiency *as it would reflect the highest level of harm or potential for harm.*

Overview

Psychosocial outcomes (e.g., changes in mood and/or behavior) may result from a facility's noncompliance with any regulatory requirement. A resident may have experienced (or may have the potential or likelihood to experience) a negative physical outcome and/or a negative psychosocial outcome resulting from facility noncompliance.

Psychosocial and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level should reflect *the* highest level of harm/potential harm.

The presence of a given affect (i.e., behavioral manifestation of mood) does not necessarily indicate a psychosocial outcome that is the direct result of noncompliance. A resident's reactions and responses (or lack thereof) also may be affected by his/her pre-existing psychosocial issues, illnesses, medication side effects, and/or other factors. Because many
nursing home residents have sadness, anger, loss of self-esteem, etc. in reaction to normal life experiences, the survey team must determine that the negative psychosocial outcome is a result of the noncompliance and not a pre-existing condition for the resident.

Psychosocial outcomes may be the result of facility noncompliance with any regulation. This

also includes psychosocial outcomes resulting from *a* facility*'s* failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, leading to continuation or worsening of the condition.

Instructions

This Guide is designed to be used separately for each resident included in the deficiency.

NOTE: For instances of abuse, see also Appendix PP-Tag F600, Deficiency Categorization.

To determine the severity of the psychosocial outcome, the team should obtain evidence through observation, interview, and record review. For example, the team should interview the resident, and collect information regarding the resident's verbal and non-verbal responses. If a psychosocial outcome is identified, compare the resident's behavior (e.g., their routine, activity, and responses to staff or to everyday situations) 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 should attempt to interview other individuals who are familiar with the resident's routine or lifestyle, such as the resident's representative, the resident's family, Ombudsman, the resident's direct care staff, and/or medical professionals, to assess the psychosocial impact on the resident. If no such changes are apparent or documented, the surveyor should consider the response as a reasonable person in the resident's position would exhibit in light of the triggering event.

Application of the Reasonable Person Concept

There are circumstances in which the survey team should apply the "reasonable person concept" to determine *the outcome and the* severity of the deficiency, such as when a resident's psychosocial outcome may not be readily determined through the investigative process. *The following are examples of circumstances in which a resident's psychosocial outcome may not be readily determined through the investigative process and the reasonable person concept should be used:*

- 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. Such circumstances may include, but are not limited to, the resident's death, cognitive impairments, physical impairments, or insufficient documentation by the facility; or

- When a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person *in the resident's position* would have to the deficient practice.

To apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person

in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in a similar situation to suffer as a result of the noncompliance). The survey team should consider the following regarding the resident's position, which may include, but is not limited to:

- *The resident may consider the facility to be his/her "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.*
- *The resident trusts and relies on facility staff to meet his/her needs.*
- *The resident may be frail and vulnerable.*

The surveyor should document the resident's actual response and the perspectives of someone familiar with the resident. In addition to the evidence gathered by the surveyor, the use of the reasonable person concept should be applied and may reveal that the resident is likely to, or may potentially, suffer a greater psychosocial outcome. For example, in the case of a sexual assault, the resident did not exhibit a change in behavior as a result of the incident. In addition, the resident's relative presumed that the resident would be upset by the situation. The evidence gathered by the surveyor should still be documented, but the determination of severity would be based on how the reasonable person would experience serious psychosocial harm (immediate jeopardy) as a result of a sexual assault.

The survey team should document on the CMS-2567 when it applies the reasonable person concept in determining the psychosocial outcome(s) for a deficiency.

Severity Levels
The following are examples of severity levels of negative psychosocial outcomes that could have developed, continued, or worsened as a result of a facility's noncompliance. This Guide is only to be used once the survey team has determined noncompliance at a regulatory requirement.

Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety
Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level four include, but are not limited to:

- Suicidal ideation/thoughts and preoccupation or suicidal attempt (active or passive) such as trying to jump from a high place, throwing oneself down a flight of stairs, refusing to eat or drink in order to kill oneself, hoarding medications with the expressed intent of suicide.

- Engaging in self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident (e.g., *attempting to cut oneself,* banging head against wall).

- *Anger, agitation, or distress that has caused aggression that can be*

manifested by self-directed responses or hitting, shoving, biting, scratching others, threatening, screaming, or cursing.

- Crying, moaning, screaming, or combative behavior *that is above the resident's baseline.*

- Expressions (verbal and/or non-verbal) of *avoidable pain that is severe, and more than transient. Pain is considered avoidable when there is a failure to assess, reassess, and/or take steps to manage the resident's pain;*

- *Fear/anxiety that may be manifested as panic, immobilization, screaming, and/or agitated behavior(s) (e.g., trembling, cowering); avoidance of the situation(s), person(s) or place; preoccupation with fear; resistance to care and/or social interaction; sleeplessness; fear of speaking, and/or verbal expressions of fear.*

- *Expressions of feelings of hopelessness, worthlessness or guilt (not merely self-reproach or guilt about being sick or needing care);*

- Expressions of dehumanization or humiliation in response to an identifiable situation.

- *Withdrawal from former* social patterns, such as isolation from staff, friends and family.

Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy
Severity Level 3 indicates noncompliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the resident's inability to maintain and/or reach his/her highest practicable well-being. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level three include, but are not limited to:

- Decline from former social patterns that does not rise to a level of immediate jeopardy.

- Depressed mood that may be manifested by verbal and nonverbal symptoms such as:
    - *Decreased engagement in social activities*; apathy; tearfulness; crying; moaning;
    - *Change* of interest or ability to experience or feel pleasure *as usual*
    - Psychomotor *movements* (e.g., inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects);
    - *Change in* psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering) *unrelated to medical diagnosis*;
    - Verbal *expressions* (e.g., repeated requests for help, groaning, sighing, or other repeated verbalizations), *that may be* accompanied by *a* sad *tone*;
    - Diminished ability to think or concentrate.

- Expressions (verbal and/or non-verbal) of *moderate* pain or physical distress (e.g., itching, thirst) that has compromised the resident's functioning such as diminished level of participation in social interactions and/or ADLs, intermittent crying and moaning, *or loss in interest for eating.* Pain or physical distress has become a central focus of the resident's attention, but it is not *severe* or overwhelming (as in Severity Level 4).

- *D*istress (e.g., under stimulation as manifested by fidgeting; restlessness; repetitive verbalization of not knowing what to do, needing to go to work, and/or needing to find something), *unrelated to medical diagnosis.*

Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy
Severity Level 2 indicates noncompliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided. Examples of negative psychosocial outcomes as a result of the facility's noncompliance at severity level two include but are not limited to:

- Sadness, as reflected in facial expression and/or demeanor, or verbal/vocal *disappointment.*

- Feelings and/or complaints of discomfort *or* irritability.

- Complaints of boredom and/or reports that there is nothing to do.

Severity Level 1 Considerations: No Actual Harm with Potential for Minimal Harm
Severity Level 1 is not an option because any facility practice that results in a reduction of psychosocial well-being diminishes the resident's quality of life. The deficiency is, therefore, at least a Severity Level 2 because it has the potential for more than minimal harm.

While the survey team may find negative psychosocial outcomes related to any of the regulations, the following areas may be more susceptible to a negative psychosocial outcome or contain a psychosocial element that may be greater in severity than the physical outcome.

Areas where the survey team may more likely see psychosocial outcomes when citing a particular deficiency include, but are not limited to:

483.10 Resident Rights
F557, Respect, Dignity/Right to Have Personal Property;
F558, Reasonable Accommodation of Needs/Preferences;

483.12 Freedom from Abuse, Neglect, and Exploitation
F600 Free from Abuse and Neglect;

F602 Free from Misappropriation/Exploitation;
F603, Free from Involuntary Seclusion;
F604, Right to be Free from Physical Restraints;
F605, Right to be Free from Chemical Restraints;
F607, Develop/Implement Abuse/Neglect, etc. Policies;
F609, Reporting of Alleged Violations;
F610, Investigate/Prevent/Correct Alleged Violation;

483.21 Comprehensive Resident Centered Care Plans
F656, Develop/Implement Comprehensive Care Plan;
F657 Care Plan Timing and Revision;

483.24 Quality of Life
F675, Quality of Life
F679, Activities Meet Interest/Needs of Each Resident;

483.25 Quality of Care
F699, Trauma Informed Care

483.40 Behavioral Health Services
F740, Behavioral Health Services;
F741 Sufficient/Competent Staff – Behavioral Health Needs;
F742, Treatment/Services for Mental/Psychosocial Concerns;
F743, No Pattern of Behavioral Difficulties Unless Unavoidable; F745, Provision of Medically Related Social Services;

483.45 Pharmacy Services
F757, Drug Regimen is Free from Unnecessary Drugs; and
F758, Free from Unnecessary Psychotropic Medications/PRN Use.

RoP 10/24/22 Action Items Checklist

PROACTIVE MEDICAL REVIEW

Resident Rights

- ☐ Update policy and procedures
  - Visitation
  - Substance Use
  - Smoking
  - Resident Privacy
  - Beneficiary notices (ABN and NOMNC)
- ☐ Staff training
  - Signs & symptoms of substance use
  - Actions to take if staff suspect a resident is under the influence or that resident and/or a visitor is brining illegal substances into facility
  - Medicare Coverage notices
- ☐ Maintain a log and copy of all NOMNC and ABN notices provided

Abuse, Neglect, & Exploitation

- ☐ Update abuse policy and procedures
  - Elder Justice Act Requirements
    - Conspicuous notice of employee rights
    - Prohibiting retaliation against employee who reports a suspicion of a crime
    - Identification of who in the facility is considered a covered individual
    - Identification of crimes that must be reported
    - Identification of what constitutes "serious bodily injury;"
    - The timeframe for which the reports must be made; and
    - Which entities must be contacted, for example, the State Survey Agency and local law enforcement
    - Annual notification to each covered individual of their obligation to comply with the reporting requirements
  - Abuse reporting requirements
  - How staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program
- ☐ Ensure that a conspicuous notice of employee rights is posted that includes the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint
- ☐ Ensure that a process is in place to annually notify covered individuals of their obligations related to reporting reasonable suspicion of a crime
- ☐ Staff training
  - What constitutes abuse and neglect
  - Protecting residents from abuse
  - Abuse/Neglect reporting requirements
  - Capacity to consent to sexual activity
  - Elder Justice Act requirements
  - Precautions to take to preserve evidence when it is suspected that a crime has been committed
  - Updating resident's care plan if residents medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse
- ☐ Be aware of the expansion and potential implications of the Neglect section of guidance

- ☐ Be aware of the expansion and the potential implications of the portions of the Psychosocial Outcome Severity Guide specifically included in the Deficiency Categorization for §483.12(a)(1)

Admission, Transfer, & Discharge Requirements

- ☐ Review of Transfer/Discharge Policy and/or processes to ensure following are addressed:
  - What to do when skilled services end, but resident is not ready to discharge
  - Facility's responsibility to resident when MCR coverage ends
  - Return to facility following acute care transfers
- ☐ Updates to notice of transfer/discharge
  - Specific location where resident is being transferred/discharged to
    - Name of new provider and/or address if discharging to a residence
  - Requirement to provide new notice if destination changes
  - Information on how to obtain an appeal form
  - Mailing and email address of Ombudsman
- ☐ Staff education on requirement to provide Notice of Transfer/Discharge prior to the transfer/discharge for facility-initiated transfers/discharges, including transfers to hospital for acute events.
- ☐ Ensure process in place to provide Notice of Transfer/Discharges to Ombudsman
- ☐ Review/update bed hold policies
  - Address allowing all residents, regardless of payer source, to return after hospitalization or leave unless resident meets a discharge requirement
- ☐ Examine how you determine that you are unable to meet residents needs when deciding not to allow residents to return to a facility
  - Ensure these determinations are appropriate based on the regulation and ensure documentation coincides with requirements

Culturally-Competent & Trauma-Informed Care

- ☐ Care Plan Reviews
  - Interventions reflect resident's cultural preferences, values & practices
  - For residents with history of trauma
    - Does care plan describe interventions for care that account for resident's experiences & preferences to eliminate or mitigate triggers?
- ☐ Screening/Assessment tools
  - History of trauma
  - Cultural Needs
- ☐ Policy & Procedures
  - Trauma-Informed Care
  - Cultural Competence
  - Comprehensive Care Plans
- ☐ Develop process for trauma-informed care planning
- ☐ Develop process for culturally-competent care planning
- ☐ Establish a champion to build awareness about trauma-informed care
- ☐ Evaluate community resources
- ☐ Staff training and competency assessment

Quality of Care

- ☐ Policy & Procedure Review/Updates
  - Pressure Ulcer Risk Assessment – frequency of completion

- Foot Care – Infection Control Requirements
- Use of electronic cigarettes
- Care of residents with substance use disorders
- IV Therapy
- Pain Management
- Opioid Overdose
- Bed Rails

☐ Assessments
- Ability to safely handle e-cigarette devices
- Risk for substance use
- Bed Rails- include alternatives attempted prior to use of bed rails, entrapment risk assessment, assessment of risk/benefits, informed consent prior to use

☐ Education/Competency Assessments
- Maintaining separation of clean & contaminated podiatry equipment
- Recognizing signs & symptoms of substance use
- Addressing emergencies r/t substance use
- IV Therapy
- Monitoring for side effects of opioids

Physician Services

☐ Educate providers on authority for non-physician practitioners to perform visits, sign orders, and sign Medicare Part A Certifications/Recertifications

Behavioral Health

☐ Policy & Procedure Review/Updates
- Facility Assessment – Addresses behavioral health needs
- PASARR
- Behavioral Contracts
- Substance Use

☐ Care Plan/Assessments
- Address mental disorders & history of substance use

☐ Education/Competency Assessments
- Caring for residents with behavioral health or substance use disorders

Pharmacy Services

☐ Policy & Procedure Review/Updates
- Disposal of Fentanyl patches
- Psychotropic Use
- Gradual dose reductions

☐ Education/Competency Assessments
- Disposal of Fentanyl patches
- Appropriate indications for psychotropic use

Food and Nutrition Requirements

☐ Educate staff involved in distributing and serving food on good hygienic practices

Nursing Staffing

☐ Review process for how sufficient staffing is determined for your facility

☐ Review/update policy and procedure for ensuring sufficient staffing

Payroll Based Journal

☐ Review monthly Provider Preview in CASPER folder

RoP 10/24/22 Action Items Checklist

PROACTIVE MEDICAL REVIEW

- ☐ Prior to quarterly submission deadline, review PBJ data and ensure accuracy, by reviewing CASPER reports:
  - 1700D Employee Report
  - 1702D Individual Daily Staffing Report
  - 1702S Staffing Summary Report
- ☐ Follow policies in PBJ policy manual
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html
- ☐ Review process for ensuring PBJ data is accurate and submitted timely
- ☐ Establish back-up coverage for PBJ data submission

Arbitration Requirements

- ☐ Review policy and procedures
- ☐ Review language of agreement
- ☐ Review process for communication with residents/RP
- ☐ Staff training on new guidance for those responsible for reviewing agreement with residents/RPs
  - Return demonstration of clear explanation of arbitration agreement that meets standards

QAPI

- ☐ Develop, implement and maintain an effective, data driven QAPI program focusing on indicators of outcomes of care and quality of life that may include, but is not limited to:
  - Develop & implement systems and reports demonstrating systematic identification, reporting, investigation, analysis & prevention of adverse events
  - Develop systems of documentation demonstrating development, implementation, & evaluation of corrective actions or performance improvement activities
- ☐ QAPI Policies and Procedures
  - Design & Scope of Program addresses all care and services including clinical care, quality of life and resident choice
  - Governance and leadership roles, accountability and resource allocation
  - Program feedback, data collection systems and monitoring including method and frequency
  - Developing, monitoring, and evaluating performance indicators
  - Establishing priorities for performance improvement
  - System for tracking medical errors and adverse events
  - Program systematic analysis and systemic action
  - Program activities including but not limited to performance improvement projects (PIPs)
  - QAA committee

Infection Control

- ☐ Review/Update Policy and procedures
  - Standard Precautions
  - Transmission-based precautions
  - Environmental Cleaning and disinfection
  - Antibiotic Stewardship Program
  - Infection Preventionist
- ☐ Review/Establish Water Management Program

- ☐ Validate staff competency in cleaning and disinfecting blood glucose meters and ensure process is consistent with manufacturer's instructions
- ☐ Ensure qualified Infection Preventionist, with specialized training, is in place

Physical Environment Requirements

- ☐ Evaluate Resident Call System to ensure 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 each resident's bedside & toilet & bathing facilities
- ☐ Explore ways that you can allow for more single occupancy rooms

Compliance & Ethics

- ☐ Establish written standards, policies & procedures that meet requirements at 483.85(c)
- ☐ Assign specific high-level individual(s) to oversee compliance & ensure sufficient resources & authority
- ☐ Communicate standards to entire staff, contracted individuals, & volunteers
- ☐ Establish & implement monitoring & auditing systems to detect criminal, civil and administrative violations
- ☐ Implement & publicize reporting system to report violations anonymously without fear of retribution
- ☐ Implement process of maintaining reporting data
  - o violation response processes
  - o investigation
  - o tracking log
- ☐ Establish consistent enforcement of standards, policies, procedures through appropriate disciplinary mechanisms
- ☐ Ensure reasonable steps are taken to respond to detected violations including any necessary modifications to the operating organization's program to prevent and detect violations
- ☐ Establish a process to annually review the program
- ☐ Establish an effective means of communicating program standards, policies & procedures through a training program or another practical manner which explains the requirements under the program
- ☐ 5 or more facilities:
  - o Mandatory Annual training
  - o CO that reports to the Governing Body with Liaison each facility

Training Requirements

- ☐ Ensure required training topics are addressed including, but not limited to:
  - o Effective Communication
  - o Resident Rights & Facility Responsibilities
  - o QAPI Program Elements & Goals
  - o Written standards/Policies & Procedures for IPCP
  - o Compliance & Ethics
  - o Behavioral Health
  - o Required Nurse Aide Training must address areas of weakness based on performance reviews & Facility Assessment, & may address special needs of residents