NURSING HOME SURVEILLANCE UPDATE

March 18, 2016

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Center for Health Care Provider Services and Oversight

March 18, 2016

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Mission Statement

THE DIVISION OF NURSING HOMES AND ICF/IID SURVEILLANCE WILL ENSURE RESIDENTS OF NYS NURSING HOMES AND ICF/IID FACILITIES ARE PROTECTED FROM HARM THROUGH:

● CLOSE SURVEILLANCE MONITORING TO ENSURE FACILITIES MEET APPLICABLE FEDERAL AND STATE HEALTH STANDARDS; AND

● FOSTERING OF CONTINUOUS IMPROVEMENTS THROUGH COLLABORATION WITH THE LONG-TERM CARE COMMUNITY

SURVEY PERFORMANCE
SURVEY PERFORMANCE

- On average, 8.7 (LSC and Health) citations are issued per recertification survey in NYS
- The national average is 9.4 citations

![Chart showing NYS and National Average citations]

SURVEY PERFORMANCE

Top 5 Citations, FFY-2015
(Represent 24% of Citations Issued)

- F0371  STORE/PREPARE/DISTRIBUTION FOOD UNDER SANITARY CONDITIONS
- F0225  NOT EMPLOY PERSONS GUILTY OF ABUSE
- F0323  FACILITY IS FREE OF ACCIDENT HAZARDS
- F0309  PROVIDE NECESSARY CARE FOR HIGHEST PRACTICABLE WELL BEING
- F0441  FACILITY ESTABLISHES INFECTION CONTROL PROGRAM
SURVEYS WITH IMMEDIATE JEOPARDY (IJ) CITATIONS ISSUED

- 37 SURVEYS RESULTED IN IJ CITATIONS DURING FFY 2015
- 34 SURVEYS RESULTED IN IJ CITATIONS DURING FFY 2014
- 42 SURVEYS RESULTED IN IJ CITATIONS DURING FFY 2013
- 59% OF THE IJ CITATIONS WERE IDENTIFIED DURING ABBREVIATED/COMPLAINT SURVEYS

TOP IMMEDIATE JEOPARDY (IJ) CITATIONS

- Accidents
- Medications
- Abuse & Mistreatment
- Advance Directives

QAA Committee & Administration are routinely cited in IJ citations
Advance Directives

2007 DAL

- State regulations (10 NYCRR 400.21) and federal regulations (42CFR 483.10; Part 489, Subpart I) require nursing homes to maintain written policies and procedures addressing directives, such as health care proxies, orders not to resuscitate, Medical Orders for Life Sustaining Treatment (MOLST) forms and living wills.
- Also, under 10 NYCRR 415.13, 415.26(c)(1)(iii)(a)(4) and 415.26(f)(3), nursing homes must have sufficient personnel to provide services, including CPR, to all residents on a 24-hour basis and must train all staff regarding resident emergency procedures and carry out staff drills.
Advance Directives

- Advance Directives IJ’s have consistently been in the top IJ findings
- Immediate Jeopardy regulatory tags cited in either:
  - F155- failure to identify or know resident wishes
  - F309- failure to act correctly
- IJ cited in both standard and complaint surveys
- The Department expects that nursing facilities will have in place systems, policies and procedures that ensure that resident advance directives regarding basic life support will be identified, known, and honored.

What Surveyors look for

- A written policy and procedure regarding advance directives
- Each resident has an identified decision maker, when they can no longer make their own decisions
- Residents and their representatives are provided with Advance Directive education (both verbal and written) and are being provided with the right to formulate an advance directive choice. This should be done as soon as possible following admission.
- A physicians order is obtained and is the same as the resident’s chosen advance directive.
- The advance directive is documented and communicated to staff
- Facility staff knows how to access the resident advance directive information in routine and/or urgent situations
- Facility is trained, react appropriately and deliver care as directed by the advance directive. See 1-23-15 Update to F 155 guidance.
Advance Directives

Findings:
- The system to identify Advance Directives is not current and/or consistent with residents’ wishes
- Staff are unaware of the system to identify residents’ wishes
- Staff are not aware of the guidance regarding CPR
- Systems are convoluted and confusing

Complications:
- Resident has a change in status or condition
- Resident or legal representative change decision about directives

Best Practice:
- Obtain Advance Directive status on admission and follow through on documentation to support residents’ wishes
- Have documentation of residents’ Advance Directive wishes easily obtainable

Complaint Program
Overview of Complaint Program

• The Centralized Complaint Intake Unit enters over 12,000 complaints/incidents per year; approximately 8,000 become investigations

• The focus of the DOH investigation is on regulatory compliance, abuse, neglect and mistreatment

• Approximately 12% of all investigated complaints result in a Statement of Deficiency (SOD)

Common Complaints by Third Party

• Care issues-family reports symptoms to staff, no action taken
• Development of pressure sores
• Medications not available (especially pain meds)
• Staffing concerns
• Medication use of particular drug or overuse of psychoactive medications
• Not assisting with toileting, incontinence care and eating. No call bell response.
• Abuse allegations
Common Complaints by Third Party

- Activity time includes transport time
- Discharge/Eviction was the most frequent complaint category processed by the LTC Ombudsman Program nationally in 2013 (8478 complaints) & had been the 1\textsuperscript{st} or 2\textsuperscript{nd} frequent complaint category since 2006.

Common Facility Reported Incidents

- Abuse, neglect, mistreatment, and misappropriation of resident property
- Resident to Resident abuse
- Dignity issues-staff treating residents poorly
- Elopements
- Medication errors
Discharge Planning

The goal is to have the resident live in the least restrictive environment as possible.

The assessment:
- Should begin on admission
- Should be comprehensive
- Should involve all responsible parties
- Should be well documented
- Should be reflected in Section Q of the MDS 3.0
DISCHARGE PLANNING

● **Do**… issue written notices of transfer or discharge and/or cite regulatory basis prior to any transfer or discharge (long term care and subacute)
  
  Acceptable bases for transfer or discharge include:
  
  ◦ Resident welfare and resident need cannot be met after reasonable attempts at accommodation
  ◦ Resident health has improved sufficiently so resident no longer needs services
  ◦ Health or safety of individuals in the facility are endangered and all reasonable alternatives have been explored
  ◦ Failure to pay

● **Do**… readmit nursing home residents who are temporarily hospitalized (next available semi-private bed)
  
  ◦ Without regard to payment source
  ◦ With or without bed hold

● **Do**… follow transfer and discharge requirements for the subacute population

HOSPITALS ARE NOT ACCEPTABLE FINAL DISCHARGE LOCATIONS!!
Care for Residents with Dementia

Dementia Care Principles (7)

- 1. Person Centered Care
- 2. Quality and quantity of staff
- 3. Thorough evaluation of new or worsening behaviors
- 4. Individualized approaches to care
- 5. Critical thinking related to antipsychotic drug use
- 6. Interviews with prescribers
- 7. Engagement of resident and/or representative in decision-making
Partnership to Improve Dementia Care in Nursing Homes

On March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) launched the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (this is now referred to as the Partnership to Improve Dementia Care in Nursing Homes). The goal of this Partnership is to optimize the quality of life and function of residents in America’s nursing homes by improving the approach to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia.

Improving Dementia Care with the Use of Non-Pharmacological Interventions to Manage The Behavior Symptoms of Dementia

Goal: Individualized, systematic process to care for residents with Dementia. Medications are not the ONLY focus, just a piece of the puzzle.

Initiative promotes the four “R’s”.
- Rethink-Rethink our approach to Dementia care.
- Reconnect- Reconnect with residents via person centered care practices.
- Restore- Restore health and quality of life.
- Respect- Respect resident dignity.
Reducing the Use of Antipsychotic Medications in Nursing Home Residents

CMS Antipsychotic Initiative

- Goal to enhance the use of non-pharmacological approaches and person centered care practices
- Initial Focus: reduce the national rate of antipsychotic medication in persons living in nursing homes by 15% by the end of 2012, new goal of 25% reductions by end of 2015 and 30% by end of 2016

NYS DOH Antipsychotic Initiative

- NYS DOH continues to focus on increasing knowledge and supporting surveyors to determine compliance and evidence of alternatives
- NYS currently ranked 17th nationally for Q3 2015 (lower=better)
- Data demonstrates 26.1% relative improvement Q4 2011-Q3 2015 with a rate of 15.74% for Q3 2015
### CMS Comparative AP Reduction Analysis

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Source: CMS Quality Measure, based on MDS 3.0 data. For more information see the MDS 3.0 Quality Measures Users Manual

### In Case You Wanted to Know...

[Image of CMS Regional Offices Regional Map]
Do You Know

• What is your antipsychotic rate?
• What is last year’s antipsychotic rate?
• What steps have been taken to reduce off label use of antipsychotic medication in your facility? Describe who, what, when and how.
• How does the facility provide individualized care and services?
• What are the facility policies related to the use of antipsychotics in residents with dementia?

Facility Accountability

• Facility must ensure that every antipsychotic medication prescribed is clinically indicated, that non-pharmacological approaches to care are implemented prior to the introduction of medications, unless contraindicated, and a system is in place to document, monitor and revise the resident’s care plan on a consistent basis
Reducing the Use of Antipsychotic Medications in Nursing Home Residents

Definitions:

Behavioral interventions: Individualized approaches provided as part of a supportive physical and psychosocial environment...

Person-Centered or Person-Appropriate Care: Care tailored to all relevant considerations for the individual, including physical, functional, and psychosocial aspects...

Behavioral or Psychological Symptoms of Dementia (BPSD): Term used to describe behavior or other symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause…”

Reducing Inappropriate Use

Despite serious safety concerns and minimal overall effect on symptomatology, antipsychotics are frequently prescribed off-label for BPSD. In 2010, the Centers for Medicare and Medicaid Services (CMS) reported that 39% of U.S. nursing home residents were inappropriately prescribed an antipsychotic without having a clinical indication for treatment.

March 18, 2016

**What You Need to Know About Antipsychotic Drugs for Persons Living with Dementia**

**What is an antipsychotic drug?** An antipsychotic drug is a medicine that works in the brain, which may help to block certain chemicals that can cause symptoms of psychosis, such as hallucinations or delusions.

- **Hallucinations** are when a person sees or hears things that are not there
- **Delusions** are when a person believes something that isn’t true, even after being told.

Some people with some mental illnesses like schizophrenia and bipolar disorder often have these symptoms.


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March 18, 2016

**Behavioral or Psychological Symptoms of Dementia (BPSD)**

Antipsychotic medications are only appropriate for elderly residents in a small minority of circumstances (unless the antipsychotic is prescribed to treat previously diagnosed mental illness such as schizophrenia or possibly other conditions). All antipsychotic medications carry a Food and Drug Administration (FDA) Black Box Warning. Since June 16, 2008, FDA warned healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of death in elderly patients treated for dementia-related psychosis.

Ref: S&C: 13-35-NH p. 43
Black Box Warning

Because of these dangers, the US Food and Drug Administration (FDA) requires a warning on the label of all antipsychotic drugs. Such “black box” warnings are only required for drugs with serious risks. The warning includes the following:

**WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS.** ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS TREATED WITH ANTIPSYCHOTIC DRUGS ARE AT AN INCREASED RISK OF DEATH. [NAME OF ANTIPSYCHOTIC] IS NOT APPROVED FOR THE TREATMENT OF PATIENTS WITH DEMENTIA RELATED PSYCHOSIS.

ADDITIONAL INFORMATION AT: HTTP://WWW.FDA.GOV/DRUGS/DEFAULT.HTM

Critical Thinking Related to Antipsychotic Drug Use

In certain cases, residents may benefit from the use of medications. The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record. Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.
All of the previous indications/diagnoses where antipsychotic medications may possibly be appropriate, but diagnoses alone do not warrant the use of an antipsychotic unless the following criteria are also met:

The *behavioral symptoms present a danger to the resident or others*

AND one or both of the following:

- The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); OR
- Behavioral interventions have been attempted and included in the plan of care, except in an emergency.

Ref: S&C: 13-35-NH p. 44

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**Additional Criteria:**

**Acute Situations/Emergency**

Use must meet the criteria and all of the following requirements:

- Acute treatment period is limited to 7 days or less; AND
- A clinician in conjunction with the IDT must evaluate and document within 7 days to identify and address any contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic.
- If the behaviors persist seven days beyond the emergency, pertinent non-pharmacological interventions must be attempted, unless clinically contraindicated, and documented following resolution of the acute psychiatric event.
Enduring Conditions (non-acute; chronic; or prolonged)

Target behavior/s must be clearly/specifically identified and documented. Monitoring must ensure the behavioral symptoms are:

- Not due to a **medical condition** or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; AND
- Not due to **environmental stressors** alone that can be addressed to improve the symptoms or maintain safety; AND
- Not due to **psychological stressors** alone, anxiety or fear stemming from misunderstanding related to his or her cognitive impairment that can be expected to improve or resolve as the situation is addressed; AND
- **Persistent.** There must be clear documented evidence that the situation/condition continues or recurs over time and that other approaches attempted have failed to adequately address the behavioral/psychological symptoms and that the resident’s quality of life is negatively affected.

New Admissions:

Residents admitted already on an antipsychotic. The facility is responsible for:

- **Preadmission screening** for mentally ill and intellectually disabled individuals, and;
- Obtaining **physician’s orders** for the resident’s immediate care.
- Residents not requiring a Level 2 screening and admitted on an antipsychotic. Use of the antipsychotic must be **reevaluated at the time of admission and/or within 2 weeks** (initial MDS) to consider whether the medication can be reduced or discontinued.

**Dosage:** Treatment should be at the lowest possible dose to improve the target symptoms being monitored. [Includes a table as a general guide for residents with dementia who meet all of the [above] criteria.]

**Duration:** Refers to Guidance Section V—Tapering of a Medication Dose/Gradual Dose Reduction (GDR).

- **Monitoring:** Periodic evaluation of ongoing effectiveness and potential adverse consequences; use of any other psychopharmacological medications given to the resident.
- **Potential Adverse Consequences:** The facility assures residents are adequately monitored for adverse consequences, e.g., anticholinergic effects, falls, excessive sedation; cardiovascular; metabolic; neurologic.
What You Need to Know About Antipsychotic Drugs
for Persons Living with Dementia

What are common antipsychotics?
- Haldol (Haloperidol)
- Quetiapine (Seroquel)
- Olanzapine (Zyprexa)
- Aripiprazole (Abilify)
- Risperidone (Risperdal)

Why are these drugs used in people with Dementia?
These drugs can help for some people with dementia who do have psychosis. However, most of the time these drugs are used when a person acts in way that is challenging or disturbing to others, such as:
- hitting, yelling, screaming
- refusing care, walking around
- crying, banging, throwing things

What can these drugs NOT do?
These drugs do not help:
- Stop yelling or repeating questions over and over
- Calm being restless, fidgety or uneasy
- Stop memory problems
- Persons do more for themselves
- Persons interact better with others
- Stop inappropriate things being said
Antipsychotic medications in persons with dementia should not be used if the only indication is one or more of the following:

- wandering
- poor self-care
- restlessness
- impaired memory
- mild anxiety
- insomnia
- inattention or indifference to surroundings
- sadness or crying alone that is not related to depression or other psychiatric disorders
- fidgeting
- nervousness
- uncooperativeness (e.g. refusal of or difficulty receiving care).

Ref: S&C: 13-35-NH pp. 44-45

Residents’ records reflect implementation of the following care processes:

- Recognition and Assessment
- Cause Identification and Diagnosis
- Development of Care Plan
- Individualized Approaches and Treatment
- Staffing and Staff Training
- Involvement of Medical Team
- Monitoring, Follow-up and Oversight
- Quality Assessment and Assurance (QAA)
Compliance Decisions

- If the behavioral symptoms represent a change or worsening, was a medical workup performed to rule out underlying medical or physical causes of the behaviors, if appropriate?
- If a medical cause was identified (e.g. UTI), was a treatment initiated in a timely manner (if indicated)?
- If medical causes are ruled out, did the staff attempt to establish a root cause of the behaviors, using individualized knowledge about the resident when possible?
- Were family, caregivers or others who knew the resident prior to his/her dementia consulted about prior life patterns, responses to stress, etc.?
- Was the initial clinical indication for the medication clear and appropriate for the medication prescribed?
- Were non-pharmacologic, person centered interventions attempted first? Were the results documented?
- Was the resident or appropriate legal representative consulted about the decision to use an antipsychotic medication and was that discussion documented?
- If the drug is being continued, is there a defined time frame with an end point? Is the original clinical indication still valid?
- Is the appropriate monitoring in place for improvement of target behaviors and is the team aware of the potential side effects?
- Was there IDT review documentation?
Proposed Reform of Requirements for Long-Term Care Facilities

March 18, 2016

Background

- The requirements for Long-Term Care (LTC) facilities are the health and safety standards that LTC facilities must meet in order to participate in the Medicare and Medicaid Programs/Conditions of Participation
- The current requirements are found at 42 CFR 483 Subpart B
- Requirements have not been comprehensively updated since 1991 despite significant changes in the industry
- Proposed revisions reflect advances in the theory and practice of service delivery and safety and implement sections of the Affordable Care Act (ACA)
- Presenting “Highlights” not an exhaustive list of changes
- Proposed rule was published in the Federal Register on 7/16/2015; Comment Period End 10/15/2015 and Final Action September 2016
Themes of the Rule

- Person-Centered Care
- Quality
- Facility Assessment, Competency-Based Approach
- Alignment with HHS priorities
- Comprehensive Review and Modernization
- Implementation of Legislation

Person-Centered Care

Residents and Representatives: Informed, Involved and In Control.

- Existing protections Maintained
- Choices
- Care & Discharge Planning
Quality

Quality of Care and Quality of Life—overarching principles for every service

● Quality of Life and Quality of Care: Additional special care issues: restraints, pain management, bowel incontinence, dialysis services, and trauma-informed care

● Quality Assurance and Performance Improvement: Based on the pilot – resources available http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/nhqapi.html

Facility Assessment and Competency-Based Approach

Facilities need to know themselves, their staff and their residents

● Not a one-size fits all approach

● Accounts for and allows for diversity in populations and facilities

● Focus on each resident achieving their highest practicable physical, mental, and psychosocial well-being
Align with Current HHS Initiatives

Advance Cross-cutting priorities
- Reducing unnecessary hospital readmissions
- Reducing the incidences of healthcare acquired infections
- Improving behavioral healthcare, and
- Safeguarding nursing home residents from the use of unnecessary psychotropic (antipsychotic) medications

Comprehensive Review and Modernization

Bringing it into the twenty-first century
- Reorganized
- Updated
- Consistent with current health and safety knowledge
  - Revised care and discharge planning requirements
  - Current infection control standard, including antibiotic stewardship
  - Updated special care issues like pain management and dialysis
  - Allow professional to practice to their full scope of practice where possible
Implementation of Legislation

*It’s the Law*

- Section 6102(b) of ACA, compliance and ethics program
- Section 6102(c) of ACA, QAPI
- Section 6703(b)(3) of ACA, requirements for reporting to law enforcement suspicion of crimes
- Section 6121 of ACA, dementia and abuse training
- Section 2 of the IMPACT Act, discharge planning requirements for SNFs

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Proposed Reform of Requirements for Long-Term Care Facilities

**Highlights**

**Resident Rights (§483.10)** Comprehensive restructuring: improve logical order, update provisions to advances such as electronic communication, this includes

- term resident representative will replace interested family member and legal representative
- addressing roommate choice
- physician credentialing licensed in the state where resident resides and meet professional credentialing requirements of facility

HHS (CMS) Federal Register Vol. 80 NO. 136 July 16, 2015
Proposed Reform of Requirements for Long-Term Care Facilities

Facility Responsibilities (§483.11) New Section focus on the responsibilities of the facility to protect rights of their residents, enhancing quality of life, relocating provisions from existing Resident Rights (§483.10) and Quality of Life (§483.15)
- Visitation establish open visitation similar to hospitals

Transitions of Care (§483.15) revised title formerly “Admission, transfer and discharge rights
- Require transfer & discharge be documented in the clinical record and specific information including history of present illness, reason for transfer, past medical and surgical history be exchanged with receiving provider

Proposed Reform of Requirements for Long-Term Care Facilities

Freedom From Abuse, Neglect and Exploitation (§483.12)
- Previously Resident Behavior and Facility Practices §483.13 re-designate and revise
  - Specify that facilities cannot employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property.
  - Require facilities to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and mistreatment of residents or misappropriation of their property.
Proposed Reform of Requirements for Long-Term Care Facilities

Resident Assessments (§483.20)

- Preadmission Screening and Resident Review (PASARR) clarify what constitutes appropriate coordination of a resident’s assessment with the PASARR program under Medicaid
  - require facility to notify the state mental authority or intellectual disability authority after a significant change in the resident.
  - replace the term mental retardation with intellectual disability

Comprehensive Person Centered Care Planning (§483.21) New Section

- Baseline Care Plan developed within 48 hrs of admission with instructions needed to provide effective & person-centered care that meets professional standards and quality care
- PASARR care plan to address any specialized services or specialized rehab services as a result of PASARR recommendations
- IDT add a nurse aide, a member of food & nutritional services staff and social worker as required members that develop the comprehensive care plans; documentation in the record if participation of the resident and their representative is determined not to be practical
Comprehensive Person Centered Care Planning (§483.21)

- Discharge Planning
  - Document in care plan resident’s goal’s for admission, assess resident’s potential for future discharge and discharge planning
  - Discharge summary include reconciliation of all discharge medications with admission medications (prescribed & over the counter)
  - Discharge summary include arrangements for follow up care and any post discharge medical and non-medical services

Proposed Reform of Requirements for Long-Term Care Facilities

Quality of Care and Quality of Life (§483.25)

- Overarching Principles quality of care and of life principles be applied in the delivery of care to every service provided
- Relocate current requirements of an activities program from §483.15
- Soliciting comments on current requirements for Activities Director
- Special Need Issues-ensure residents receive necessary and appropriate pain management, trauma survivors, skin integrity, incontinence, enteral feedings, restraints with focus on side rails
- Re-designation of Requirements relocate provisions regarding unnecessary drugs, antipsychotic drugs, medication errors and influenza and pneumococcal immunizations to Pharmacy Services
Proposed Reform of Requirements for Long-Term Care Facilities

Behavioral Health Services (§483.40) New Section

Provide necessary behavioral health care and services to residents
● Facility Assessment to determine their direct care staff needs
● Staff have the appropriate competencies and skills to provide behavioral health care and services for caring with residents with cognitive impairment, mental and psychosocial illnesses and implementing non-pharmacological interventions
● Social Worker gerontology to the list of possible human services fields from which a bachelor degree could provide the minimum educational requirements

Pharmacy Services (§483.45)

● Drug Regimen Review
  ○ Psychotropic drugs revise existing requirements regarding “antipsychotic” drugs to refer to “psychotropic” drugs
  ○ Define psychotropic drug as any drug that affects brain activities associated with mental processes and behavior
  ○ PRN (as needed) orders for psychotropic drugs be limited to 48 hours unless documented by the primary care provider the rational for the order in the record
Proposed Reform of Requirements for Long-Term Care Facilities

Dental Services (§483.55)

● Prohibit SNF from charging Medicare resident for the loss or damage of dentures when the lost of damage is the responsibility of the facility
● Regard to referral for lost or damaged dentures, promptly means within 3 business day

Quality Assurance and Performance Improvement (QAPI) (§483.75) New Section

● Facility to develop, implement, and maintain an effective comprehensive, data-driven QAPI program that focuses on systems of care, outcomes of care and quality of life:
  ○ Monitor data (indicators, measures and reports of staff/residents/families), determine root causes of problems, design and use performance improvement projects (PIPs) to promote continuous improvement, develop and implement plans that effect system improvement and monitor the success of the systematic approach to improve quality.
Proposed Reform of Requirements for Long-Term Care Facilities

Infection Control (§483.80)

- Infection Prevention And Control Program (IPCP) system for preventing, identifying, reporting, investigating and controlling infections and communicable disease.
- Infection Prevention and Control Officer (IPCO) designate an IPCO for whom the IPCP is their major responsibility and they are a member of the QAA committee
- Antibiotic stewardship program that includes antibiotic use protocols and a system for monitoring use

Training Requirements (§483.95) New Section

Facility must develop, implement, and maintain for all new & existing staff an effective training program that includes

- Communication
- Resident Rights and Facility Responsibilities
- Abuse, Neglect, and Exploitation
- QAPI & Infection Control
- Compliance And Ethics
- In-Service Training for Nurse Aides 12 hr dementia and abuse training per year
- Behavioral Health Training for all staff based on the facility assessment
Thank You