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FEBRUARY 2020
ISSUE 2, VOLUME 10

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THE ADELMAN ADVANTAGE

by Rebecca Adelman

F837 – GOVERNING BODY - A Regulatory and Legal Overview

Regulatory and legal issues regarding F837, the Governing Body, which is included in the Administration regulations for skilled nursing facilities, arise in surveys and in litigation. The issues primarily relate to the responsibilities and composition of the Governing Body and the legal liability for the Body or its individual members. This article will provide an overview of the regulations and legal authorities as well as initial recommendations for evaluating your organization's governing body.

Skilled Nursing Administration

42 CFR § 483.70 governs the administration of skilled nursing facilities as a Condition Of Participation in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid. An initial review of the Administrator of the facility is helpful in discussing the Governing Body's role.

§483.70 Administration states:

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The survey Guidance offers the following:

§483.70 Resources include but are not limited to a facility's operating budget, staff, supplies, or other services necessary to provide for the needs of residents.

Procedures for the surveyors are set forth at §483.70:

Cite this tag if the ***actions, inactions****, or* ***decisions in administering*** *the facility contributed to deficient practice(s).* ***The facility's administration is not limited to the administrator and may also include the facility's governing body, management company, and/or others identified by the facility as part of the facility administration.***

The investigation must demonstrate how the administration knew or should have known of the deficient practice and how the lack of administration involvement contributed to the deficient practice found. When citing this F835, it is not acceptable to simply reiterate the non-compliance from any other associated tags and then refer to this tag. ***Surveyors must document how the administration knew or should have known of the deficient practice and taken action(s) as appropriate.***

In addition to a multitude of other administration requirements, the facility must have a **Governing Body**. The regulation states as follows, and I've included prompts and recommendations.

§483.70(d) Governing body. *§483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is* ***legally responsible for establishing and implementing policies regarding the management and operation of the facility****; and*

1. Who are the members of your governing body? The governing body should include the administrator, nursing and quality assurance directors, medical director and possibly a corporate representative or company depending on the corporate structure.
2. Who in the organization currently establishes and implements policies regarding the management and operation of the facility? The answer to this question may be "management", or "regional", or "corporate". Specifically identify the company or group of people designated, as the governing body will limit the risk of survey deficiency.

§483.70(d)(2) The governing body appoints the administrator *who is— (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body.*

1. Does the administrator know that these are his/her responsibilities per the regulations? Review the federal and state regulations on administration on a quarterly basis with the governing body.
2. What and when does the administrator report to the governing body? Establish clear expectations and performance plans for the administrator consistent with the regulations.

§483.70(d)(3) The governing body is responsible and accountable for the QAPI program*, in accordance with §483.75(f). [§483.70(d)(3) Governing body responsibility of QAPI program will be implemented beginning November 28, 2019 (Phase 3).]*

1. Who comprises the QA committee and how is the organization's QAPI program implemented? Identify the QA committee and include a member on the governing body.
2. How does the QA committee communicate the QAPI performance to the governing body? Develop QA protocols complaint with the federal and state regulations governing QAA and QAPI.

Notably, per the State Operations Manual (SOM) the intent of this regulation is set forth below along with the definition. I've included prompts and recommendations.

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INTENT §483.70(d) This regulation is intended **to ensure that the facility has an active (engaged and involved) governing body that is responsible for establishing and implementing policies regarding the management of the facility**.

and is defined as:

DEFINITIONS §483.70(d) "Governing body" refers **to individuals such as facility owner(s), Chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility.**

1. Does the organization have a governing body that is "engaged" and "involved" understanding its responsibilities regarding operations and management? Measure the involvement and engagement of the governing body and assign it operational and management projects to accomplish. Review and revise as needed facility policies for management and clinical care so they reflect best practices for the organization in its locale.
2. Does the facility have management and ancillary service contracts? Review each contract and ascertain the rights and obligations of the parties. Revise as needed to reflect the actual business structure and practices between the parties.

For purposes of survey and certification, the following guidance is provided per the SOM and these points serve as a roadmap for your organization on regulatory compliance and litigation risk mitigation. I've included prompts and recommendations.

GUIDANCE §483.70(d)

The facility **must** determine: **A process and frequency by which the administrator reports to the governing body, the method of communication** between the administrator and the governing body including, how the governing body responds back to the administrator and what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported directly to the governing body; How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing, supplies, etc.).; and; How the administrator and the governing body are involved with the facility wide assessment in §483.70(e) Facility assessment at F838.

1. Does the organization have a written protocol that that describes process and the method for communication between the administrator and the board? If not, develop this protocol and reference the federal and state regulations on Governing Body.

2. How does the governing body respond back to the administrator? This issue will become important if there are issues of understaffing, budgeting, lack of compliance with policies. Establish communication methods through the QA committee to possibly rely on protections available for these communications.

3. Does the governing body policy and corporate structure account for what specific types of problems and information are reported or not reported directly to the governing body? Specify this information and reference the federal and state regulations in the policy.

4. How are expectations for the administrator established and how is the administrator held accountable? Review state regulations on licensed administrator responsibilities and establish performance plans that reflect the federal regulations on accountability. Include how the administrator reports information about the facility's management and operation (i.e., audits, budgets, staffing, supplies, etc.);

5. How are the administrator and the governing body are involved with the facility wide assessment as this will be a focus for surveyors? Establish protocols for the governing body in its policy that includes specifically its involvement with the facility wide assessment and delegate responsibilities as needed.

The following procedures must be followed to comply with the federal regulations (**and statute regulations may have additional requirements**) on governing bodies. State surveyors will request this information and it should be readily available as part of the policy on governing bodies.

PROCEDURES §483.70(d) Request the **names and contact information of the members** of the governing body at the Entrance Conference. If there are concerns, conduct an **interview with the administrator** and if possible, with one or more members of the governing body or designated person(s) functioning as the governing body.

State Regulations on Governing Body

It is critical to note that each state may have separate regulations on a Governing Body for compliance that may be stricter than the federal guidelines. For example, in Michigan, the governing body of a nursing home shall assume full legal responsibility for the overall conduct and operation of the home. In the absence of an organized governing body, the owner, operator, or person legally responsible for the overall conduct and operation of the home shall carry out the functions of the governing body.

In West Virginia, the governing body shall adopt and enforce rules governing the health care and safety of residents, the protection of their personal and property rights, and the operation of the nursing home. The governing body shall develop a written nursing home plan that will be reviewed annually. In addition to the other requirements described in law and in the rule, the nursing home plan shall include:

An annual operating budget, including all anticipated income and expenses; and

A capital expenditure plan for at least a three-year period.

The governing body shall assure the development and maintenance of written policies and procedures that govern the services the nursing home provides.

The policies and procedures shall include as a minimum all policies and procedures required by this rule.

A copy of each written policy and procedure shall be available for inspection on request by the nursing home's staff and residents and by members of the public.

Recap on Regulatory Issues

State surveyors focus on F837 as operations and management have responsibilities related to a multitude of other regulatory compliance issues such as QAPI, facility assessments, staffing and other clinical regulations. Understanding the federal and state regulations; evaluating your organization's corporate structure; creating a body and policy that supports the management and operation of the facility; educating involved members and staying "active" as a governing body will mitigate survey concerns, claim risks and increase the delivery of quality care.

Legal and Litigation Issues

In litigation, I have defended not only the operating and licensed skilled facility and management but individuals who serve in a corporate capacity (CEOs, CFOs, Administrators) as well as the facility's

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Getting on the Same Page by Paige Hector, LMSW

Common Trauma, Unique Experience

Webinars, conferences, book, articles and blogs - new trauma-informed care resources are springing up all over the place. My personal library consumes an entire shelf in my office, and it's still growing. There are definitions, diagnoses, protocols, paradigms, statistics, models, regulations and Ftags, concepts, principles, trauma-informed care and trauma-informed treatment (yes, different), screenings and assessments (again, different processes), direct and indirect screening, universal precautions, care plans, resources, and policies and procedures. Phew.

As healthcare providers from diverse disciplines, we all have a role in providing trauma-informed care. Our organizations, and the staff within them, have the responsibility of embarking on the journey towards creating a trauma-informed environment with staff that are knowledgeable of trauma-informed principles and skilled in engaging in trauma-informed interventions. I don't know about you, but all of this can feel a bit overwhelming and cause even the most skilled administrator and management staff to wonder how and where to start.

While all of those components in the first paragraph are integral to a trauma-informed organization and staff, I wonder if it would be helpful to step away from the elements of trauma-informed care and consider the experience of coping and living with trauma.

Throughout our lifetime, each of us will experience trauma, some in the form of one-time big events, others being repetitive events that occur over a period of time. Many will experience both. You may or may not think of them as "traumas" or "traumatic." Regardless of the word or description you use to describe these life experiences, a key principle of trauma-informed care is that traumas accumulate. They do not go away as people age.

Every day in nursing homes and assisted living communities, staff care for people living with a multitude of diagnoses and experiences, filtered through their personalities, goals, hopes and concerns. We become accustomed to "typical" diagnoses and situations related to growing older, as well as the effects of chronic illnesses and tragedies across the lifespan. And therein lies the problem. We become *accustomed*. Ask any staff member in a nursing home if they've cared for an octogenarian with cognitive impairment and a recent hip fracture. Or, a resident with pneumonia and diabetes who doesn't feel like eating or getting out of bed. How about people struggling with grief after a partner has died, who can no longer live in their home independently and have depression. Of course, we *are* long term care. Those situations are what we are trained for. In a sense, they do become commonplace.

Barbara Ganzel, an expert in trauma-informed care, says, "You can't discount things just because they're common." Please, stop here and consider the importance of that statement. You can't discount things just because they're common. What is common to us as healthcare workers, is certainly not common to the individual experiencing those events, in that way, at that moment in time. Consider the following scenario.

Here's a one-sentence statement from a person's medical record. "Resident is an 85 y/o male with gastric reflux and dysphagia, hx of depression, aspiration pneumonia and oxygen dependency, recently diagnosed with c-diff." No biggie, right? A common, clinical presentation of any number of people living in long-term care at this moment. *Common to us, but not to that individual*. Now, consider this version of the same, common, scenario. But here's the twist. Imagine this resident is YOU.

You are 85 years old, your health is declining, you believe that your life might be nearing an end, your lifelong spouse with whom you've shared the same bed for dozens of years is living alone and you're living in a nursing home. You worry about your spouse and what will happen when you die. Your mental acuity is changing (either because of depression, dementia, trauma or a combination of all three), you have a virulent infection that causes multiple episodes of loose stools daily and the only human contact you have is with staff donned with gloves and gowns. You have trouble swallowing and easily choke, you're attached to an oxygen tube, your appetite is crummy and all you eat are soft or liquid foods, your days are largely spent sitting in a wheelchair or lying in bed, and you have to have help with every aspect of daily care from getting out of bed to wiping your peri area after every bowel movement.

Same resident, different perspective. There is nothing wrong with the common, clinical presentation. But, it's incomplete. It's missing the human element that conveys so much more than that one-sentence medical summary. Trauma-informed care requires us to broaden our thinking to incorporate a more robust version of person-centered care, of wellness, of appreciating the impact of life's events at a given point in time.

Think of it this way. If there are five people living with the same cancer diagnosis or dementia in your facility, there are FIVE *different* people with different experiences of living with that diagnosis. Are there similarities in terms of disease progression, interventions and perhaps treatment? Sure. Might there even be similar responses of grief and mourning? Of determination and coping? Absolutely. However, each person is unique in their individual experience of a diagnosis or any life event, no matter how common to the human experience or to growing older. As staff, our challenge is to recognize and honor that individuality, how it informs one's current life circumstances, and how to put the individual in control of their environment, body and experience.

Contact Paige at 520-955-3387 or at paige@paigeahead.com
Discover more about her at www.paigeahead.com

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QM Savvy in a QRP World

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

As an industry, PAC is heading toward a "one world" system. Universal Post-Acute Care, or UPAC is what this will be known as. The IMPACT Act has legislated that soon, LTACHs, IRFs, SNFs and HHs will all be driven by site neutral quality measurement and site neutral payment. The Quality Reporting Program has been materializing for some time and Both the PDPM for SNFs and the PDGM for HHs are the first foray in site neutral payment. Our world is surely changing.

The PDPM will adjust over time as CMS determines its course. However, we are currently faced with a quality reporting world that is still a sort of hybrid of the MDS based quality measures we have all come to know through CASPER and Nursing Home Compare and a mix of MDS based and claims based measures that are quickly transitioning to QRP as the standard. Providers need to have all of the resources necessary to remain up to date with what each measure. Here is a list to help you on your way. There have been plenty of updates lately so be sure you have the latest versions.

1. **Quality Measures –** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures In the downloads section of this site you will find a link to the most recent quality measures manuals. This download contains the measure specifications for the current QMs as well as the MDS and claims based QRP measures.

2. **Medicare Spending Per Beneficiary -** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/2016_07_20_mspb_pac_ltch_irf_snf_measure_specs.pdf This separate manual details the only claims based measure not found in any of the other QM manuals.

3. **5-Star User's Manual** - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS Updated in October 2019, this is the most current version of this manual. It is located in the downloads section of this site.

4. **IMPACT ACT website** - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures This website gives the background and helpful onsight into the IMPACT ACT and the effect it will have on the PAC settings.

5. **SNF QRP** - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information This site contains everything QRP. It should be accessed regularly for updates. The downloads section contains change tables and other resources relative to current QRP revisions.

6. **SNF QRP Training** - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training Contains training resources related to SNF QRP. The latest update is a very helpful training video about IMPACT and QRP.

7. **SNF QRP FY 2021 Updates, Final Specifications for SNF QRP Quality Measures and Standardized Patient Assessment Data Elements (SPADEs) -** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos Find this document in In the downloads section of this site as well as a related change table showing the changes coming to MDS 3.0 v1.18.0.

8. **MDS 3.0 Technical Information -** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation Find the DRAFT version of MDS 3.0 v1.18.0 effective October 1, 2020.

I hope these links are helpful. There is much to assimilate. Do you have a challenging MDS, Reimbursement, QM or QRP question, give us a shout the ask the expert link at https://www.broadriverrehab.com/expert/? Broad River Rehab is knowledgeable and compassionate partner, we would love to help.

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Governing Body. While it is not often litigated and there is limited case law on the issues of the Governing Body's liability for negligence or malpractice, there are a few instructive cases with lessons learned.

In a 2012 Arkansas Supreme Court, the personal representative of a deceased nursing home resident's estate brought action against a nursing home and the sole member of home's governing body for ordinary negligence, medical malpractice, and violation of the Residents' Rights Act in connection with resident's care. The Circuit Court entered judgment on a jury verdict awarding estate $5.1 million in damages that **included a finding that the individual owner had a duty to the resident arising from the federal regulation covering the obligations of governing bodies of nursing homes and from an internal nursing home policy**. The Supreme Court disagreed and, after citing the regulation, stated "… it is clear to this court that this regulation is a rule that nursing homes must follow to qualify for participation in Medicare and Medicaid, and we will not interpret it to create a duty in tort. The funding regulations specifically limit themselves to "serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid." 42 C.F.R. § 483.1(b).

Lessons Learned: The federal and state regulations do not provide a private right of action or create a duty for a sole member of the governing body but may establish a standard to be considered by the court.

In a 2015 United States District Court case from Oklahoma, the Court also declined to find a duty of a member of the governing body of the nursing home defendant using the same analysis.

The Court found *"…the regulation plaintiffs rely upon in support of their assertion that Lusk had a duty to Ms. Mayberry, 42 C.F.R. § 483.75(d), does not impose such a legal duty for purposes of holding Lusk liable for negligence. The regulation at issue falls within Part 483 of Title 42 of the Code of Federal Regulations; the regulations within this part contain the requirements that an institution must meet in order to qualify to participate as a [Skilled Nursing Facility] in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.*

42 C.F.R. § 483.1(b). Nowhere in Part 483 is there any mention of a private right of action or any legal consequences other than having federal funding denied to a health care facility that does not satisfy Part 483's requirements.

Accordingly, the Court finds that plaintiff has not established the existence of a duty on the part of Lusk to protect Ms. Mayberry from injury and Lusk, therefore, is entitled to summary judgment."

Lessons Learned: The federal and state regulations do not provide a private right of action or create a duty for a sole member of the governing body but may establish a standard to be considered by the court.

However, a 2004 Florida appeals court suggests that a governing body may be liable to a resident under the regulations. The resident's estate argued that the concept of piercing the corporate veil does not apply in the case of a tort, and that it presented sufficient evidence of one of the owner's negligence, by act or omission, for the jury to reasonably conclude that he caused harm to the resident by ignoring complaints to the governing body about under-staffing and other operational concerns.

It argued that the owner had the responsibility of approving the budget for the nursing home. He also functioned as the sole member of the "governing body" of the nursing home, and pursuant to federal regulation, the governing body is legally responsible for establishing and implementing policies regarding the management and operation of the facility and for appointing the administrator who is responsible for the management of the facility. The owner was thus required by federal mandate to create, approve, and implement the facility's policies and procedures. Because he ignored complaints of inadequate staffing while cutting the operating expenses, and because the problems the resident suffered, pressure sores, infections, poor hygiene, malnutrition and dehydration, were the direct result of understaffing, argued the Estate. It argued that a reasonable jury could have found that the owner's elevation of profit over patient care was negligent.

The appeals court concluded that the trial court erred in granting the directed verdict in favor of the owner because there was evidence by which the jury could have found that the owner's negligence in ignoring the documented problems at the facility contributed to the harm suffered by the resident. This was not a case in which the plaintiffs were required to pierce the corporate veil in order to establish individual liability because the owner's alleged negligence constituted tortious conduct, which is not shielded from individual liability. A new trial was granted.

Lessons Learned: Establishing protocols for the governing body that reflect the federal and state regulations and also set expectations for the governing body as it relates to management and operations may have limited the risk of liability for this owner.

Legal Recap: With corporate ownership transparency and more scrutiny on operations and management in skilled nursing, there is increased legal risk for owners, managers and the governing body. Reviewing all applicable contracts and revising as needed; establishing proper protocols and prioritizing corporate compliance are the best proactive means to mitigate litigation risk.

Please reach out to me for further legal guidance; state regulation comparisons, policies and best practices.

The National Long-Term Defense Summit - Adelman Law Firm hosts the annual National Long-Term Care Defense Summit. PLEASE SAVE THE DATES OF April 22-23, 2020 for the 8th annual Summit! 2019 was amazing and look forward to education, networking and fun in New York City in 2020! You'll love The Parker Hotel and the penthouse Estrela conference room with a 360 degree views of the city and Central Park!

Please plan to join us!!!! For more information, please contact me at rebecca@adelmanfirm.com.

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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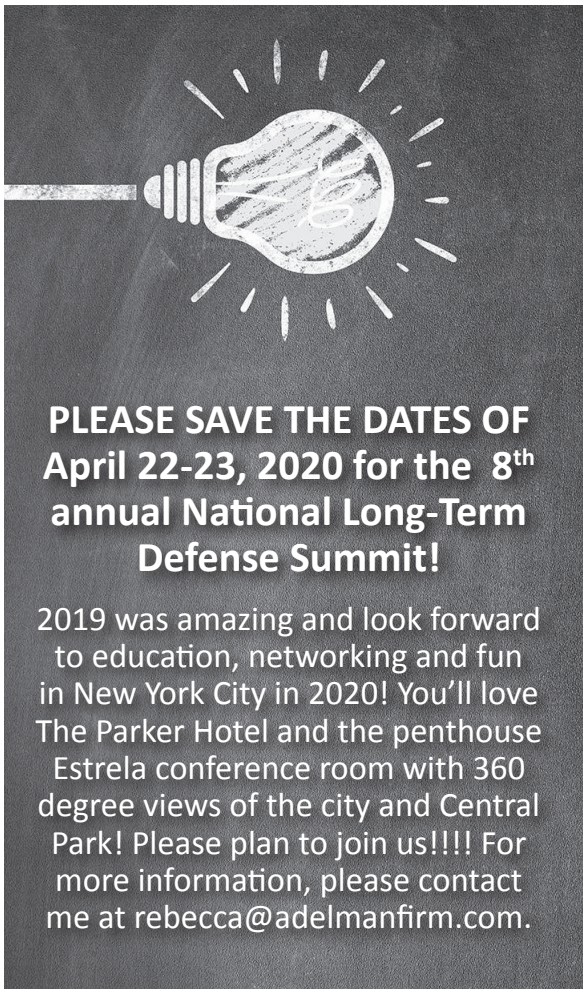

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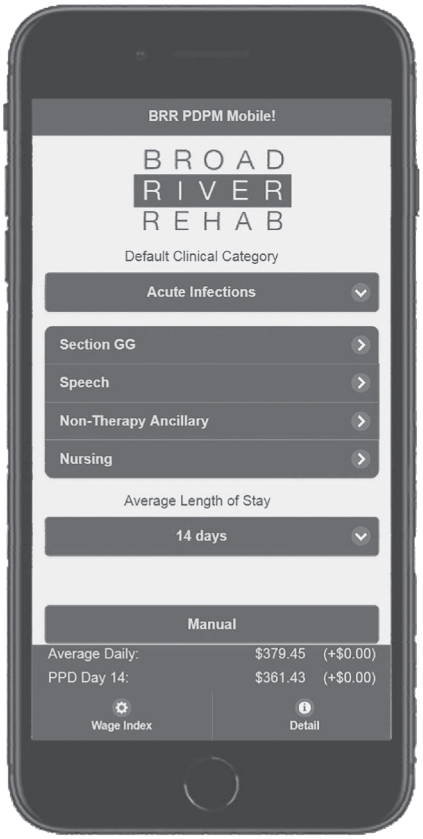

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