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A MEDICARE LEARNING NETWORK® (MLN) EVENT

Nursing Home Facility Assessment Tool and State Operations Manual Revisions

September 7, 2017



Acronyms in this Presentation

- LTC - Long-term Care
- RUG - Resource Utilization Groups
- MOU - Memorandum of Understanding
- QAA - Quality Assessment and Assurance
- QAPI - Quality Assurance and Performance Improvement
- BCP - Baseline Care Plan
- PRN - As-Needed
- IP - Infection Preventionist



Agenda

Facility Assessment Tool

Jay Weinstein, CMS

Angel Davis, CMS

Marilyn Reiersen, Stratis Health

Kelly O'Neill, Stratis Health

Frequently Asked Questions – State
Operations Manual Appendix PP
Revisions

CMS Subject Matter Experts



Nursing Home Facility Assessment Tool

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Facility Assessment Tool – Introduction

Jay Weinstein, NHA, Health Insurance Specialist, Division of Nursing Homes, Survey and Certification Group, CMS

Angel Davis, MBA, MS, BSN, RN, Center for Clinical Standards and Quality, Quality Improvement and Innovation Group, Division of Beneficiary Healthcare Improvement and Safety, CMS

- Tool requirement and intent
- Tool overview, development process, and pilot
- Closer look at the tool – walk through each section



Optional Facility Assessment Tool Design

- Reflect Facility Assessment requirements described in the regulation
- Be simplified as much as possible
- Help nursing facility teams in planning for their assessment
- Modifiable – Allow a team to consider and add items appropriate for their own facility and to individualize their assessment to meet the intent of the regulation
- Support translation of assessment findings into a plan
- Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance



Facility Assessment Tool Purpose and Intent

- Purpose: to determine what resources are necessary to care for residents competently during day-to-day operations and emergencies
- May be used to make decisions about direct care staff needs as well as capabilities to provide services to the residents in your facility
- Intent: For the facility to evaluate their resident population and identify resources needed to provide necessary person-centered care and services required by residents



Tool Development Process

- Iterative process with CMS
- Draft tool shared during a pilot test (July 2017)
 - National partner and stakeholder organizations – representing nursing homes, administrators, directors of nursing, medical directors, consumers, and surveyors
 - Nursing homes, 17 homes representing 7 states, mix of rural/urban, large/medium/small, for profit/nonprofit, ownership
- Comments and feedback used to revise the tool



Facility Assessment Tool Overview

Introduction

- Requirement, purpose, overview of the tool, guidelines for conducting the assessment, table to capture when the assessment was completed/updated and those involved

Three parts

- Resident profile and factors that impact care and support needs
- Services and care offered based on resident needs
- Facility resources needed to provide competent care for residents

Two attachments

- References to the facility assessment in the October 2016 Reform of requirements for Long-Term Care (LTC) facilities
- Sample process for conducting the assessment (intended for internal nursing home use only)
 - Plan for the assessment
 - Complete the assessment
 - Synthesize and use the assessment findings
 - Evaluate your process and plan for future assessments



Pilot Test Comments and Feedback

- Agreement that it was helpful in providing direction for the assessment
- Nearly all agreed the tool was aligned with the regulations and interpretive guidance, included clear descriptions of what was being asked, provided helpful examples, and could be used to determine what resources are necessary to care for residents
- Agreement that lists and examples in the tool were helpful, to help teams think more in-depth and not overlook key areas

“Makes us analyze what our resources are and lack of resources to meet the needs and requests of our clientele.”

“It triggers a pause for leadership to comprehensively look at the facility’s operations and compare that to its stated goals (if any), identified challenges, etc.”



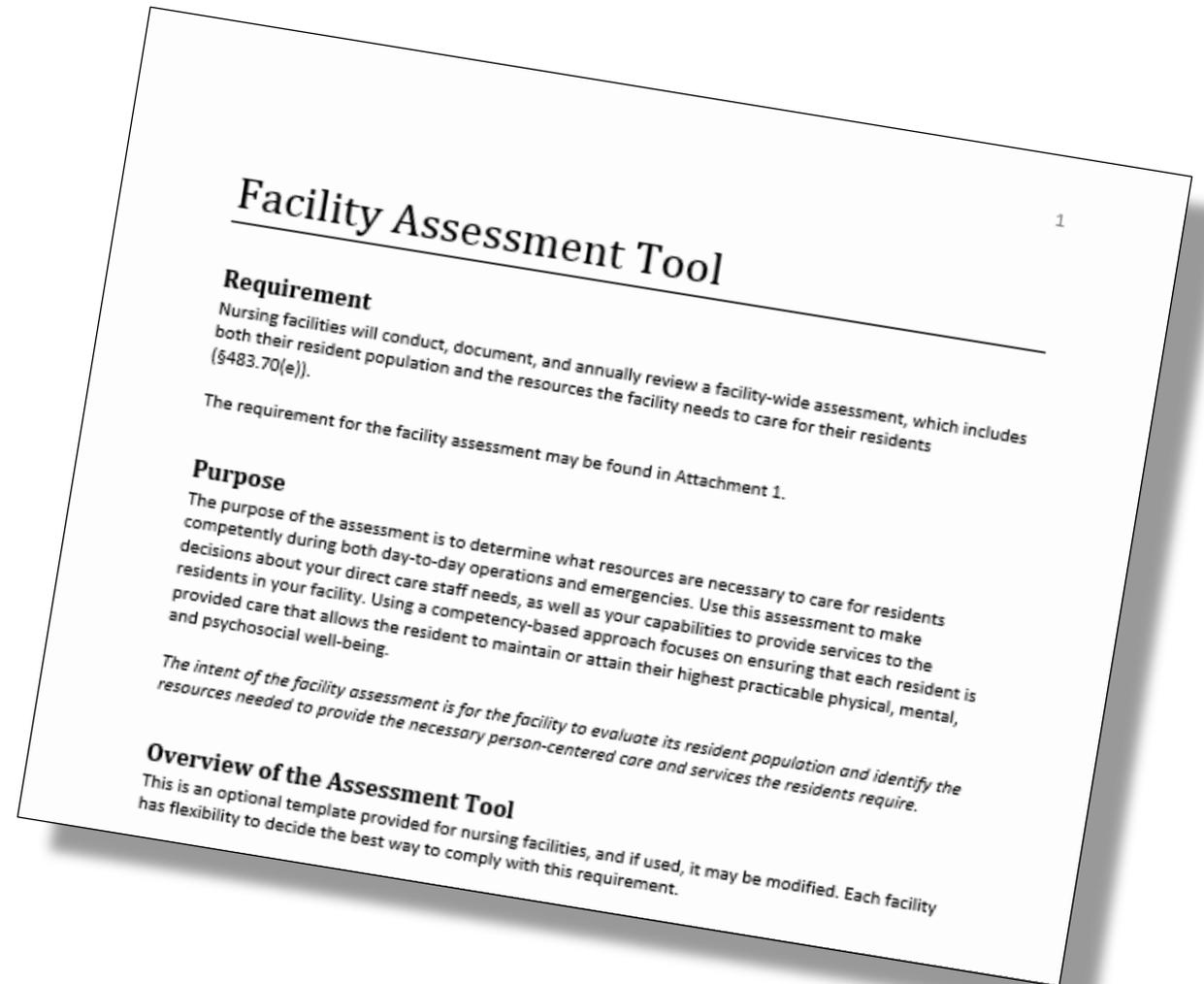
Pilot Test Comments and Feedback

- Agreement that Attachment 2 “Suggested process for the assessment,” including “synthesis and use of findings” was helpful
- Mention that describing acuity can be challenging
- Some commenters asked for more information in the staffing section, others asked for less
- Some requests for algorithms or resident classification systems to determine staffing needs, patterns, etc.
- Some comments that the first assessment may take some time, but after that, updates should be quicker
- Many helpful comments to strengthen the tool



Let's Look at the Tool

Link for the tool:
[Facility Assessment Tool](#)



Facility Assessment Tool: Guidelines for Conducting the Assessment

- Use data from a variety of sources
- Plan for an inclusive process to include persons that care about this
- Conduct at the facility level
- Review and update annually or when there are significant changes
- Use as a record to understand reason for staffing and resource decisions
- Understand how the assessment may be used in the survey process
- See Attachment 2 for a suggested process for conducting the assessment



Part 1: Resident Profile

- Numbers: licensed beds, average daily census, # persons admitted/discharged
- Common diseases/conditions, physical and cognitive disabilities (to help identify types of resources needed to meet the needs of residents living with these conditions or combinations of conditions)
- Decisions regarding caring for residents with conditions that you do not commonly see
- Acuity – to identify potential implications regarding the intensity of care and services needed
 - Three examples provided:
 - Major Resource Utilization Groups (RUG)-IV categories
 - Special treatment and conditions
 - Assistance with activities of daily living
 - Other
- Ethnic, culture, religious or other factors that may affect the care provided



Part 2: Services and Care

- Resident support and care needs based on what your resident population requires – to identify and reflect on resources needed to provide these types of care
- Sample list provided – to be modified based on your population



Part 3: Facility Resources Needed to Provide Competent Care

- Staff type
- Sample list provided for type of staff and other professionals/practitioners
- Staffing plan – general approach to staffing
 - For discussion on how to determine sufficient staffing, see Attachment 2, 7.b
 - Two examples provided
 - Overall number of staff needed
 - General staffing plan
- Individual staff assignment
- Staff training/education and competencies
- Sample lists provided (not inclusive)
- Policies and procedures for provision of care



Part 3: Facility Resources Needed to Provide Competent Care

- Working with medical practitioners
- Physical environment and building/plant needs
- Other
 - Contracts, Memorandum of Understanding (MOU) or other agreements with third parties
 - Health information technology resources
 - Infection prevention and control program
 - Facility-based and community-based risk assessment



Attachment 1: Regulatory Mentions of Facility Assessment

- For your reference
- Not inclusive



Attachment 2: Sample Process for Conducting the Assessment

Plan for the assessment

- Designate a leader
- Leader prepares
- Team formed and included in discussions about the intent of the assessment and the process and timeline to be used
- Inclusive process – have all voices represented in the assessment
- Leadership supports the work of the team – check in frequently

Complete the assessment



Attachment 2: Sample Process for Conducting the Assessment

Synthesize and use the findings

- Review the findings
- Remember the purpose and intent – make decision about needed resources, including direct care staff needs as well as their capabilities to provide services and support to residents; identify opportunities for improvement
- Work through the suggested questions
 - What has changed with our population?
 - Do we need to make any changes to staffing?
 - How do we know if we have sufficient staffing?
 - What training, education competency needs do we have?
 - How can we better collaborate with medical practitioners?
 - Any infection control issues?
 - Any Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement (QAPI) opportunities?
 - Does our budget include the resources we need?



Attachment 2: Sample Process for Conducting the Assessment

Evaluate your process and plan for future assessments

- Be prepared to respond to surveyor questions listed in the interpretive guidance
- Debrief with your team: what went well, what can we do differently next time?
- Establish a process for updating the assessment



What's Next

- Nursing homes can use or adapt this optional tool
- CMS: “Due to the significant variations in the types of LTC facilities, resident populations, and resources among the LTC facility facilities, we believe that the facilities need the flexibility to determine the best way for each facility to comply with this requirement...and conduct that assessment, as long as it addresses or includes the factors or items set forth in § 483.70(e).” We have not required any specific methodology for facilities to use for the facility assessment.”
- Experience and feedback: As nursing homes conduct their assessments, we expect to learn more about what has worked best for them, and hope this information will be shared among homes, and long term care stakeholder groups



Frequently Asked Questions - State Operations Manual Appendix PP Revisions

CMS Subject Matter Experts



§483.12 Freedom from Abuse, Neglect, and Exploitation

What are the Different Requirements for Reporting of Suspected Crimes v. Alleged Violations?

	Suspected Crimes	Alleged Violations
What	Any reasonable suspicion of a crime against a resident	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigations of alleged violations
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	SA and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	The facility administrator and to other officials in accordance with State law, including to the SA and the adult protective services where state law provides for jurisdiction in long-term care facilities
When	Serious bodily injury- Immediately but not later than 2 hours after forming the suspicion No serious bodily injury- not later than 24 hours	All alleged violations-Immediately but not later than 1) 2 hours- if the alleged violation involves abuse <u>or</u> results in serious bodily injury 2) 24 hours- if the alleged violation does not involve abuse <u>and</u> does not result in serious bodily injury. Results of all investigations of alleged violations- within 5 working days of the incident



§483.12 Freedom from Abuse, Neglect, and Exploitation

What is the Definition of Serious Bodily Injury?

- “Serious bodily injury” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse (See section 2011(19)(A) of the Act)



§483.15 Admission, Transfer, and Discharge

Facility-initiated and resident-initiated transfers and discharges:

- “Facility-initiated transfer or discharge”: A transfer or discharge which the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences
- “Resident-initiated transfer or discharge”: Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment)



§483.15 Admission, Transfer, and Discharge

Sending copy of transfer/discharge notice to ombudsman:

- Applies to facility-initiated discharges
- For emergency room transfers, may send notice to ombudsman when practicable such as in a list of residents on a monthly basis
- Notice of transfer or discharge not required for resident-initiated discharges



§483.15 Admission, Transfer, and Discharge

Is a resident's transfer or discharge facility- or resident-initiated?

- For a transfer or discharge to be considered resident-initiated:
 - “The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care.” (F623 guidance)



§483.21 Comprehensive Resident Centered Care Plans

How can providers meet the 48 hour requirement if admission occurs on the weekend?

- The regulations do not specify how to create the Baseline Care Plan (BCP); Facilities will have to devise a process that ensures new admissions have their BCP done within the required 48 hours. It may be necessary for BCP to be developed over the course of several shifts

E.G., New admission at 11:40 pm on Friday – BCP complete by 11:40 pm on Sunday.



§483.21 Comprehensive Resident Centered Care Plans

What must be included in the BCP?

483.21(a) states, "...The BCP must—

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to –

- (A) Initial goals based on admission orders
- (B) Physician orders
- (C) Dietary orders
- (D) Therapy services
- (E) Social services
- (F) PASARR recommendation, if applicable"

It is expected that the admission orders will be used, along with information gathered by the admitting nurse, which will include input from the resident or representative.



§483.21 Comprehensive Resident Centered Care Plans

Can the BCP be written before admission, or before talking to the resident?

- It may be possible to begin development of parts of the BCP before the actual admission based on information received from the transferring provider, however, the information must be verified by the admission orders and admitting nurse's observation and interview of the resident



§483.21 Comprehensive Resident Centered Care Plans

Is a verbal summary of the BCP acceptable?

- The guidance at F655 states, “The facility must provide the resident and the representative, if applicable, with a written summary of the baseline care plan...”



§483.45 Pharmacy Services

Two separate requirements for As-Needed (PRN) orders for:

- Psychotropic medications
- Anti-psychotic medications

Psychotropic medications include, but are not limited to, medications in the following categories:

- Antipsychotic
- Anti-depressant
- Anti-anxiety
- Hypnotic



§483.45 Pharmacy Services

From interpretive guidance at F757/F758:

Type of PRN Order	Time Limitation	Exception	Required Actions
PRN orders for psychotropic medications, excluding antipsychotics	14 days	Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order.	Attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate a specific duration.
PRN orders for antipsychotic medications only	14 days	None	If the attending physician or prescribing practitioner wishes to write a new order for the PRN antipsychotic, the attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.



§483.45 Pharmacy Services

Evaluation of resident before writing a new PRN order for antipsychotic medication:

- The attending physician or prescribing practitioner must directly examine the resident and assess the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed
- The attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record:
 - Is the antipsychotic medication still needed on a PRN basis?
 - What is the benefit of the medication to the resident?
 - Have the resident's expressions or indications of distress improved as a result of the PRN medication?



§483.60 Food and Nutrition Services

Qualified Dietician

A qualified dietitian or other clinically qualified nutrition professional is one who—

- Holds a bachelor's or higher degree;
- Completed at least 900 hours of supervised dietetics practice;
- Is licensed or certified as a dietitian or nutrition professional by the State; and
- Meets the requirements of education and experience of §483.60(a)(1)(i) and (ii).

Note: If you were hired before Nov 28, 2016, you have 5 years to meet these requirements.



§483.60 Food and Nutrition Services

483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services

Designated persons include:

- A certified dietary manager (or)
- A certified food service manager (or)
- Someone who has similar national certification for food service management and safety from a national certifying body (or)
- Someone who has an associate's or higher degree in food service management or in hospitality, if the course study includes food services or restaurant management, from an accredited institution of higher learning.

Note: These designees must receive frequent scheduled consultations from a qualified dietitian or other qualified nutritional professional.



§483.75 QAPI

What needs to be in place now?

A QAA committee which –

- Is composed of:
 - Director of Nurses;
 - Medical Director (or designee); and
 - 3 other staff, one of which must be Administrator, owner, board member or other individual in leadership role.
 - Infection Control & Prevention Officer - effective 11/28/19
- Meets at least quarterly and as needed to:
 - Identify which QAA activities are necessary, and
 - Develop & implement appropriate plans of action to correct identified quality deficiencies.



§483.75 QAPI

What changes will go into effect on November 28, 2017?

Present QAPI plan to state or federal surveyors -

- A QAPI Plan describes the process for conducting QAPI/QAA activities such as identifying and correcting quality deficiencies and opportunities for improvement
- The QAPI plan should be tailored to reflect the specific units, programs, departments, and unique population each facility services



§483.75 QAPI

Will CMS provide a template for the QAPI Plan?

- [QAPI Written Plan How-to Guide](#), developed by Lake Superior Quality Innovation Network for participants in the National Nursing Home Quality Care Collaborative
- Visit the [Nursing Home QAPI Website](#) for additional tools and resources



§483.80 Infection Control

Is documentation of the information we have provided and correspondence regarding our antibiotic stewardship policies and the practitioner's continued use of antibiotics without a valid cause enough for us to prove due diligence on the part of the facility?

- F881, Antibiotic Stewardship Program
- F757, Unnecessary Drugs



§483.80 Infection Control

Does the antibiotic stewardship program apply only to the use of antibiotics or would such a program also apply to the use of antifungals and antivirals, which would be included under the broader title of an “antimicrobial stewardship program”?

Does the program apply to all formulations of antibiotics (e.g., ophthalmic antibiotics, topical antibiotics)?

- Antibiotics
- All formulations



§483.80 Infection Control

Does an Infection Preventionist (IP) have to be certified and by what date is this required?

- The role and qualifications of the IP are effective November 28, 2019
- The IP must be qualified by education, training, experience or certification



Question & Answer Session



Resources

- Visit the [CMS Survey and Certification – Nursing Homes](#) webpage
- Contact us at NHSurveyDevelopment@cms.hhs.gov



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