Nursing & Assisted Living Facility *Professional*

"NEWS AND VIEWS YOU CAN REALLY USE"

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

THE ADELMAN ADVANTAGE

by Rebecca Adelman

The Road to Life Safety / Emergency Prep Survey Success is Well-Traveled

I am so grateful to co-author this month's article with Stan Szpytek, President of , Fire and Life Safety, Inc. Not only is Stan a highly regarded expert and consultant, he is a trusted friend and I appreciate all of our industry collaborations. This month, Stan is offering insights on Life Safety and Emergency Preparedness and CMS regulations.

As we've discussed and explored in prior articles, updates to the CMS Emergency Preparedness Final Rule (EP Rule) have been under discussion since it went into effect in September 2016. On February 1, 2019, CMS released an update to the EP Rule that went into effect immediately. An all-hazards approach is a central tenet of the CMS emergency preparedness rule. CMS urged healthcare providers to focus on risks that are relevant to their facilities and environment. A significant change in the February 2019 update to Appendix Z is an expanded definition of an all-hazard approach to emergency management planning.

On September 30, 2019 CMS the *Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care Final Rule* which revised some of the emergency preparedness requirements for providers and suppliers. Those final changes that impact Long Term Care providers includes eliminating requirements that facilities document their efforts to contact local, tribal, regional, state, and federal emergency preparedness officials and facilities' participation in collaborative and cooperative planning efforts.

As a result, its proposal to change the testing requirements for most inpatient providers to increase their flexibility is finalized. Under the final rule, one of the two annually required testing exercises may be an exercise of the provider's choice which could include a full- scale exercise, a functional exercise, a drill or a tabletop exercise. Inpatient providers subject to this change include inpatient hospice facilities, PRTFs, hospitals, LTCFs, ICFs/IIDs, and CAHs. Most commenters supported the proposed differentiation of requirements for inpatient providers from those for outpatients.

CMS also finalized clarifications to the application of the testing exemption for facilities that have experienced an actual event. If a facility experiences an actual natural or man-made emergency that requires activation of their emergency plan, then they would be exempt from their next required full-scale exercise for one year following the onset of the event.

Consider Stan's insights on these issues. Compliance with CMS Life Safety Code regulations and Emergency Preparedness Requirements of Participation (RoP) has certainly been a challenge for skilled nursing facilities (SNF) around the nation. These complex rules and regulations are designed to provide health care facilities residents with a safe and prepared environment of care. Many providers have implemented specific methodologies to help promote "survey success" in these areas of regulatory compliance through the development good documentation practices and a formal compliance program that often includes mock survey.

While compliance for "compliance sake" is never a good approach to achieving survey success, embracing these particular CMS regulations and implementing compliance programs should be a top priority to help safeguard residents, staff and visitors in every Long Term Care facility whether they are regulated by CMS or other state and local authorities having jurisdiction. One major element of compliance in the areas of Life Safety and Emergency Preparedness is proper documentation practices. A common approach to good organization of all of the documents associated with compliance pertaining to the multitude of systems and processes is the creation of compliance binders. The binders are essentially a "book of evidence" that should be neatly organized and tabbed to illustrate each individual compliance element that requires proper documentation. While in no specific order, here are some of the tabbed sections that would be included in a Life Safety Code (NFPA 101, 2012 edition as enforced by CMS in SNFs) compliance binder:

- Inspection, Testing and Maintenance Records
  - Fire alarm system
  - Fire sprinkler system
  - Fire Extinguishes
  - Kitchen hood fire suppression system
  - Kitchen hood cleaning
  - Emergency generator system
  - Smoke / fire dampers
  - Emergency lights
  - Exit signs
  - Electrical outlets

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- o Piped medical gas
- o Alcohol-based hand rub dispensers

- Fire Drills- one per shift per quarter (date, time and shift)
- Smoking policy and procedure
- Fire Watch policy and procedure
- Annual Fire Door Assembly Inspection (FDAI) records
- NFPA 99 Risk Assessment policy and procedure

While the frequency and nature of inspection, testing and maintenance of the systems itemized above varies, each tabbed section should include all data in accordance with frequency and scope as required by applicable National Fire Protection Association (NFPA) codes enforced by CMS.

Compliance with the CMS Emergency Preparedness RoPs is an area of regulation that many providers nationwide have mastered through proper documentation organization. Essentially, developing a compliance binder that is an alignment with all of the E-Tags that are associated with the RoPs is a logical way to illustrate compliance. Organizing your EP compliance binder with the specific E-Tags that apply to SNFs and providing comprehensive evidence to support those requirements in each tabbed section will help ensure a smooth survey process and more importantly, help promote a safe and prepared environment of care.

The use of a mock survey process is also an excellent strategy in helping to achieve survey success for both Life Safety Code and Emergency Preparedness compliance purposes. It sometimes boils down to a "fresh" perspective provided by an objective subject matter expert who is able to perform a "mock survey" to duplicate the formal survey process. Identifying potential deficiencies during the mock survey process and initiating corrective action in advance of the formal survey will help to promote compliance in these important areas of facility operations.

By utilizing logic, common sense and good organizational practices, Long Term Care providers can achieve survey success through the development of comprehensive documentation compliance programs to help promote safety and preparedness. For those long term providers that are not regulated by CMS, these same concepts can be utilized as Best Practices to help ensure the same objective of creating a safe, prepared and compliant environment for your residents.

BE PREPARED!

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, a Women's Business Enterprise National Council (WBENC) certified Women Business Enterprise (WBE) established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation.

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Stan Szpytek is the president of Fire and Life Safety, Inc. (FLS) and an Illuminage consultant. FLS is a consulting firm that provides life safety, risk management and emergency preparedness programs for providers of all types with special focus on healthcare, long-term care facilities and senior services. Stan is a former deputy fire chief and fire marshal with a Chicago area fire department having served the community for 26 years and honorably retired in 2003. He is also the Life Safety / Disaster Planning Consultant for the Arizona Health Care Association (AzHCA) and California Association of Health Facilities (CAHF). Stan has also worked with several states' long-term care associations including CO, IL, IN, KY, RI, MD, MI, MS, NC, ND, NY, OH, OK, RI, SC, TN, TX, UT and WA as well at the American Health Care Association, Leading Age (state affiliates) and Argentum.

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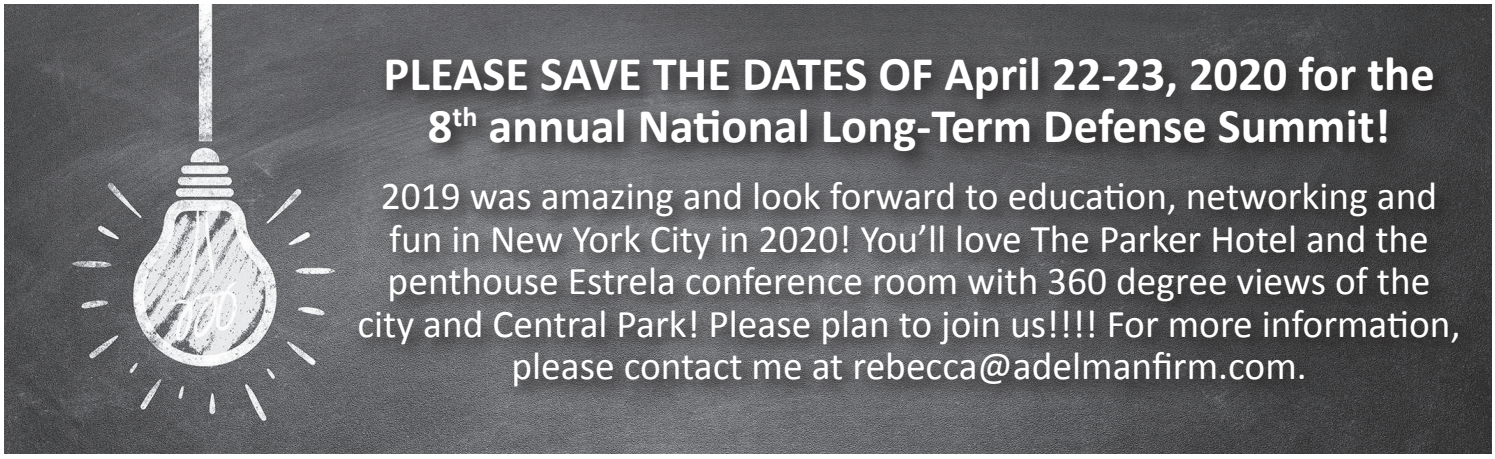

Getting on the Same Page by Paige Hector, LMSW

Acknowledging Grief, Allowing Time to Heal

Finding the inspiration and words to write this month's column has been particularly challenging. Actually, writing has been difficult this entire summer. I've stared at blank pages for long stretches, mulled over ideas on my early morning dog walks and tried to put my thoughts into some semblance of order. Rather than pretend the struggle isn't present, I've decided to bare my heart and share my story.

My mom, who had been living with dementia for many years (diagnosed in her late 60's) died in June. Over the course of several years, we watched as her mind became more confused, her ability to function safely worsened, and the need for more assistance to manage basic care increased. As a family, we walked the journey of someone living with dementia and during that time, I learned patience beyond what I thought was possible. My family came up with creative strategies to manage the challenges of this terrible disease and the particular ways that it manifested in my mom. We modified the environment, and ourselves, to accommodate her needs and did our very best to uphold her dignity and preserve all vestiges of her independence.

We began noticing subtle changes in Mom earlier in the spring and by the first week of June, we knew something was definitely different. Thankfully our family was all in agreement regarding aggressive comfort measures and we also knew that's what Mom wanted. Mom told us that she was ready to "go home." She wanted to see her own mother, Lizzie, who died many years ago.

Toward the end of the first week of June, it was obvious death was getting closer. I communicated with Mom's physician to report the changes. We had discussed hospice on several occasions throughout Mom's journey and while her physician agreed now was probably the time, she asked to see her before making the referral. I appreciated that she wanted to see Mom, she had been her physician for over a decade. As a medical social worker married to a physician, I know the bonds that develop between providers and patients and I wanted to honor that. The earliest she could see Mom was the following Tuesday. My sister arrived that weekend.

While Mom was walking very slowly, her speech slightly slurred and she had difficulty swallowing, none of those issues were causing her distress or pain. She hadn't had an appetite for years and hardly ever felt hungry. Each day we brought her a beloved caramel Frappuccino and I even took her out for this treat the Monday before she died. I knew it would be the last time I would ever be able to take her anyplace. She dozed in my car but perked up and smiled when I handed her that sweet treat.

We went to see her physician that next Tuesday. By now Mom could no longer walk, so we used the wheelchair. The medical assistant took her vitals, her O2 saturation level was 66%. My mom, dad, sister and I were ushered into the exam room and waited just moments until the physician came in. Incredibly, Mom was her usual jovial self, kidding with the physician. When the physician first looked at the vitals, she mistook the O2 level for Mom's heart rate. When I clarified, she made an audible gasp and quickly looked at Mom who was showing no signs of distress, except at the inconvenience of being in the physician's office. Clearly, a hospice referral was in order. Her physician kissed mom on her head before we left.

The hospice referral was made immediately, but the hospice nurse couldn't come out until the next morning. We began having some difficulty with pain management later that afternoon as Mom choked on a pain pill. My dad and sister stayed by her side that night and did what they could to make Mom comfortable. Finally, the hospice nurse arrived around 9AM the next morning and made it a priority to get liquid pain meds to the house.

As happens with many people close to death, Mom had the most remarkable period of alertness the morning of the day she died. She wanted to go outside so for two hours Dad toured her around the property and yard where they lived for almost 50 years of their life.

As I was telling the hospice nurse about Mom that morning, I cried. I cried because I felt I had failed her. How many hundreds of times over the years had I advised people to get hospice involved sooner rather than later? I personally had facilitated those referrals and initial introductions. And, here I was in my own story, a hospice referral made on the day that my mom would likely die. I've thought a lot about the sequence of events and believe that until a couple weeks before she died, Mom probably wouldn't have qualified for hospice. Even then,

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we already had a caregiver to help with bathing and we were managing her pain. She didn't like strangers in the house and any change to her routine was incredibly stressful, for everyone.

Looking back over these years, I think we did a good job taking care of Mom. Did we fall short many times? Yes, we did. And, I've used those examples in my work to demonstrate how complex caring for someone living with dementia is, and to relate to people with similar experiences.

My story is not unique and I've no doubt that many of you reading this have similar experiences of your own. I'm telling this story for a couple of reasons. First, it's cathartic to share and to be vulnerable, to admit that I'm feeling emotionally exhausted. I've born witness to many deaths over my career as a medical social worker, sat at the bedside of people dying and when they take their last breath, accompanied family members into the room of a deceased loved one so they wouldn't have to do it alone. But witnessing the decline and death of my parent is unlike any of those. My social work skills and years of experience helped me and my family navigate this journey and hopefully prepare us a little better. But, in the end, when we were gathered around her as she breathed ever more slowly and eventually died, that experience was solely mine as her daughter, as it was for my dad and my sister.

Second, it's important to acknowledge, and reflect on, the impact of life events, like a death, on our being. To allow time to grieve and time to not feel "on top of our game." That's a little scary for me, and maybe for some of you. That if we slow down, if we don't push as hard, that somehow, we won't be able to recover. Intuitively, I know that's not true but it sure is a tough lesson to accept. So, I accepted that writing this month's article was not going to be easy.

When we are grieving a loss of any kind, what kindnesses do we allow ourselves? Do we allow time to feel, really feel, the sadness and loss and to grieve? Do we allow ourselves time to be "in a funk" or "out-of-sorts"? Is your work culture supportive at those times when you struggle to manage the complexities of life outside of work and still do quality work? As administrators and other leaders, is your facility culture kind and patient with staff who are struggling to "hold it together" when life deals a tough blow?

A very dear colleague, Dr. Karl Steinberg, just wrote a beautiful column in the *Caring for the Ages* publication called "Impermanence and Loss." He shares his own struggles with growing older, enduring losses and facing his own mortality. Like me, he too, misses his mom. I realized when I read his story, that my mom's death also means I'm getting older and that there are more losses to come. Such is true for all of us. His story and his sharing helped me feel not so alone in my sadness and grief. Thank you, Dr. Steinberg.

To read Dr. Steinberg's article, go to - https://www.caringfortheages.com/article/S1526-4114(19)30423-8/fulltext?rss=yes.

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Holiday Shopping Facts

The National Retail Federation considers the "holiday shopping" season to be the full months of November and December, which is usually 55 days.

Nearly 40% of Americans begin their holiday shopping before Halloween.

December 15-24th is the crux of the holiday shopping season, accounting for 40% of holiday business.

Six percent of the U.S. population can be considered "compulsive buyers," which is an addiction to shopping that affects both men and women equally.

Single shoppers make 45% more impulse buys than married shoppers.

Researchers have proven that a "50% off" sign leads in increased sales, even if shoppers don't know the original price or what a reasonable price for the product would be.

Retailers rely on several psychological triggers to attract consumers into their store, such as placing limits on items, offering "gifts" with purchase, employing visual tricks, and declaring that sales are ending soon (when in fact discounts are common throughout the season).

One in 3 holiday shoppers believe that it is more important to spend money on loved ones than it is to stay within a budget.

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PDPM - So how are You doing?

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affairs

I was recently teaching an educational seminar for a state healthcare organization on The quality driven milieu we find ourselves in currently in LTC. Related to PDPM, what is considered a "skilled" level of care all tied to the QM/QRP/VBP 5-Star measurements, and I found myself uttering this statement, "Back in the day under RUG-4…". It was as if I was waxing nostalgic, like RUGs were so far in the past. I chuckled.

RUG-4 does seem like it was a long time ago, for Part A that is. And yet, vestigial pieces of the "old way" seem to cling to us, like a dust bunny that you can never seem to reach with the vacuum cleaner hose or some cat hair that you can never seem to get rid of no matter how many lint rollers you use.

There has been much said recently about the first month of PDPM. Generally, providers faired well, partly because of the reality that Part A patients who were admitted prior to Oct. 1 had a transitional IPA completed that reset their payment schedule to day 1. Under PDPM there are definite financial benefits to that. That will not happen in November so most providers will see a slight drop in their averages though not enough to avoid an inevitable rebase of the rates by CMS to compensate for their apparent budget neutral mispredictions.

Getting rid of the old and embracing the new is a must under PDPM. It is true that the more attention a provider pays to things like the nursing categories, the multiple diagnostic comorbidities in the SLP and NTA categories (Remember I8000), the better off they will be. Even with the good month that many had in October, reports are and we have seen, that providers are still leaving dollars on the table related to things like, missed depression and indicators, SLP and NTA comorbidities (Remember I8000), inappropriate primary diagnosis selection, misidentifying swallowing disorders and mechanically altered diet and cognitive deficits.

It is imperative that providers have the right tools to ensure that they will weather the reality checking month of November and beyond, as well as any future adjustments to the rates CMS may implement to adjust for what appears to be a non-budget neutral state of affairs. At Broad River Rehab, we are a unique knowledgeable and compassionate rehab company that helps our clients achieve overall success with PDPM. With our PDPM Navigator and now version 2 of our Documentation Navigator, our clients can see the forest and the trees and pick out the NTAs in the preadmission documentation haystack with precision.

We would love to show you how Broad River Rehab can help you achieve PDPM savvy and stay PDPM robust. Let us show you our Navigators. Checkout a review of Document Navigator version 2.0 at https://www.broadriverrehab.com/blog/2019/11/22/document-navigator-version-20 Give us a call, 800.596.7234, we would love to show you how it can be put to work for you. Got a tough PDPM or reimbursement question, ask us at https://www.broadriverrehab.com/expert/

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