Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

AUGUST 2015
ISSUE 8, VOLUME 5

SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE HAT ADVANTAGE by Rebecca Adelman

CHANGING THE RULES FOR BETTER OR WORSE LTC REGULATORY REFORM

Comment Period Ends September 14

For the past 25 years, the Medicare and Medicaid rules and regulations governing long-term care facilities have been at the roadmap for my litigation defense practice, risk management and industry education. I've become an expert in "CFR 483" and the "F-Tags". I've also experienced the evolution of the mission and vision of long-term care in America and the impact of litigation, risk management and the delivery of care. Well, the landscape is about to change. The proposal announced last month at the White House Conference on Aging would make major changes "to improve the care and safety of the nearly 1.5 million residents in the more than 15,000 long-term care facilities or nursing homes that participate in the Medicare and Medicaid programs." According to the 400 plus pages of commentary and recommended changes, "unnecessary hospital readmissions and infections would be reduced, quality care increased, and safety measures strengthened for the more than 1 million residents in these facilities."

Since 1991 (incidentally the year I began to defend nursing home lawsuits), there have been no major revisions to the regulations. CMS research to support the proposed changes suggests that the number of Medicare beneficiaries who accessed care in a SNF increased from 636,000 (or 19 per 1,000 enrollees) in 1989 to 1,839,000 (or 52 per 1,000 enrollees) in 2010, not including managed care enrollees. Other factors driving the changes include a higher acuity in the nursing home resident population; an increase in assisted-living facilities and other alternatives to nursing home care, such as home care; and nursing homes caring for many residents who require behavioral health services. Estimated compliance costs are $730 million for the first year and $640 million for year two and after

As we know, the health concerns of individuals residing in LTC facilities have become more clinically complex. The LTC population includes a mix of elderly individuals, younger residents with intellectual or developmental disabilities who are chronically ill, and residents needing post-acute rehabilitation services. Since the1980s, the nursing home resident population has had significant changes. Some have resulted in nursing homes having to care for many residents that generally have a higher acuity.

According to HHS, one of the goals in revising the minimum health and safety requirements for LTC facilities is to ensure that the regulations align with current clinical practice and allow flexibility to accommodate multiple care delivery models to meet the needs of the diverse populations that are provided services in these facilities. In addition, the revisions could contribute to a reduction in unnecessary hospital admissions and a reduction in the unnecessary use of antipsychotic medication and improvements in the quality of behavioral health care. Accelerating health information exchange (HIE) is included in the proposal. Notably, the proposal references raising awareness about the special care needs of trauma survivors, including a targeted effort to support the needs of Holocaust survivors living in the United States. Trauma survivors, including veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors, and survivors of abuse are among those who may be residents of long-term care facilities. For these individuals, the utilization of trauma-informed approaches is an essential part of person-centered care which is a focus of the revisions.

I am completing an assessment on 1) the validity of whether the new requirements where necessary, eliminate duplicative or unnecessary provisions, and 2) whether they reorganize the regulations as appropriate. Further, HHS suggests that many of the revisions are aimed at aligning requirements with current clinical practice standards to improve resident safety along with the quality and effectiveness of care and services delivered to residents. It believes that these proposed revisions may eliminate or significantly reduce those instances where the requirements are duplicative, unnecessary, and/or burdensome. I'll be reporting on these HHS goals in the next months and will focus on the changes and possible areas of concerns at the 2015 THCA/TNCAL Convention & Trade Show August 30 to September 2, 2015 at Music City Center in Nashville, Tennessee.

The changes include:

- Making sure that nursing home staff is properly trained on caring for residents with dementia and in preventing elder abuse.
- Ensuring that nursing homes consider the health of residents when deciding on the kinds and levels of staffing a facility needs to properly take care of its residents.
- Ensuring that staff members have the right skill sets and competencies to provide person-centered care to residents. The care plan developed will take the resident's goals of care and preferences into consideration.

Continued on page 4

Pathway to Rehabilitation Excellence

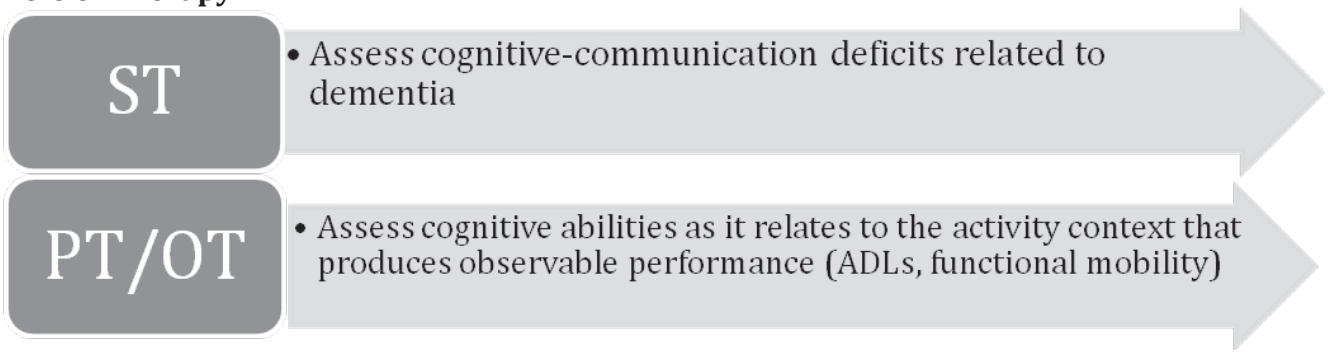
By Melissa Ward
Director of Clinical Services

Dementia Staging

Can help you…

▶ gather facts - it is hard to know what you are working with or if you're improving if you're not measuring	▶ create structure for making decisions - clear criteria to evaluate merits of each option and use them consistently
▶ be mindful of subtle cues - small changes can have big effects	▶ foster awareness - help yourself and colleagues focus on patient-centered care
▶ determine baseline & detect changes	▶ understand realistic choices
▶ learn remaining abilities and strengths	▶ establish realistic goals that match abilities
▶ determine level of external aides and training that will be required to maximize success	▶ educate on strategies to maximize function & promote effective communication

Role of Therapy



Sample Staging Tools (refer to FP Assessment Toolbox for more info)

Allen Cognitive Level Screen

- Leather and lacing (ACLS) or Allen Diagnostic Module can be used to obtain information on global cognitive processing capacities, learning potential, and can detect unrecognized or suspected problems related to functional cognition. Allen levels define what a person pays attention to, their motor response, and verbal performance.

Brief Cognitive Rating Scale (BCRS)

- Based on reviewer's observation and interaction with patient; measures 5 domains: concentration, recent memory, past memory, orientation, and functioning & self-care.

Global Deterioration Scale

- Provides an overview of the stages of cognitive function for those suffering from a primary degenerative dementia such as Alzheimer's disease. Has 7 stages ranging from no cognitive decline (stage 1) to very severe (stage 7).

Saint Louis University Mental Status Exam (SLUMS)

- 11 question test that assesses orientation, memory, attention, and executive function.

For more information, please contact
Melissa Ward, Director of Clinical Services, Functional Pathways at mward@fprehab.com or call 865-531-2204.
You may also discover more at www.functionalpathways.com

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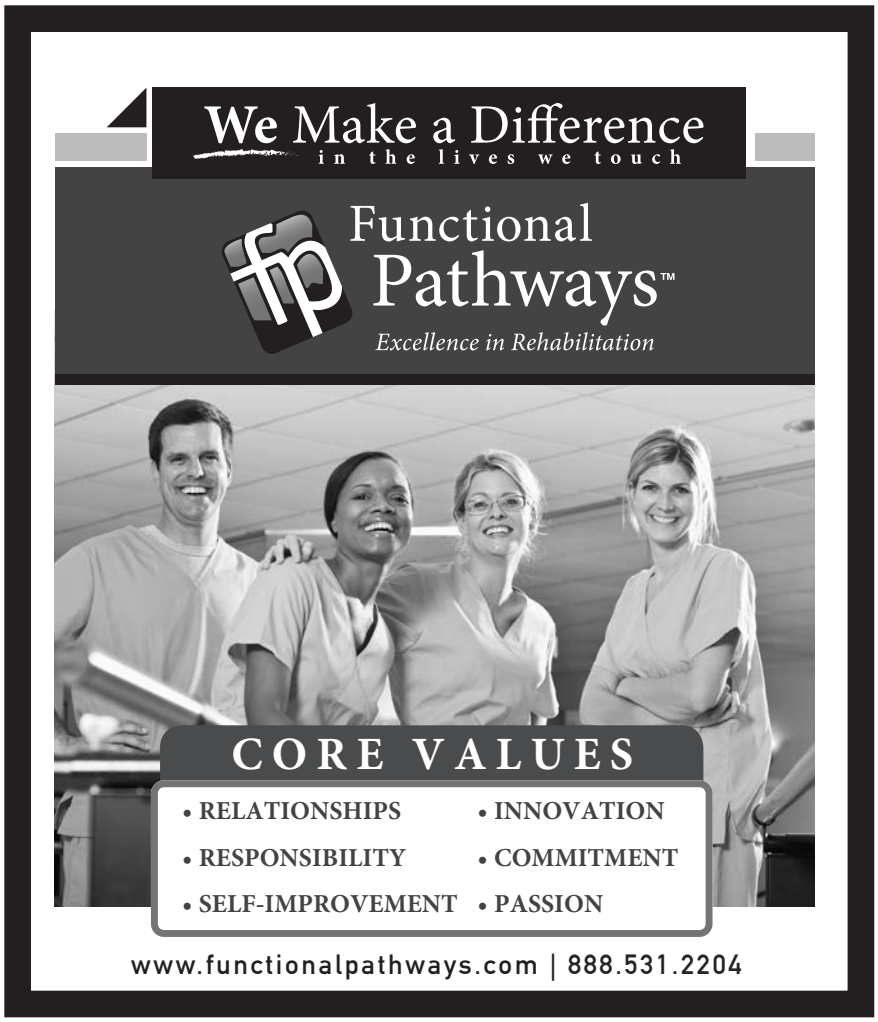

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The HAT Advantage continued from page 1

- Improving care planning, including discharge planning for all residents with involvement of the facility's interdisciplinary team and consideration of the caregiver's capacity, giving residents information they need for follow-up, and ensuring that instructions are transmitted to any receiving facilities or services.

- Allowing dietitians and therapy providers the authority to write orders in their areas of expertise when a physician delegates the responsibility and state licensing laws allow.

- Requiring nursing homes to provide greater food choice for residents while also giving flexibility for nursing homes.

- Updating the nursing home's infection prevention and control program, including requiring an infection prevention and control officer, and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

- Addressing rights of nursing home residents, including placing limits on when and how binding arbitration agreements may be used.

The following is a brief summation of the proposed changes in more detail which can be fully reviewed in the Federal Register which was published July 16, 2015.

- **Definitions (§483.5):**
  - Adds definitions for "adverse event"; "documentation"; "posting/displaying"; "resident representative" "abuse"; "sexual abuse"; "neglect"; "exploitation"; "misappropriation of resident property"; and "person centered care".
- **Resident rights (§483.10):**
  - CMS would retain all existing residents' rights, but update language and organization to include, e.g., electronic communications. Proposed revisions would:
    - Eliminate language, such as "interested family member"; replace "legal representative" with "resident representative."
    - Address roommate choice.
    - Add language regarding physician credentialing to specify that the physician chosen by the resident must be licensed to practice medicine in the state where the resident resides, and must meet professional credentialing requirements of the facility.
- ***New Section:*** **Facility responsibilities (§483.11)**
  - Focuses on facility responsibilities (protecting the residents' rights, enhancing quality of life). This section parallels many residents' rights provisions.
    - Visitation: Would establish open visitation, similar to the hospital conditions of participation (CoPs).
    - Abuse/Neglect/Exploitation (§483.12): Would revise "Resident behavior and facility practices," to "Freedom from abuse, neglect, and exploitation"; and
    - Prohibit employment of individuals with disciplinary actions against their professional license by a state licensure body following a finding of abuse, neglect, mistreatment, or misappropriation of property.
    - Require implementation of written policies and procedures that prohibit and prevent abuse, neglect, mistreatment, and/or misappropriation of property.
- **Transitions of Care (§483.15):** Revises "admission, transfer and discharge rights," to apply to all transfers of resident care.
  - **Transfers / Discharge:** Would require specific information/data elements, e.g., demographic; history of present illness including, e.g., active diagnoses, functional status, medications; reason for transfer and past medical/surgical history, be exchanged with the receiving provider. CMS is not proposing a specific form, format, or methodology.
- **Resident assessments (§483.20); Preadmission Screening and Resident Review (PASRR):** Would clarify appropriate coordination of resident assessment with PASRR.
  - Would add exceptions to PASRR requirements for mental illness and intellectual disabilities for admission regarding transfers to or from a hospital.
  - Would require notification of state mental health or intellectual disability authorities promptly after a significant change in the mental or physical condition of a resident with a mental illness or intellectual disability.
- ***New Section:*** **Comprehensive Person-Centered Care Planning (§483.21)** – Would require development of a baseline care plan for each resident within 48 hours of admission, including instructions needed to provide effective and person-centered care meeting professional standards.
  - **PASRR**: Would require the care plan to include any specialized services or specialized rehabilitation services the facility will provide because of PASRR; a rationale for disagreement with PASRR findings must be documented in the medical record.
  - **Interdisciplinary Team (IDT):** Would add a nurse aide, food and nutrition services, and a social worker to the IDT that develops the comprehensive care plan.
  - Would require written explanation in the medical record if participation of the resident and their resident representative are determined not practicable.
- **Discharge Planning [as part of Comprehensive Person-Centered Care Planning]:** Would implement IMPACT Act requirements for long-term care facilities to take into account quality, resource use, and other measures to inform and assist the discharge planning process, while accounting for resident treatment preferences and goals.
  - Would require facilities to document the resident's goals for admission in the care plan; assess potential for future discharge; include discharge planning in the comprehensive care plan.
  - Would require the discharge summary to include reconciliation of all discharge medications with pre-admission medications (prescribed and OTC).
  - Would require addition to the post discharge care plan a summary of arrangements made for follow up and any post discharge services.
- **Quality of care and Quality of Life (§483.25) [retitled]** – Would clarify that quality of care and quality of life are overarching principles in all care and services.
  - Would clarify the requirements regarding a resident's ability to perform ADLs.
  - No proposal, but CMS is seeking comments on whether current requirements for activities' director are appropriate; what minimum requirements should be.
  - Would modify requirements for nasogastric tubes to reflect current clinical practice, and include enteral fluids in requirements for assisted nutrition and hydration.

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Getting on the Same Page

by Paige Hector, LMSW

"Here, Here, Read All About It! The State Operations Manual"

Last month I discussed the importance of policies and procedures. This month I'm tackling the state operations manual (SOM). Here's my call to action. Ready? Read the SOM! You must be thinking I've lost my mind. READ the state operations manual I say?! Okay, so you'd probably rather dive into the latest Lee Childs thriller or a juicy summer romance novel. I really get it but…let me see if I can sway you just a bit.

One of the first questions I ask a department manager is whether they have a copy of the regulations that pertain to their department. Unfortunately, my question is often met with a look that conveys a sentiment something like "are you kidding me?" I know what the manager is thinking, he can hardly keep his head above water and now he's being asked if he has a copy of the regulations handy. Oh, and not just any copy, the most current one.
Consider this analogy. You are driving along the highway at 75 mph with four flat tires but you don't have time to stop and change them. That's how some facilities operate. They are so busy with the business of operating the facility that they get lose track of important things like making sure the right employees have the right copies of the right regs.

Do the nurse aids know what the 4 pages of regs say about F241 Dignity and that it specifically states to not change a radio or television station without the resident's permission, to not use derogative terms like "feeders", to remove facial hair for women and the expectation that toileting assistance be provided during mealtimes?

Does the social worker have a copy of F250 Medically Related Social Services and understand that assistive devices like hearing aids, dentures, and podiatric shoes are addressed in this regulation?

What about the oft cited F309 Quality of Care? It's not so long ago that this regulation received a major overhaul. The 15 pages just on pain management offer a wealth of great information that the interdisciplinary team should read and follow. F309 is where hospice services are addressed. Consider making copies for the hospice agencies you work with and engage in team meetings to ensure all nine bullets in the Guidance to Surveyors are in place.

Does your medical director have a copy of F501 Medical Director as well as the nationally accepted statements referenced in that regulation that are available from the American Medical Director's Association? When conflicts over care arise in the facility, is your medical director involved and do they provide guidance for their resolution? How about when transfers don't go smoothly? This is yet another area for medical director involvement.

Every time I open the SOM, I learn something new. Sometimes I just open it to a random page and start reading! Let's see…opening the manual and I land on F203 Notice Before Transfer. Ah yes, this is a good one. Just a few months ago, I was having a discussion with an administrator and DON about why their discharge notice was insufficient. Neither person had read (recently) about the very specific components that must be included in the notice. Unbelievable you think? Not so. There are thousands of regulations in the SOM, not to mention all the policies and procedures that that administrator is responsible for. It's unrealistic to expect any one person to know it all. But, it's totally reasonable to expect that the administrator and key management staff has ready access to and refers to the SOM daily if necessary. In the aforementioned facility, the discharge form in use was a relic of the previous administration that was not reviewed during or soon after the transition to new management.

A dear colleague of mine, Cindy Mason, once said of the Quality Indicator Survey (QIS) Process, "It's an open book test. Operationalize it." That's how I think of the SOM. Everything that surveyors know and use is in that book.

Empower staff by assigning each person a different reg, or small sections of the larger ones. Ask them to prepare a short (5-10 minute) inservice for their colleagues. Encourage creativity! Not only is this a fun way to get staff involved but they get to share the responsibility of teaching as well as operationalizing the regs. Was your facility cited during the last survey? In all likelihood, your Plan of Correction (POC) followed the template format replete with "training" and "inservices." Take a fresh look at the POC. How can staff be involved with learning the F-tags outside of sitting through yet another inservice?

On July 16, 2015 CMS issued proposed rules to revise the requirements for long-term care facilities to participate in Medicare and Medicaid programs. This means that many of the regulations are up for revision. Here's another call to action. Go to https://www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities and print the proposed revisions. Divvy up the sections to the appropriate managers and floor staff. Get them involved and submit your facility's comments to CMS. It may be a super chance for your voice to be heard and to make a difference!

Paige Hector is a clinical educator, who gives workshops and seminars across the country on diverse topics including clinical operations for the inter-professional team, meaningful use of data, advance care planning, refusal of care, documentation and care plans. She is skilled at inspiring staff to critically evaluate their own organizations and then gives them the resources and guidance to make necessary changes. Contact Paige at ***520-955-3387 or at*** *paigehector@gmail.com plus you more discover more about her at www.paigeahead.com*

The HAT Advantage continued from page 4

- Would add a new requirement that facilities ensure pain management needs are met
- Would move current provisions for unnecessary drugs, antipsychotics, medication errors, and influenza and pneumococcal immunizations to Pharmacy services.

- **Physician Services**
  - Would require an in-person evaluation by a physician, a physician assistant (PA), nurse practitioner (NP, or clinical nurse specialist (CNS) before an unscheduled transfer to a hospital.
  - Would allow physicians to delegate dietary orders to dietitians and therapy orders to therapists.
- **Nurse Staffing -** Would add a competencies/skill set requirement for determining sufficient nursing and direct care staff based on a facility assessment, including but not limited to: # of residents, acuity, range of diagnoses, and care plan content.
- ***New Section:*** **Behavioral health services (§483.40)** – Would focus on provision of necessary behavioral health care and services to residents in accordance with comprehensive assessment and plan of care.
  - Would require staff to have appropriate competencies to provide behavioral health care and services, including care of residents with mental and psychosocial illnesses and implementing non-pharmacological interventions.
    - CMS notes in the Preamble that reference to mental health/illness includes substance abuse disorders.
  - Would add "gerontology" bachelor's degree to the minimum social worker educational requirements.
- **Pharmacy services (§483.45); Drug Regimen Review**
  - Would require pharmacist review of a resident's medical chart at least every six months and when the resident is new to the facility, a resident returns or is transferred from a hospital or other facility, and during each monthly DRR when a resident has been prescribed or is taking a psychotropic drug, an antibiotic or any drug the QAA Committee has requested be included in the monthly drug review.
  - Would require the pharmacist to document any irregularities noted during the DRR, including at minimum, the resident's name, the relevant drug and irregularity identified, to be sent to the attending physician, medical director, and director of nursing.
  - Would require the attending physician to document he/she has reviewed the identified irregularity and what action they have taken. "Irregularities" would include "unnecessary drugs."
  - Would require facilities to ensure residents who have not used psychotropic drugs not be given these drugs unless medically necessary; receive gradual dose reductions and behavioral interventions unless clinically contraindicated.
    - "Psychotropic drug" would include any drug that affects brain activities associated with mental processes and behavior.
  - PRN orders for psychotropic drugs would be limited to 48 hours unless the primary care provider reviews and documents the rationale.
- ***New Section:*** **Laboratory, radiology, and other diagnostic services (§483.50)**
  - Would clarify that a PA, NP, or CNS may order laboratory, radiology, and other diagnostic services in accordance with state and scope of practice laws.
  - Would clarify that the ordering practitioner be notified of abnormal laboratory results when they fall outside of clinical reference ranges, in accordance with facility notification policies and procedures.
- **Dental services (§483.55)**
  - Would prohibit SNFs from charging a Medicare resident for the loss or damage of dentures determined to be the facility's responsibility.
  - Would require NFs to assist eligible residents to apply for reimbursement of dental services under the Medicaid state plan.
  - Would clarify that a referral for lost or damaged dentures "promptly" means within 3 business days absent documentation of any extenuating circumstances.
- **Dietary Services**
  - Would require facilities to employ sufficient staff with appropriate competencies to carry out dietary services in accordance with resident assessments, individual care plans, and facility census.
  - A "qualified dietitian" is registered by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics or meets state licensure or certification requirements. Dietitians hired/contracted with before these regulations, would have five years to meet the new requirements.
  - The director of food and nutrition service must be a certified dietary manager, certified food service manager, or be certified for food service management and safety by a national certifying body or have an associate's or higher degree in food service management or hospitality; would have to meet any state requirements for food service managers.
  - Would require menus to reflect religious, cultural and ethnic needs and preferences, be updated periodically, and reviewed by the qualified dietitian or other clinically qualified nutrition professional for nutritional adequacy while not limiting residents' right to personal dietary choices.
  - Would require facilities to consider resident allergies, intolerances, and preferences and ensure adequate hydration.
  - Would allow attending physicians to delegate prescribing resident diets to registered or licensed dietitians, including therapeutic diets, in accordance with state law.
  - Would require availability of suitable, nourishing alternative meals and snacks for residents who want to eat at non-traditional times or outside of scheduled meal times in accordance with the plan of care.
  - Would require documentation in the care plan the clinical need for a feeding assistant and the extent of dining assistance needed.
  - Would clarify facilities may procure food items directly from local producers and may use produce grown in facility gardens.
  - Would clarify residents are not prohibited from consuming foods not procured by the facility.
  - Would require a policy regarding use and storage of foods brought to residents by family and other visitors.

Continued on page 7

The HAT Advantage continued from page 6

- **Specialized rehabilitative services (§483.65)**
  - Would add respiratory services to specialized rehabilitative services.
  - Would clarify what constitutes rehabilitative services for mental illness and intellectual disability.
  - Would establish new health and safety standards for provision of outpatient rehabilitative therapy services.
  - Facility Assessment – would require facilities to conduct, document, and update annually and when needed an assessment to determine resources to care for its residents competently during both day-to-day operations and emergencies.
  - Would include resident population (#, overall care needs and staff competencies required, cultural aspects); resources (e.g., equipment, and overall personnel); and a facility- and community-based risk assessment.
- **Clinical Records -** Would establish requirements that mirror some found in the HIPAA Privacy Rule (45 CFR part 160, and subparts A and E of part 164).
- **Binding Arbitration Agreements**
  - Proposes specific requirements for the facility and the agreement itself to ensure that if a facility presents binding arbitration agreements to its residents that the agreements be explained and acknowledged regarding understanding; that they be entered voluntarily; and arbitration sessions are conducted by a neutral arbitrator in a location that is convenient to both parties.
  - Admission to the facility could not be contingent upon signing of a binding arbitration agreement.
  - The agreement could not prohibit or discourage communication with federal, state, or local health care or health-related officials, including representatives of the Office of the State Long-Term Care Ombudsman.
- ***New Section*: Quality assurance and performance improvement (QAPI) (§483.75)**
  - Would require all LTC facilities to develop, implement, and maintain an effective comprehensive, ongoing, data-driven QAPI programs that focus on systems of care, outcomes of care and quality of life.
  - Facilities would submit the QAPI plan at the first standard survey after one year from the final rule effective date; and at each subsequent standard survey upon request; documentation and evidence of ongoing implementation required upon request.
  - Facilities would maintain effective feedback systems from staff, residents/resident representatives; establish priorities; have a process for identifying, reporting, analyzing, and preventing adverse/potential adverse events; systematic determination of underlying causes; measure/monitor the success of actions taken and track performance for sustainability; and include Performance Improvement Projects (PIPS).
  - QAA Committee requirements would be maintained with amendment.
- **Infection control (§483.80)**
  - Would require a system (Infection and Control Program – IPCP) for preventing, identifying, surveillance, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing services based upon facility and resident assessments as reviewed and updated annually; would also require incorporation of an antibiotic stewardship program.
  - Would require designation of an Infection and Prevention Control Officer (IPCO) for whom the IPCP is their major responsibility and who would serve as a member of the facility's quality assessment and assurance (QAA) committee.
- ***New Section:* Compliance and ethics program (§483.85)**
  - *W*ould require the operating organization for each facility to have in operation a compliance and ethics program with established written compliance and ethics standards, policies and procedures capable of reducing the prospect of criminal, civil, and administrative violations in accordance with section 1128I(b) of the Act.
  - Required components: established written standards, policies, procedures; assignment of high-level personnel; sufficient resources and authority for these individuals; due diligence to prevent delegation to individuals with propensity for criminal, civil, administrative violations; effective communication and mandatory training; reasonable steps, e.g., monitoring/auditing systems, to achieve compliance; consistent enforcement; appropriate response to correct and prevent future occurrences.
- **Physical environment (§483.90)**
  - Facilities initially certified after the effective date of this rule would be limited to two residents per bedroom.
  - Facilities initially certified after the effective date of this rule must have a bathroom equipped with at least a toilet, sink, and shower in each room.
  - Would require policies, in accordance with applicable federal, state and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety.
- ***New Section:* Training requirements (§483.95)**
  - Would add a new section setting forth all requirements of an effective training program for new and existing staff, contract staff, and volunteers. Proposed topics include effective communication; resident rights and facility responsibilities; abuse, neglect, and exploitation; QAPI & infection control; compliance and ethics.
  - Annual training would be required for organizations operating five or more facilities.
  - Would require dementia management and resident abuse prevention training as part of the 12 hours per year in-service training for nurse aides.
  - Would require facilities to provide behavioral health training to all staff, based on the facility assessment.

There are many other revisions and we are working with our clients and industry organizations to understand the proposed changes and conference about concerns and questions and plans for comments to the proposal. To be assured consideration, **comments must be received by 5 p.m. September 14, 2015.**

Rebecca Adelman, Esq. - Ms. Adelman, PLLC is a founding shareholder of Hagwood Adelman Tipton and practices in the Memphis, Tennessee office. She is the chair of the firm's Strategic Planning Committee and Women Rainmakers Mentoring Program. For 25 years, Rebecca has concentrated her practice in insurance defense litigation representing national insurance carriers and self-insureds with a concentration in healthcare law. Please feel free to contact her at radelman@hatlawfirm.com.

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