Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

AUGUST 2017
ISSUE 8, VOLUME 7

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

THE HAT ADVANTAGE by Rebecca Adelman

Fall Is Coming and So Is Phase 2 – *Are You Ready?*

Phase 2 of the **"Mega-Rule"**, the most comprehensive revision of CMS's requirements for nursing homes since 1991, is set for implementation on November 28, 2017. In preparation for Phase 2, CMS released revised surveyor guidance through Interpretive Guidelines; revised the nursing facility F-Tags to correspond to new regulatory sections; implemented a new, computer-based Long Term Care survey system; and offers a number of trainings for increased understanding of the new requirements.

CMS will provide a one- year restriction of enforcement remedies for specific Phase 2 requirements. Specifically, CMS will not utilize civil money penalties, denial of payment, and/or termination. Should a facility be found to be out of compliance with these new requirements beginning in November of 2017, CMS would use this year-long period to educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional directed in-service training. Enforcement for other existing standards (including Phase 1 requirements) would follow the standard process.

Currently, the **Nursing Home Five Star Quality Rating System** calculates a rating based on each facility's survey performance as compared to others' in the same State. Most facilities will be surveyed for compliance with Phase 2 requirements using the revised survey process within a year of the November 28, 2017 effective date. However, due to the differing standards being phased in over the year, CMS will be holding constant for one year the Nursing Home Compare health inspection rating for any surveys conducted after November 28, 2017. More information is available in the June 30, 2017 S&C: 17-36-NH - Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

A brief **overview of the Mega-Rule** shows that it implements a number of pieces of legislation from the Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, including the following:

Quality Assurance and Performance Improvement (QAPI)
Reporting suspicion of a crime
Increased discharge planning requirements
Staff training section

Regarding Phase 2, Providers must be in compliance with Phase 2 regulations. All States will use new computer–based survey process for nursing home surveys and all training on the new survey process needs to be completed before November 28, 2017.

Phase 2 includes, but is not limited to:

Behavioral Health Services
Quality Assurance and Performance Improvements (QAPI Plan Only)
Infection Control and Antibiotic Stewardship
Physical Environment – smoking policies
Resident Rights and Facility Responsibilities – Required Contact Information-
Freedom from Abuse, Neglect, and Exploitation
Admission, Transfer, and Discharge Rights – Transfer/ Discharge Documentation
Comprehensive Person-Centered Care Planning
Pharmacy Services – psychotropic medications
Dental Services – replacing dentures
Administration – Facility Assessment

CMS is revising the nursing facility **F-Tags** to correspond with the new regulatory sections. Check out the CMS website for the following:

1) A **revised list of the F-Tags** under each regulatory group; and, 2) A crosswalk of old tags to new tags. **F Tag Crosswalk** shows the original regulatory grouping and the new associated grouping; the original regulation number and the new associated regulation number; and the original F Tag and the associated new F Tag.

Given the re-structuring of the regulation, some tags were combined, and some tags were split into multiple subparts as described in these documents. These new F-Tags will be used

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Pathway to Rehabilitation Excellence

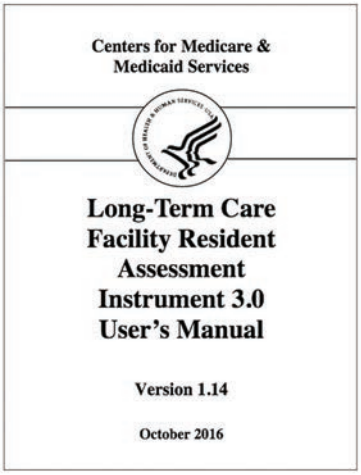
By Gina Tomcsik
Director of Compliance
Privacy Officer

Changing the "Not My Job" Mentality

How many times have you heard someone say, "That's Not My Job!"? Most likely you've heard this before — you may have even said it yourself!

The thing is, though, when we think about compliance, it is *everyone's* job to try to help ensure compliance with therapy documentation and billing is in line. Therapists are required by their state practice act to ensure accurate recording of the care they provide. Medicare requires therapy documentation to ensure accurate reflection of the care we provide is medically necessary and requires the skills of a therapist. The therapist's compliance list is endless.

But what about the MDS? Whose job is it to ensure the MDS is opened timely, completed timely, and is submitted timely? The Registered Nurse Assessment Coordinator (RNAC) of course is ultimately responsible for the MDS; however, there are many **key players** who contribute to the data that goes into the MDS. From nurse aides to therapists, everything we enter into the medical record to reflect the actual care of the resident can be used for MDS data collection. There are many item-set rules that we all must follow, but the MDS leader is the RNAC.



"*Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide* ***a RN to conduct or coordinate the assessment and sign off the assessment as complete***." MDS-30-RAI-Manual-V114-October-2016.pdf

Sure, therapy is responsible for ensuring the number of therapy days and therapy minutes is accurately provided to the RNAC for entry into section O is completed. But why would a facility want therapy to be **solely** responsible for information in any other section when their time with the resident is significantly lower than their nursing colleagues?

"A*n accurate assessment requires* ***collecting information from multiple sources****, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment."* MDS-30-RAI-Manual-V114-October-2016.pdf

When it comes to the MDS, it IS "our job" to timely, thoroughly, and accurately document the care we provide. We are an Interdisciplinary Team working to care for our nation's sick and most vulnerable folks. We truly would not be caring for residents if we don't work as a team and accurately document the great care we provide. And ensuring this happens, IS "our job"!

For more information, please contact Gina Tomcsik, Director of Compliance, Functional Pathways at gtomcsik@fprehab.com or call 865-531-2204. You may also discover more at www.functionalpathways.com

Getting on the Same Page by Paige Hector, LMSW

What Can Nursing Homes Learn From Disney?

Whether or not you're a fan of Disney theme parks, nursing home leadership can learn valuable management lessons from the fantasy-filled trailblazer. Like the theatre or a musical performance, Disney is in the business of creating an experience, rather than merely providing a service. Healthcare is not so different (we just don't realize it yet!).

Nursing homes are very familiar with the service industry mode of thinking. Get the admission orders, complete the assessments, enter data into the medical record, order medications, change dressings, take vital signs, schedule care conferences, and the list goes on. While every one of those tasks is vital to the success of the facility, those are not the areas that patients and families consider when they rate their 'satisfaction.'

When it comes to satisfaction, people talk about the *experience* they had at your facility, not the services they received. To quote Fred Lee, "Patients judge their experience by the way they are treated as a person, not by the way they are treated for their disease." Similarly, people talk about their *experience* at Disneyland, not the service they received. Often, experiences are told as stories - a favorite ride, an exciting new exhibit, meeting Mickey Mouse and how nice staff was in providing directions or finding a lost backpack.

What are the stories that people tell about your facility? Do they talk about the compassion staff showed a son that was scared his mom was dying, how staff decorated the private dining room for a "date night" to honor a resident and his wife's anniversary, how the physician sat on the bed and held a patient's hand during wound care, how the activity director found a copy of a favorite movie and made homemade popcorn, or how the nurse brought her dog to work and let it cuddle on your mom's bed to soothe her?

People remember, and talk about, their experiences. They tell their family members and friends the stories of their experience in your facility.

Take a look at the satisfaction survey your facility uses. Patient and family satisfaction is a major driver of facility surveys and the public image that nursing homes strive to create. But, therein lies the problem. Nursing homes shouldn't be measuring satisfaction; they should be measuring the person's perception of their experience in the facility, just like Disney. Disney is the leader in creating experiences for each guest at any of their properties.

Experiences occur where we work, shop, dine, vacation, at home and anywhere else. As human beings, we develop a perception of each experience which isn't necessarily reality *but our interpretation of reality*. That is, *our perception.* One of my favorite sayings is "Feedback is a perception being shared, not a truth being declared." A person's interpretation of an experience is theirs to have, and to share. Hopefully, the experiences in your facility are memorable in a wonderful way.

To truly measure satisfaction in nursing homes (current residents and after discharge), we need to ask different questions such as "Was there anything frustrating or disappointing about your experience?" and "What would make your stay better?" (Lee)

How about this list of questions (Marshall): Was my loved one kept clean? Was staff nice to me? How well did the medical provider explain the problem? Was the coffee hot and the juice cold? Was the room clean? How did the facility smell? Was the wait time to answer a call light acceptable? Was weekend care equal to weekday care? Was I able to get enough sleep?

Nursing homes have much to learn from the Disney principles of creating guest experiences. You don't have to go to places like Disneyland and California Adventure to embrace their concepts of management and leadership to help transform your facility culture, but if you do visit, bring back your stories to share!

Lee F. *If Disney Ran Your Hospital 9 ½ Things You Would Do Differently*. Bozeman, MT: Second River Healthcare Press; 2004.

Marshall C, *Satisfied Customers Seldom Sue*. Marblehead, MA.: HCPro, 2009.

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

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after November 28, 2017.

CMS' changes to the survey process seeks to build the best of both the Traditional and QIS process to establish a single nationwide survey process. Per CMS, the **goals** are:

Same survey for entire country
Strengths from Traditional & QIS
New innovative approaches
Effective and efficient
Resident-centered
Balance between structure and surveyor autonomy

Understanding the new survey process guidelines will ensure that facilities understand the health and safety expectations that will be evaluated through the survey process.

There are **three parts** to new Survey Process:

Initial pool process
Sample Selection
Investigation

For the Initial Pool Process,

Residents are selected offsite
Vulnerable residents who are dependent on staff (this is a subgroup because these residents are at a high risk for care concerns)
New admissions within the last 30 days (this is a subgroup since new admissions are typically excluded from the resident listing because they have not had an MDS submitted yet and they have unique needs)
Active complaints or FRIs (Facility Reported Incidences- federal only)
Any other resident who has a significant concern that does not fall into any of the other subgroups

Resident interviews are completed with a full observation, interview, and limited record review for each resident included in the initial pool. The observation, interview, and limited record review include a wide range of care areas. For the full observation, surveyors address the probes listed in each care area. Surveyors conduct rounds until questions are answered for all observation care areas. Formal observations for wounds or incontinence care may be conducted if the situation presents itself or is necessary—for example, if a resident has not been assisted to the bathroom for a long period of time or is covered in bed. **Representative interviews** or family will be completed for non-interviewable residents.

The next step in the survey process is the Sample Selection. The CMS guidance states that:

Prioritize using sampling considerations:
Replace discharged residents selected offsite with those selected onsite
Can replace residents selected offsite with rationale
Harm, SQC if suspected, IJ if identified
Abuse Concern
Transmission based precautions
All MDS indicator areas if not already included

The system will select five residents for an Unnecessary Medication review based on information entered by the surveyor during interviews, observations, record review, and information from the MDS.

The selection process considers all psychotropic medications, insulin, anticoagulants, opioids, diuretics and antibiotics, as well as some adverse consequences, including falls, weight loss, and sedation. The residents selected for the full medication review will include insulin, an anticoagulant, and an antipsychotic with Alzheimer's or dementia, if available.

The final part of the survey process is the **Investigation**. General guidelines are:

Conduct investigations for all concerns that warrant further investigation for sampled residents
Continuous observations, if required
Interview representative, if appropriate, when concerns are identified

Comments from CMS regarding **Investigation** direct that during investigations, the majority of surveyor time should be spent on the floor observing and interviewing the residents and staff, only using the record to corroborate what is seen and heard.

Surveyors must l use critical element, or CE, pathways to help guide the investigation. The pathways include guidance on the areas (e.g., MDS, physician's orders and care plan) that should be reviewed initially to help guide the observations and interviews. The pathways include observation, interview, and record review investigative probes for a number of care areas, including pressure ulcers and dialysis. All of the pathways are being updated to reflect the new rule changes. There are a number of care areas that do not have a pathway, such as dignity and personal property. If a care area does not have a pathway, surveyors refer to the guidance and protocols in Appendix PP.

Once you have completed your investigation, you will make a compliance and severity decision for each CE listed for that care area. The CEs are critical components of care—they cover provision of care and services, as well as the facility assessment and care planning.

Other aspects of the survey include Facility Task Investigations, Dining, Infection Control, SNF Beneficiary Protection Notification Review, Kitchen Observation, Medication Administration, Medication Storage, Resident Council Meeting, Sufficient and Competent Nurse Staffing Review and Environment.

Along with the survey process, the revised Appendix PP, "Guidance to Surveyors for Long-term Care Facilities," in the State Operations Manual has changed significantly—even for regulations not specifically impacted by Phase 2.

Recommendation for survey preparedness and implementation of Phase 2 include:

1. **Read the new Appendix PP as a team!**
2. **Use past and current problems to identify areas for review**
3. **Target areas where CMS is focusing education**

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THE CMS 2018 Final Rule is here - Will You be Ready?

By Joel VanEaton
BSN, RN, RAC-CT

The Final Rule for SNF PPS FY 2018 has been released and contains not only information related to changes that will affect the upcoming fiscal year but future years as well. CMS has made it clear that the train has left the station related to how they intend to tie quality, rather than volume, to payment. Here are some of the areas that have been finalized in this year's SNF PPS final rule. There will be a 1% increase to SNF payments. However, you should check your wage indexes to see if you will have a net increase. Also, remember sequestration that still takes away 2%.

CMS will be adding several quality measures in the coming years that will affect your payments as well related to how the data to calculate these measures is reported in the MDS. Remember, for SNF Quality Reporting Program (QRP) measures, facilities are required to report 100% of the data necessary to calculate the QM's, including exclusion and covariate data, at least 80% of the time or face an additional 2% reduction to their rate. New items will be added to the MDS this year and next year a host of items to accommodate the QRP will be added.

CNMS is moving forward with finalizing how facility data related to SNF Value Based Purchasing (VBP) will affect facility payments in 2019, just a short year and 2 months away. Everyone will receive an additional 2% reduction to their rates that year, and the only way to get it back is to have stellar re-hospitalization data in CY 2017 compared to 2015.

Finally, CMS is proposing a new payment system for SNF PPS. While this new system, RCS-1, is not detailed in the final rule, the prospects for its implementation in FY 2019 seem all but certain. Extended Care Products will be hosting a webinar titled on Tuesday, October 3rd- "FY 2018: What's it All About? Join me as I leads you into a discussion related to these topics and more.

Please go to WebinarLTC.com to discover more and register for Joel VanEaton's upcoming CMS 2018 Final Rule webinar to be held on Tuesday, October 3rd. There will be two webinar times to choose from. You may also call 800-807-4553 for more information and to register.

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CMS has developed a video education series for surveyors targeting **nine areas** of revised interpretive guidance—a sure sign that DNSs should highlight these areas as well in their survey preparation activities. The videos (and the related Appendix PP sections) are as follows:

- *Admission, Transfer, and Discharge Rights* (§483.15, F620 - F626);
- *Behavioral Health Services* (§483.40, F740 - F745);
- *Facility Assessment* (§483.70(e), F838);
- *Freedom From Abuse, Neglect, and Exploitation* (§483.12, F600 - F610);
- *Infection Control* (§483.80, F880 - F883);
- *Person-Centered Care* (§483.10, Resident Rights: F552 - F555, F557 - F559, F561, F563 - F565, F573, F576; §483.21, Comprehensive Person-Centered Care Plans: F655 - F657, F660 - F661; §483.24, Quality of Life: F675; §483.25, Quality of Care: F684; §483.60, Food and Nutrition Services: F800, F803, F809; and 483.70(e), Facility Assessment: F838);
- *Quality Assurance and Performance Improvement: The Basics* (§483.75, F865, F867, F868);
- *Quality of Life and Quality of Care* (§483.24, F675; §483.25, F684) Note: F684 is F309 in the current survey process; and
- *Nursing Services* (§483.35, F725 - F726, F729 - F730).

In the **Overview video**, CMS officials describe how the revised Appendix PP is structured and how providers can use that structure to understand more about the survey process. All F-tags will still begin with the regulatory citation and the exact regulatory language in bold. Then they follow this structure:

* **Intent.** This section "offers additional information and key context for the regulation," say officials. "What is the purpose? What is the intended quality issue that this addresses?"

*** Definitions**. "These definitions come from a couple of places. In some cases, they come directly from 483.5, which is the Definitions section of the regulation. In other cases, we added definitions that are relevant for that regulatory section," say officials. "For example, in the Admission Transfer, and Discharge interpretive guidance [at F622], we define facility-initiated [transfer or] discharge vs. a resident-initiated [transfer or] discharge. We have added this definition because it is important to understanding compliance with that particular requirement."

*** Interpretive Guidance.** "This section is the primary component where CMS describes what is compliance with that particular section. We may reference important concepts related to compliance, may establish frameworks that allow facilities to think about different aspects of compliance, and reference standards of practice," say officials. "As a reminder, surveyors must cite to the regulations themselves and not to the interpretive guidance."

*** Investigative Summary / Investigative Summary and Probes / Procedures and Probes / Investigative Protocol.** "This section may be called any of these items. The reason they can be called a few different headings is that this will guide you in understanding whether or not there are other survey documents called critical element pathways or CE pathways that are used by surveyors in determining compliance," say officials.

"In general, this section is intended to tell the reader how compliance with that section will be investigated or evaluated. There are three sources of information: interview, observation, and record review," they explained. "This section will describe exactly what will be reviewed if there are concerns identified."

If **Investigative Summary** is the section heading, "there is a specific **critical element** pathway or facility task that the surveyor would use to investigate that area," say officials. "What is in Appendix PP is a high-level summary of that CE pathway [or task]. Investigation of subjects like assistance with activities of daily living, personal funds, and sufficient staffing are covered in a facility task or a critical element pathway. In these cases, we refer the surveyor to those documents to avoid duplication and confusion."

* **Key Elements of Noncompliance**. "This is a new section that we have added to certain tags," say officials. "[W]ithin all the guidance, we didn't want the key points to be lost, and we didn't want to just restate the regulation. Our goal was to try and summarize the key elements and make it as clear as we could, and share with the surveyor what the main points to focus on include."

To develop the **Key Elements of Noncompliance**, "in many cases we looked at the case law to determine what was needed and what wasn't needed to have a deficiency," say officials. "For example, in the area of sufficient staffing [F725], there was the belief that, to cite a sufficient staffing tag, resident outcomes needed to be explicitly tied back to the resident's care plans in all cases. Based on our review, that does not need to be the case where there are certain basic needs like perhaps being fed or having assistance with activities of daily living. The surveyor [doesn't] have to have an explicit care plan reference for those areas."

* **Deficiency Categorization**. "This section is intended to provide examples of level 1, 2, 3, and 4 deficiencies. These are examples to help identify the types of noncompliance that rise to [each] level of deficiency," say officials. "In some cases, depending upon the tag we have indicated that severity level 1 would not apply for that particular regulatory requirement. These examples are those cases where any level of noncompliance with that has the potential to result in more than minimal harm."

* **Potential Tags for Additional Investigation.** "When surveyors have finished their investigation, "there may be related systems or processes or outcomes that may also have noncompliance. This section identifies the major tags," say officials. "As a reminder, these are not automatic citations for other areas, and there must be an independent investigation of those tags before cross-referencing. It is not just a copy and paste of the same evidence."

Continue to study the guidance and prepare for the November 28, 2017. We've been working with our industry clients on checklists and mock survey tools and welcome the opportunity to educate and collaborate on this important next phase.

SAVE THE DATE FOR 6TH ANNUAL LITIGATION RISK AND DEFENSE STARTEGIES FOR LONG-TERM CARE & ASSISTED LIVING PROVIDERS, INSURERS AND BROKERS.

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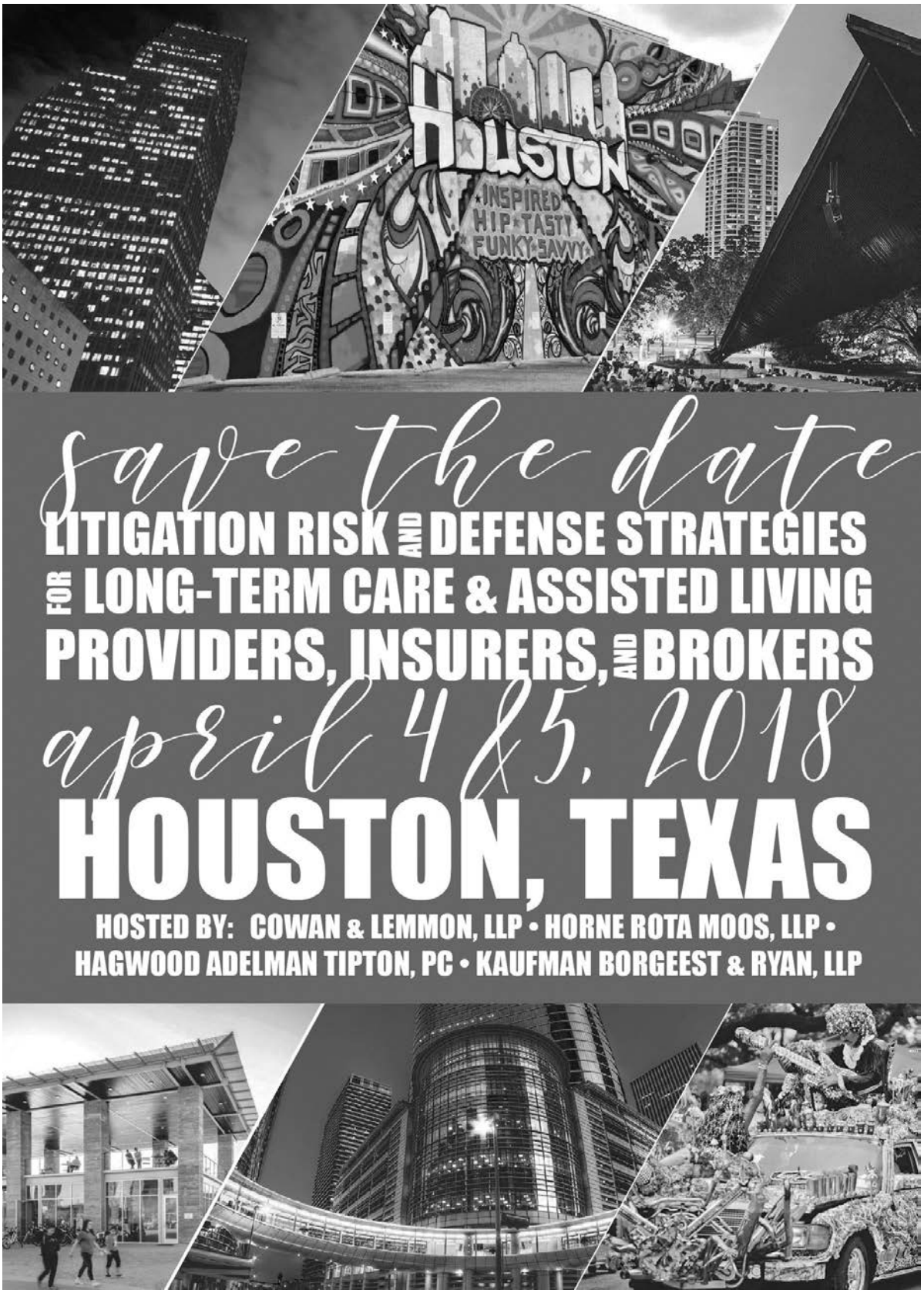
Join me and my firm and co-hosts Cowan & Lemon, LLP, Horne Rota Moos, LP and Kaufman Borgheest & Ryan, LP for our annual conference held in Houston April 4-5, 2018. Stay tuned for more information on our program! Email me at radelman@hatlawfirm.com for updates.

Rebecca Adelman, PLLC, Esq. - Ms. Adelman is a founding shareholder of Hagwood Adelman Tipton, PC and practices in the firm's Memphis, TN office. She is the chair of the firm's Strategic Planning Committee and Women's Rainmaker Mentoring Program. For over 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 or visit her website: www.rebeccaadelman.com.



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