LeadingAge Florida LINK Articles
Volume 25, December 1, 2017 – November 30, 2018

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REGULATORY – LeadingAge LINK, Volume 25, Issue 49, Nov. 30, 2018

Nursing Home Staff Competency Assessment Toolkit

It's important that you be made aware that this week the Center for Medicare and Medicaid published the first of three planned toolkits as part of its continued commitment to help reduce adverse events, improve staffing quality and improve dementia care in nursing homes.

Toolkit 1: Nursing Home Staff Competency Assessment: The competency assessment is a tool to help nursing homes break down and self-examine some of the most important building blocks of quality care. The competency assessment can be used to identify areas where your nursing home is doing well, versus where your facility might need support.

In the toolbox are three competency assessment areas. They are the CNA assessment, LPN and RN assessment, and management assessments for DON, ADON and Administrator.

The assessments pose questions about behavioral, technical and resident-based competencies and should be completed as needed. The toolkit can support your nursing home's existing learning and development standards of practice. The toolkit also includes an Instruction Manual to support managers in implementing the assessment. The guide provides resources, including videos, talking points, an email memo, a poster, an assessment completion tracker, a manager's guide to meeting one-on-one with staff, and an assessment results worksheet to compile and analyze results.

Click here to view the various CMS assessments.

REGULATORY – LeadingAge LINK, Volume 25, Issue 48, Nov. 16, 2018

Upcoming Changes in Reimbursement

On Wednesday of this week Linda Kirk, President & CEO of Lutheran Haven Retirement Community hosted LeadingAge Florida members at a workshop on changes in the ways nursing homes will be reimbursed by Medicaid and Medicare in the future.

A highlight of the presentation by Boris Kushnir of Moore Stephens Lovelace, P.A. on Medicaid reimbursement changes is now reimbursement will be price-based rather that the current cost-based system. One important take-away from this presentation is that there will be two peer group price based-rates and all facilities within a group will be paid the same base rate per day. The two peer groups are North, which includes SMMC regions 1-9, less Palm Beach & Okeechobee and South, which includes regions 10-11, plus Palm Beach & Okeechobee. The key components of Medicaid reimbursement are Cost, Quality, Fair Rental Value, Add-ons, and Pass-thrus.

I discussed the quality measure component of the new Medicaid reimbursement plan and reviewed how Medicaid determined the points for each measure and how improvement of your quality measures may, if the funding of this component continues in the future, positively impact the dollar reimbursement received per Medicaid resident per day. The key takeaway from my presentation is that you need to understand how CMS determines your quality measures, make sure you have a full understanding of how the measures are triggered, and find ways to improve these outcomes. Current reimbursement per quality point is $1.23 per Medicaid patient per day and is based on a 40-Point System. The current minimum threshold to qualify for quality points is 10.5 points.

Boris and Jennifer Leatherbarrow of Richter Healthcare reviewed the proposed change from the current prospective payment system of reimbursement by Medicare to the patient-driven payment model (PDPM). The proposed 2019 change removes therapy minutes as the basis for payment and is designed to provide more equitable resources to facilities treating vulnerable populations by making payment dependent on a wide range of clinical characteristics.

Both of these changes in reimbursement methodology reflect a shift from cost reimbursement to a system of patient-driven reimbursement based on the quality of care and services you provide to your residents. Because the PDPM system was designed to be budget-neutral there will be winners and losers. Our commitment is to ensure that all of our LeadingAge Florida members are winners!

I wanted to again thank Linda Kirk and her staff for their hospitality in hosting our group. Not only did they provide us with a well-equipped meeting room, they served us a wonderful lunch while at the same time her team was preparing 1400 Thanksgiving meals for persons in their community.

REGULATORY - LeadingAge LINK, Volume 25, Issue 47, Nov. 9, 2018

PATIENT-DRIVEN PAYMENT MODEL WORKSHOP - NOV. 14

Please join Boris Kushnir of Moore Stephens Lovelace, P.A., Jennifer Richter of Richter Healthcare, and me for a six-hour workshop at Lutheran Haven Retirement Community on Wednesday, November 14th.

We will be training on the motivation behind the change from the perspective payment system of reimbursement by Medicare to the patient-driven payment model (PDPM) as well as the details of the rate components related to diagnosis/conditions, case mix index, and adjustment factors. We will be discussing current practices and strategies around length of stay and MDS assessment to have optimal impact with PDPM.

We will also be discussing the quality measure component of Medicaid reimbursement and how Medicaid determines the points for each measure and how improvement of your quality measures can positively impact the dollar reimbursement you receive per Medicaid resident per day. Strategies on how you can make improvements in the area of your quality measures will be discussed for each of the eight measures Medicaid uses to determine reimbursement.

Both of these changes in reimbursement methodology reflect a shift from cost reimbursement to a system of patient driven reimbursement based on the quality of care and services you provide to your residents. Because the PDPM system was designed to be budget-neutral there will be winners and losers. Our commitment is to ensure that all of our LeadingAge Florida members are winners!

Our goal with this workshop is to assist you in being better prepared to succeed in the new reimbursement environment, and we encourage nursing home administrators, directors of nursing, MDS coordinators, physical, occupational and speech therapists, as well as billing and coding staff to attend this workshop.

REGULATORY – LeadingAge LINK, Volume 25, Issue 46, Nov. 2, 2018

KNOW YOUR NUMBERS:

There are more numbers to know than how many stars you have. CMS, the public and payers have access to a lot of information about the performance of your facility....you should know what these measures are. They include staffing, quality measures, quality claims measures, quality reporting program as well as Medicaid quality performance measures.

Here is where you find your numbers. For the CMS health inspection, staffing and quality of resident care measure you can download the CMS database. Once you reach the data download site, you can select specific reports. For example on page one are download reports by category such as Health Deficiencies and MDS Quality Measures. On page two are reports for the Medicare Quality Claims measure, staffing, short-stay and long-stay quality measures as well as Star Rating. You have the ability to filter the data in each of these reports in a number of different ways, however to see your facility specific measures filter the data by your Medicare Provider number.

It's also important to know how the Florida Medicaid program determines the payment incentive portion of your patient day reimbursement. The quality measures being used for the 2019 Medicaid reimbursement were based on May 2018 CMS data. You can use the following chart to determine your current points.

Measure	50th Percentile	25th/75th Percentile	90th/10th Percentile	Type
Flu Vaccine	96.74%	99.00%	100.00%	Process
Antipsychotic	13.92%	9.45%	5.06%	Process
Restrained	0.00%	0.00%	0.00%	Process
UTI	2.34%	1.25%	0.39%	Outcomes
Pressure Ulcers	5.56%	3.72%	2.25%	Outcomes
Falls	2.61%	1.53%	0.84%	Outcomes
Incontinence	54.05%	43.89%	33.91%	Outcomes
ADL	12.86%	9.52%	6.86%	Outcomes
Staffing (Combined Licensed and CAN)	3.99	4.27	4.66	Structure
CMS 5 Star	3	4	5	Structure
Gold Seal				Structure
ACT SW Staffing	1.48	1.90	2.72	Structure

Knowing your numbers helps you understand how you compare with other facilities and gives you areas of needed improvement as well as areas of excellence.

REGULATORY – LeadingAge LINK, Volume 25, Issue 45, October 26, 2018

More Quality Measures Published

October 24, the Centers for Medicare & Medicaid Services (CMS) released new quality measures developed from information submitted through the Quality Reporting Program (QRP). These measures provide results for the quality and resource use measures for residents who receive skilled care in nursing homes under the Medicare Part A benefit. The measures demonstrate how a SNF's performance on SNF QRP quality measures compares to that of others SNF's in their state as well as to the national average.

There are five new SNF QRP quality measures that have been added to Nursing Home Compare. Although some measures appear to be similar to others already published, remember these are for Medicare Part A beneficiaries only and are calculated from MDS data as well as claims data submitted to CMS. These new SNF QRP measures are as follows:

- Percentage of residents that developed new of worsened pressure ulcers.
- Percentage of residents whose activities of daily living and thinking skills were assessed and related goals were included in their treatment plan.
- Percentage of SNF patients who experience one or more falls with major injury during their SNF stay.
- Medicare spending per beneficiary (MSPB) for residents in SNF's.
- Rate of successful return to home or community from a SNF.

CMS has chosen not to publish the 6th quality measure for potentially preventable, 30-day post-discharge readmission at this time as they determined there was a need for additional testing of the measure.

These measures along with a comparison to state and national performance can be found in the quality measure section of your facility on Nursing Home Compare. I highly recommend you look at your numbers. It can give you an opportunity to announce your numbers if they are excellent or will show you areas to improve. Remember many others will be looking at your numbers.

REGULATORY – LeadingAge LINK, Volume 25, Issue 43, Oct. 19, 2018

New State Tag K-1150 NFPA 99 Chapter 13

We learned at the joint training that the AHCA Life Safety team will begin surveying facilities for compliance with the new security management section of NFPA 99 (2015) found in chapter 13. The regulation requires health care facilities to have a security management plan in place which allows facilities to identify a comprehensive list of issues that their facility is at risk for and to develop solutions for protection from each threat.

More specifically the regulation requires each facility to complete a security vulnerability assessment (SVA) that evaluates the potential security risks posed by the physical and operational environment of the facility to all individuals in the facility.

It also requires the facility to implement procedures and controls in accordance with risks identified by the SVA as well as having a person(s) appointed by the leadership of the health care facility to be responsible for all security management activities. In addition there are a list of required duties of the responsible person which are very comprehensive in nature and include training, drills and evaluation of the effectiveness of the security vulnerability assessment

Just as emergency preparedness has become more important, so has security.

REGULATORY – LeadingAge LINK, Volume 25, Issue 43, October 5, 2018

Achieving maximum points for reducing antipsychotic medication use.

As covered in, the September 7 ***LeadingLINK*** newsletter, almost ninety percent of our members are receiving zero points for the quality measure which tracks the number of long-stay residents who received antipsychotic drugs in the MDS target period during a seven-day look-back.

I have been reviewing how facilities are reducing the use of antipsychotic medications and have found one common theme among all of them. They have found ways to keep their residents meaningfully engaged through increasing focus on individualized care, understanding what triggers discomfort and how unmet needs are communicated, and adding meaningful and pleasant experiences throughout the day. Some of these interventions include pets for residents, calming environment, consistent staff assignments and using technology (ex. iPads).

Dementia training and staff development are essential to help daily caregivers understand how they can change what they do to get different results. Seemingly simple adjustments in communication styles, care approaches, and daily routines often result in positive changes in behavior. The main ideas are to simplify tasks and communication, use the person's history as a guide, and avoid "confronting" the person with what they are unable to remember. Breaking tasks and instructions into "doable" steps, using physical and verbal cues, and accepting "misbeliefs" as real to the person (using validation vs. reality orientation) can make a huge difference.

I remember years ago when we said we were going to reduce the use of restraints in nursing homes and some thought it was not possible, but now you rarely see a restraint being used in a long-term care facility. Some say we can't reduce the use of antipsychotics, but facilities are beginning to show a dramatic reduction in the use of this type of medication.

We will discuss this quality measure and the other seven quality measures at our upcoming training on November 14.

REGULATORY – LeadingAge LINK, Volume 25, Issue 42, Sept. 28, 2018

MDS Changes Effective October 1

There are a number of important changes happening to the MDS on October 1, 2018, some of which give a glimpse into how CMS is going to use the data for its new self-care quality measure as well as a glimpse into how diagnostic categorizations outlined upon admission will frame the proposed patient driven payment model (PDPM) reimbursement model moving forward. The most significant of the changes are:

Section GG: Functional abilities and goals added 36 new items. The item added which carries the most impact relates to the self-care score and mobility scores that will be required for the quality measure that compares the admission score to discharge score to identify a change in self-care and mobility.

Section I: Active Diagnoses. A new item I0020 was added which indicates the resident's primary medical condition category and primary reason for admission to the SNF. This new item has been added to prepare for the potential changes in the prospective payment system (PPS) to the new patient driven payment model (PDPM).

Section J: Health Conditions. A new item was added regarding major surgeries prior to admission. Again, this look likes CMS is using this item as a risk adjustment in the new self-care quality measure.

Other changes were made to the MDS section C1310 Delirium; section M Skin Conditions; section N Medication; and section O Special Treatments, Procedures and Programs. I encourage you to have your staff listen to the **CMS recorded session** on the changes to the MDS.

REGULATORY – LeadingAge LINK, Volume 25, Issue 41, Sept. 21, 2018

Achieving Maximum Points for Falls with Injuries

As covered in the September 7 LeadingLINK newsletter, more than half of our members are receiving 0 points in the quality measure for falls. This measure is a "look-back" scans measure. If the resident had one or more falls with a major injury on one or more of the look-back scan assessments, the measure will be triggered. The measure triggers if at any time during a one-year period the event/condition occurred. For this measure, the fall history is obtained with a look-back of up to six months prior to admission.

The key to receiving three (3) points for this measure is to recognize all residents are at risk for falls, and that fall interventions should be put in place upon a resident's admission. The following can help reduce falls with major injuries:

1. Hourly rounds on residents especially the first three days of admission and the days before discharge. Both of these timeframes are high risk for residents.
2. Prompted toileting can help prevent falls with injuries for resident who fall while trying to independently toilet.
3. Assessing why a resident falls and identifying individual resident care plan approaches to prevent the resident from repeat falls.
4. Keeping residents meaningful engaged can help prevent falls.
5. Completing bedside “fall rounds” with an interdisciplinary team gives the opportunity to observe the resident’s environment and determine why the resident fell. This can help identify interventions specific for that resident to prevent repeat falls.
6. Engage family members to assist with reinforcing the need for the resident to ask for assistance before getting up.
7. Ensuring there are footrests on any wheelchair transporting a resident.

Preventing falls with serious injuries must involve all employees, residents and family members. You can look at which of your residents are triggering the falls measure by accessing the data found in your facility's shared folder in CASPER. Both the Public Reporting Preview and Public Reporting Resident Report contain your quality measures, as well as the list of residents used to determine the measure.

REGULATORY – LeadingAge LINK, Volume 25, Issue 40, Sept. 14, 2018

Medicaid Quality Points

As reported in my article last week, more than half of our members are receiving 0 points in the quality measure for incontinence. This measure reports the percentage of low-risk residents who lose control of their bowel or bladder in a seven-day look-back period.

Residents will trigger this measure if the most recent Minimum Data Set (MDS) H0300/H0400 is coded as "frequently" or "always incontinent." The numerator for this measure is those residents who were coded as either 3 or 4 under either or both H0300 and H0400. The denominator for this measure is all those with the selected target assessment, except those with exclusions.

The key to achieving 3 points in this area is to ensure a resident assessed on admission as continent should remain continent, unless s/he has an exclusion.

It is important to accurately assess a resident's continent status on admission. This includes evaluating the resident's elimination patterns for at least three days. If a resident is at risk of losing the ability to toilet independently (for example, due to a resident's inability to access the toilet), interventions should be put in place to assist the resident to remain continent.

You can look at which of your residents are triggering the incontinence measure by accessing the data found in your facility shared folder in CASPER. Both the Public Reporting Preview and Public Reporting Resident Report contain your quality measures, as well as the list of residents used to determine the measure.

REGULATORY – LeadingAge LINK, Volume 25, Issue 39, Sept. 7, 2018

More on Quality Points

Effective October 1, 2018, Florida Medicaid will convert nursing home providers from a cost base reimbursement to a prospective payment system (PPS) for services rendered to Medicaid residents. One of the components of the new PPS is a quality incentive recognizing facilities that demonstrate high quality of care. The quality measures Medicaid has chosen are taken from the federal Centers for Medicaid and Medicare Services' (CMS) quality measures, and points are determined by where the facility ranks within the quality incentive model.

I have been able to review the quality points of members that Medicaid will be using to determine reimbursement for performance, and found that there is opportunity for us to work together to improve the quality measures, thus, improving quality care of our residents. The following is a brief analysis of the points Medicaid is using to reimburse our members through the PPS. Facilities can receive between 0 and 3 points, based on their CMS quality measure performance.

Measure	% Receiving 3 points	% Receiving 0 points
Flu	59%	37%
Antipsychotics	10%	42%
Restraints	90%	6%
UTI	6%	42%
Pressure Ulcer	17%	32%
Falls	10%	51%
Incontinence	8%	51%
ADL	8%	47%

Each week, for the next eight weeks, I will be focusing on ways facilities can improve their quality measure performance and, in turn, increase their opportunity to achieve a greater portion of the quality measure incentive offered to those providing care to Medicaid residents.

REGULATORY – LeadingAge LINK, Volume 25, Issue 38, Aug. 31, 2018

Medicaid Quality Points

Achieving 24 Medicaid quality points is important for all facilities, not just those with Medicaid days. The eight measures that determine the 24 points are as follows:

1. Offering residents the flu shot;
2. Proper use of an antipsychotic;
3. Not using restraints;
4. Preventing an urinary tract infection;
5. Preventing an in-house pressure sore from worsening and preventing new pressure sores from occurring;
6. Preventing falls resulting in serious injuries;
7. Helping residents remain continent; and
8. Preventing a decline in activities of daily living (ADLs).

All of these measures represent good care for a resident, and LeadingAge Florida wants to help all our members achieve all 24 quality points. On November 14, 2018, I will be training with Boris Kushnir, Senior Manager at Moore Stephens and Lovelace, P.A., in Orlando. At this training, we will discuss both the financial and clinical aspects of the Medicaid quality points. You may visit the LeadingAge Florida website calendar to register for this important education session when it becomes available.

REGULATORY – LeadingAge LINK, Volume 25, Issue 37, Aug. 24, 2018

Protect Your Stars

It isn't easy to achieve both the federal and State of Florida five star rating; so, I know you want to do everything you can do in order to protect your stars. What follows are my suggestions to ensure you keep your stars:

- **Have a good survey.** With a 'D' deficiency counting as four (4) points and an 'F' deficiency as 16 points, you can easily lose a star for just the survey. While CMS has placed a freeze on the Health Inspection ratings through February 2019, they are gathering data from surveys conducted under the new F-tags and will base your facility's new star rating using different criteria. The rating will be based on the scope and severity point system already in place; however, the distribution of points has changed and will be using 60% of the points for the most recent survey and 40% of the older survey after November 28, 2017.
- **Make sure you capture all your hours on the PBJ.** Many facilities were surprised to lose a star for staffing after the Payroll Based Journal (PBJ) was used to determine the staffing star. To ensure you don't lose a staffing star, conduct on going audits of your PBJ hours - making sure you've captured all your hours, that you have eight (8) hours of RN each day, and that your overall hours exceed Florida's required staffing hours for each day. Audit to make sure discharge assessments are completed on a timely basis to reflect the census that's tied to your staffing hours.
- **Review your quarterly Five Star Quality Metrics Report.** Every quarter, LeadingAge Florida sends you a Five Star Quality Metrics Report that shows your current quarterly star status and your potential to gain or lose stars. I suggest reviewing this report each time you receive it.
- **Keep current with all the changes.** Regulations change and clinical practice changes. LeadingAge Florida is committed to help you keep current by offering webinars, workshops and providing important information in the weekly *LeadingLink* newsletter.

Please feel free to contact me if I can help you to protect your stars.

REGULATORY – LeadingAge LINK, Volume 25, Issue 36, Aug. 17, 2018

Update from AHCA's Kim Smoak

At LeadingAge Florida's 55th Annual Convention, Kimberly Smoak, Chief of the Bureau of Field Operations, Division of Health Quality Assurance, at the state Agency for Health Care Administration (AHCA), spoke at the nursing home roundtable. Below is a summary of the information she shared with those who attended that session:

- The life safety surveyors will be at the upcoming AHCA Joint Trainings. Kim requested that facilities send to the training(s) those staff persons responsible for life safety and the federal emergency preparedness plan at your facility.
- Compliance with the E-regulations for emergency preparedness is a concern. Kim reviewed the top E-tags being cited. This is why compliance with the E-regulations will be discussed at the trainings.
- Kim suggested all facilities sign up to receive the AHCA alerts.
- The federal Health and Human Services Department Inspector General's Office (HHS/IG) is conducting an audit in Florida concerning possible abuse/neglect. HHS/IG is reviewing the diagnosis of residents transferred from a nursing home to the hospital. Depending on the diagnosis, they may request - by letter - the records from the nursing home. Kim told our members to send the records, and that if a facility does not send the records, HHS/IG will visit the facility to obtain the records.
- She also reminded members to communicate with their local AHCA office regarding any questions they may have, other agencies who contact your facilities for records or that make onsite visits, or for any other reasons/concerns.

As always, we appreciate Kim speaking at the Annual Convention, as we all have the same goal - compliance with the regulations so that all of our members' residents continue to receive quality care and services.

REGULATORY – LeadingAge LINK, Volume 25, Issue 35, Aug. 10, 2018

Don't Lose Your Staffing Stars!

The August 14, 2018, deadline for submitting your payroll hours for the quarter ending June 30, 2018, is fast approaching. It's important to ensure you capture ALL of your nursing hours--including those worked by outside contract personnel. You need to be sure to report at least eight (8) hours a day of RN hours, excluding meal times.

Also remember that CMS (the federal Centers for Medicaid and Medicare Services) calculates the census based on the minimum data set or MDS. Facilities that do not complete the MDS discharge assessments on a timely basis, or that have residents on a bed hold, risk the over counting of residents. While you may base nursing hours on your "heads in the bed," CMS is counting hours based on your active MDS.

You have the ability to review the actual hours that CMS is using to calculate your star rating. This can be done through the Certification and Survey Provider Enhanced Reports (CASPER) folder, which provides feedback on all of your submissions for the quarter. We encourage you to run the CASPER reports "1700D Employee Report," the "1702D Individual Daily Staffing Report" and the "1702S Staffing Summary Report," and submit any corrections prior to the August 14, 2018, deadline.

If you find issues within these reports and need assistance, contact the Payroll Based Journal (PBJ) help line via email or phone at 1-(877) 201-4721; also, you may contact me via email with any questions or for additional assistance.

REGULATORY – LeadingAge LINK, Volume 25, Issue 34, July 27, 2018

Restorative Care

Over the many years I have worked in long-term care, I have visited thousands of facilities. One of the distinctions that I always notice is how a facility implements its restorative care program.

Restorative care programs are any intervention that helps a resident be more independent, or maintain a resident's functioning level, or that slows down anticipated decline.

Facilities that began restorative care programs on admission and carried out programs for all residents always seemed different. As I watched residents ambulating down hallways with walkers or using adaptive equipment to eat, I felt a sense of hope. And, I knew the residents had hope that they could gain some independence back or, at least, delay inevitable decline based on their diagnoses.

Sometimes restorative care are just the simple things - giving time for a resident to complete a task, or giving providing some food that can be eaten independently. These programs should be carried out by all staff, not just one or two "restorative" care CNAs.

If a facility wants to record the restorative care program on the MDS, it must be (1) carried out for at least 15 minutes, (2) be on the care plan, (3) be periodically evaluated by a nurse and (4) staff must be trained to carry out the program.

It takes commitment to fully implement a restorative care program; however, it is so worth the effort

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REGULATORY – LeadingAge LINK, Volume 25, Issue 33, July 20, 2018

What I Know - Keep Current with Regulatory Changes and Clinical Practice

This week, I am continuing my “What I Know" article series.

What I know is how important it is to keep current with changes in regulations and clinical practice.

Looking back over the last 20 years, there have been so many changes. Just imagine the consequences if a facility hadn’t kept current with regulatory and clinical changes. Staff may still be using restraints, full side rails, geri-chairs, a high number of antipsychotics, tray service in the dining room, doing UAs for residents who fall, etc. There are new regulations in critical areas, such as patient rights, quality of care and quality of life, plus updates to state-mandated staffing levels. And, who can forget the increase in assessment requirements as covered by the MDS, the requirement to have a risk manager and, soon, an infection preventionist. More recently, facilities were required to meet the new federal emergency preparedness requirements found under the new E tags! Today, we’re dealing with new regulatory changes that include antibiotic stewardship programs and, on the horizon, changes in reimbursement for therapy.

The survey has changed many times during the last 20 years. Instead of just checking a facility's policies and procedures, surveyors are observing and interviewing the residents, and arriving at compliance decisions based on the outcomes of care.

We, at LeadingAge Florida, are committed to help you stay current with regulatory and clinical changes. Let us know how we can help you and your staff. And, I hope to see you at the convention!

REGULATORY – LeadingAge LINK, Volume 25, Issue 32, July 13, 2018

Looking Forward to Seeing You at the LeadingAge Florida Annual Convention

This week, I want to encourage you to attend our 55th Annual Convention and Exposition later this month. Your attendance is important for many reasons.

You can earn up to 14.5 continuing education units (CEUs), which includes the mandatory two-hour Medication Error Update and the two-hour Preceptor refresher to help fulfill your continuing education requirements. Also, you will meet colleagues from throughout the state, who share your passion for and struggles of caring for your residents. You will see old friends and meet new ones.

At our Nursing Home Roundtable session on Thursday, August 1, you can hear about the Agency for Health Care Administation's (AHCA) survey activities from Kim Smoak, AHCA's chief of the Bureau of Field Operations in the Division of Health Quality Assurance; and you can ask me regulatory and survey questions.

In our Exhibit Hall, you can visit more than 140 exhibitors, offering cutting-edge technologies, products and services that can help you in your work.

And, I have donated more African art and baskets for the Silent Auction; plus, there will be many other great items on which you can bid and WIN. Proceeds from the auction benefit the Scott Boord Career Development Scholarship Fund that provides LeadingAge Florida member communities with an opportunity to send eligible staff to LeadingAge Florida or LeadingAge National educational conventions, workshops and seminars.

I hope to see you at the Convention!

REGULATORY – LeadingAge LINK, Volume 25, Issue 31, July 6, 2018

This I Know - Care Plans are Important

When surveyors assess the care and treatment of a resident, they look to the care plan. They look to see if a resident's problem has been properly identified; if measurable and achievable goals have been developed; if interventions have been developed to help the resident meet those goals; and if those interventions have been implemented.

Sometimes, it seems that staff write care plans out of obligation. The care plan should be a simple document that identifies real problems, along with real solutions, and should be relevant at all times. The whole purpose of the care plan is to assess the resident's problem and come up with objective and creative ways to help the resident with solving the problem. A good way to identify the actual problem is to keep asking why until the problem surfaces. A resident's problem cannot be properly addressed if it is not properly identified.

Once the problem is ascertained, developing the rest of the care plan is easy because *the goal should always be the opposite of the problem statement*. For example, a resident is experiencing anxiety and dementia is identified as the problem. The opposite of dementia is "no dementia," which is an impossible goal. The *real* problem is that the resident cannot find his/her room; this causes the anxiety. So, the goal should be to help the resident find his/her room. Once the goal is established, then the care plan can contain an intervention that helps solve the problem for the resident. Once the problems have been identified and interventions have been put in place, the care plan document should be used by everybody, so they know how to help the resident solve an identified problem.

This I know: care planning is an important process that can improve resident care and assist a facility in achieving a deficiency-free survey.

REGULATORY – LeadingAge LINK, Volume 25, Issue 30, June 29, 2018

This I Know - Consistent Staffing Improves Care

When I had my first nursing job, I learned a valuable lesson.

I was the head nurse in a nursing home that cared for children who were very medically fragile. All of the children had very individualized needs, i.e., their positioning, feeding, suctioning and even holding them. The facility would rotate the CNAs and the nurses. It was almost impossible for staff to know the individual care needs of each child.

In an effort to improve care of the children, we created teams of children and then "permanently" assigned staff to a team. We did this for full- and part-time staff, so the children always had a caregiver who knew how to meet their special needs. Not only did care improve, but staff satisfaction with their jobs also improved. Families were happier with the care their children received. Staff attendance improved and they were more efficient in their work, mainly because they could appropriately plan their work since they knew what the children needed.

Over the years, I have found more and more facilities focusing on care for the elderly use a staffing model that provides for consistency of staff assignments. As a result, the care of the elderly resident is improved, with as it was back when I was working with the children.

This I know: consistent staffing improves care.

REGULATORY – LeadingAge LINK, Volume 25, Issue 29, June 22, 2018

What I Know - Rounding is Essential

In continuing this series, titled “What I know,” I want to talk about rounding. Rounding is essential to maintain compliance, build an effective work force and even, to ensure a good census.

All staff should round. The Administrator should round daily, seeing all residents and visiting all common and auxiliary areas. The Director of Nursing also should round, seeing all residents and interacting with families who are visiting. Unit Managers should round twice a day - at the beginning and end of the shift.

Department Managers should round daily in their respective areas. Specifically in the kitchen, it can be difficult as is to maintain compliance. I recommend that the person who turns on the lights in the morning do thorough rounds, checking refrigerators/freezers, dry storage, logs, dumpster, etc. Then, the last person who leaves the kitchen in the evening should repeat the same.

Staff should know that they are rounding to ensure compliance with regulations and safety, infection control, and satisfied residents and families. And, they should know how to immediately correct any issues noted. Training and in-services should be scheduled when repeated problems are found. Rounding also provides a great opportunity to catch staff doing things right, so they can receive positive reinforcement from you.

REGULATORY – LeadingAge LINK, Volume 25, Issue 28, June 15, 2018

What I Know...

After more years working in long-term care than I choose to share; and after being a provider, regulator and consultant, visiting more than 3,000 facilities in 30-plus states; I have, as they say, “learned a thing or two.” In the next several issues of the *LeadingLink* newsletter, I plan to share some of these things with you in a series I am calling "What I Know." I also will ask some leaders in our Association what they know, sharing those things with you, as well.

I begin today with what I believe is one of the most important things I know: focus on the regulations and not the survey. It is important for ALL staff to know the regulations. Your staffs need easy access - either via hard copy or electronically - to essential regulations. And, they need to understand how the regulations come from laws and how the interpretive guidelines explain the regulations.

All of your policies and procedures should reflect the regulations. Any system/tracking should ensure compliance with the regulations.

Also, staff should continually receive in-service training on and review of the regulations. This is important because staff can and should assist with ensuring your continual compliance all year long, and not just during the survey window.

"What I know" is that if you focus on the regulations, the survey will take care of itself.

REGULATORY – LeadingAge LINK, Volume 25, Issue 27, June 8, 2018

Infection Control Preventionist

Recently, I have received questions on requirements for the infection preventionist that facilities must have in place by Phase 3, effective November 28, 2019. According to 483.80(b), facilities are required to designate one or more individuals as the infection preventionist(s), with responsibility for the facility's infection prevention and control program. This person is not required to be in the position full-time. However, s/he must have primary professional training in nursing, medical technology, microbiology, epidemiology or other related field; be qualified by education, training, experience or certification; and have completed specialized training in infection prevention and control.

On March 16, the Centers for Medicaid and Medicare Services (CMS) released a memo indicating they are collaborating with the Centers for Disease Control (CDC) to develop a free on-line training course in infection prevention and control for nursing home staff in the long-term care setting. They anticipate this course will be available by spring 2019. Click here for a copy of the CMS memo. We will keep you updated as more information becomes available about the free on-line infection prevention and control training.

REGULATORY – LeadingAge LINK, Volume 25, Issue 26, June 1, 2018

Latest Update about Your Stars

Beginning with the April 2018 update of the Nursing Home Compare website and the Five-Star Quality Rating System, the Centers for Medicaid and Medicare (CMS) has replaced the existing staffing measures (derived from the CMS-671 form and case-mix based on RUG-III) with staffing reported through the payroll-based journal (PBJ) system, resident census derived from MDS assessments, and case-mix based on RUG-IV.

As you know, the rating system features an overall five-star rating based on facility performance for three types of performance measures, each of which has its own associated five-star rating. These domains are as follows:

- Health Inspections (measures based on outcomes from state health inspection surveys);
- Staffing (measures based on nursing home staffing levels reported through the payroll based journal); and
- Quality Measures [measures based on the CMS Minimum Data Set (MDS)].

CMS will not use deficiencies cited on Health Inspection surveys conducted on or after November 28, 2017, for a one-year period in calculating the health inspection rating for the Nursing Home Compare Five-Star Quality Rating System. However, because your ratings on both of the other measures are subject to change based on data submitted for the staffing and quality measures, there is the possibility of your overall star rating to change.

The technical user's guide effective April 2018 for the Five Star Quality Rating System can be found here.

REGULATORY – LeadingAge LINK, Volume 25, Issue 25, May 25, 2018

Under F689, Facilities Must Ensure Residents are as Free of Accident Hazards as Possible

This past week, we learned that a fire in a nursing home was caused by an overheated tablet charger that ignited and burned through the sheets, into the mattress of a resident's bed (see photo below). We were able to speak with the fire chief, who indicated the fire originated in the capacitor, which is the box where the cord from the computer and the cord for the electricity meet.

Due to the fire damage, the fire department was unable to determine if there was an issue with either of the cords or if the capacitor overheated. The fire chief indicated the tablet and cords were laying on the resident's bed on top of bedding and surrounded by work papers.

He emphasized that laptops, tablets and cell phone chargers should always be on a hard, non-flammable flat surface when charging, since bedding, pillows and blankets can easily block airflow, and trap heat, which can lead to combustion that normally would be dissipated by proper ventilation.

The device was an older model; perhaps, because of its age, there may have been excessive wear on the power cords and the charger, itself. The fire chief recommended that facilities inspect the power cords of all resident devices to ensure the cords are not damaged. Additionally, the chief advised that the facility provide training to staff on proper placement of units for charging, and ways to identify issues with power cords and chargers. Damaged or frayed cords should be discarded immediately, as well as any that are found with electrical tape on them. He also warned against overcharging devices and recommended disconnecting them from the power source once the device is fully charged.

If there is a fire caused by one of these devices, it can be extinguished using the ABC fire extinguishers found throughout your facility.

Although we could find no specific life-safety regulation that addresses inspection of device power cords, under F689, it is the responsibility of the facility to ensure that the resident environment remains as free of accident hazards as is possible.

REGULATORY – LeadingAge LINK, Volume 25, Issue 24, May 18, 2018

DOEA RELEASES FINAL ALF RULES (58A-5 FAC)

The state Department of Elder Affairs (DOEA) has released the final Assisted Living Facility Rule 58A-5, which became effective on May 10, 2018. These are the rules affecting assisted living facilities that were promulgated as a result of legislative changes to chapter 429, Part 1, Assisted Living Facilities, of the Florida Statutes.

There are numerous additions to the rule that include definitions, expanded services that can be provided by staff, and educational requirements as a result of these changes. To assist you with identifying changes to 58A-5, DOEA has highlighted those areas in the following document, 58A-5 AL Rule.

In addition, the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, has been revised and is now required to be used for all new admissions.

Since the rule became effective on May 10, all facilities will now be surveyed using the new rules. We suggest you review all the changes and begin using AHCA Form 1823 immediately. A word of caution: although additional services may be provided by unlicensed staff, there are additional training requirements found under 58-A.0191(6)(d) that must be met prior to allowing staff to do this.

REGULATORY – LeadingAge LINK, Volume 25, Issue 23, May 11, 2018

Third Most Cited Deficiency - F812

Since November 28, 2017, F812 may be the third most cited deficiency; however, with 29 of the 47 facilities being cited at an F level, it ranks number one in scope and severity.

Upon entrance to your facility, one of the first things the survey team will do is to send a surveyor into the kitchen. The Centers for Medicaid and Medicare Services (CMS) has made it clear that this is done at the time of entry so that the team member arriving in the kitchen can have an unannounced view of facility practices that are in place.

The deficiencies that have been cited mirror deficiencies that were cited prior to changes in the regulations. These citations may be avoided through rounding, follow up and consistent implementation of systems. Rounding should be done first, when facility staff arrives in the kitchen, and then the last thing staff does before they leave the kitchen. All dietary staff should know the regulations and correct anything that does not follow the regulations, i.e., uncovered food, pans not thoroughly cleaned, uncovered equipment, etc.

"Pitted, pitting, nesting, debris, caked, encrusted and chalky" are the words surveyors are using to describe the dietary deficiencies they are finding. The most frequently cited deficiencies include uncovered food not dated and labelled, use of hairnets/beard guards, and equipment not cleaned or cleaning schedule not followed. In addition, there was a citation for food prepared too early, lipped plates being damaged, drying pans with a dishtowel rather than letting them air dry, a worn and excessively gouged cutting board, insufficient portion size, and incorrect thermometer calibration.

Additionally, it’s important to point out that many of the citations found in the surveys could also be cited under F880 – infection control.

REGULATORY – LeadingAge LINK, Volume 25, Issue 22, May 4, 2018

Second Most Cited Deficiency - F656

The second most frequently cited deficiency since November 28, 2017 is F656, the failure to develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

The citations continue to be in the same areas as in the past however there appears to be a heightened emphasis on citations for not care planning resident refusal of services or treatments.

The new CMS interpretive guidelines reads "in situations where a resident's choice to decline care or treatment due to preference poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan. Additionally, a resident's decision-making ability may decline over time so the facility must evaluate the resident's decision making capacity and involve the interdisciplinary team and the resident's representative, if applicable, in the care planning process."

The top cited deficient practice at F656 indicate failure by the facility to do one or more of the following:
1. Develop a comprehensive care plan that includes measurable objectives, interventions and timeframes for how staff will meet resident's needs.
2. Implement and follow the plan of care that's been developed.
3. If a Care Area Assessment (CAA) is triggered, failure to further assess the resident to determine how the risk or need affects the resident.

REGULATORY – LeadingAge LINK, Volume 25, Issue 21, April 27, 2018

K-Tag 211: Fire Door Assembly Inspection and Testing

We understand some of our members are being cited for life safety K-tag 211 related to the annual fire door assembly inspection and testing. According to the Centers for Medicaid & Medicare (CMS) survey and certification memorandum 17-38-LSC, fire door assemblies are required to be annually inspected and tested in accordance with the 2010 National Fire Protection Association (NFPA) 80.

The inspection is not required for non-rated doors, such as corridor doors to patient care rooms and smoke barrier doors. However, it is the expectation that ALL doors will be routinely inspected as part of the facility maintenance program, as all required life safety features and systems must be maintained in proper working order.

It should be noted that inspections can be performed by employees of the facility, but they must have knowledge and understanding of the operating components of the type of door assembly being tested, in addition to meeting the definition of a "qualified person." NFPA defines a qualified person as follows: "who by possession of a recognized degree, certificate, professional standing, or skill, and who, by knowledge, training, and experience, has demonstrated the ability to deal with the subject matter, the work, or the project." Attached is a fact sheet containing NFPA resources that are available to assist you.

REGULATORY – LeadingAge LINK, Volume 25, Issue 20, April 20, 2018

Survey Preparedness, the #1 Cited Deficiency – F880 Infection Control

The most common infection control citations since November 28, 2017, have been in the following areas: hand hygiene; transmission-based precautions; wound care cross contamination; glucometer disinfection; resident care equipment; and laundry.

Many of the hand hygiene citations resulted from the staff not following the facility-specific policy for handwashing or changing gloves during a treatment. It is recommended that you review all of your facility policies that address handwashing and ensure that all staff, including therapists, are following the procedures.

Under transmission-based precautions, the citations addressed staff not following a facility's policies and procedures to prevent the spread of infection, being unaware of isolation precaution requirements, or that isolation precautions were not followed by staff upon both entering and exiting the room. In addition, citations addressed equipment taken out of patients' rooms without being disinfected. It is recommended that you review your facility policy regarding transmission-based precautions and make sure all staff members are in-serviced on how to follow them.

Citations for wound care contamination focused on improper handwashing, glove-changing, as well as soiled wound dressing disposal procedures. We know surveyors are going to be observing wound care and it is recommended that nurse leadership also have the same type of observation as a part of their regular rounds.

Glucometer disinfection and resident care equipment citations are very similar in that they specifically identified the improper cleaning of glucometers, not cleaning blood pressure cuffs and stethoscopes between resident use, as well as failure to maintain respiratory equipment in a clean and sanitary manner. For glucometers, the citations were for not following manufacturer's instructions on cleaning and for scissors not being cleaned between uses on residents. Other citations were tubing not being dated and not changed by the due date, as well as catheter bags being exposed or on the floor. Many of these citations would have been prevented through regular rounding, in addition to rounding prior to, during and after surveyors arrive.

The laundry deficiencies identified were employee cell phones and water bottles being stored on the folding table next to clean bags of linen, dirty housekeeping carts, uncovered soiled laundry bins, lint in dryers, and black biological growth on ceiling tiles. Most all of these citations could be avoided through rounding in these areas and having staff adhere to cleaning schedules.

I will continue to review completed surveys and provide updates regarding the type of deficiencies and citations being noted. LeadingAge Florida wants all our members to have excellent surveys.

REGULATORY – LeadingAge LINK, Volume 25, Issue 19, April 13, 2018

Citations for E-tags Related to the Federal Emergency Preparedness Plan

We understand some of our members are being cited for E-tags related to the Federal Emergency Preparedness Plan. In order to avoid receiving this citation, we recommend that you have a separate notebook for the federal plan using the requirements as your index.

You must have a risk assessment. For each identified risk, you must have a plan that addresses subsistence needs, resident tracking, evacuation process and shelter-in-place, protection of medical information and documentation, and arrangements with other community providers in the event of an evacuation or resident transfer.

You also must have a comprehensive communication plan that complies with federal, state and local laws. The plan must include contact information for relevant partners, processes for the exchange of resident information, and primary and alternate means of communication.

Since many facilities have asked about the CMS 1135 waiver requirements, we contacted the state Agency for Health Care Administration for the interpretive guidelines.

REGULATORY – LeadingAge LINK, Volume 25, Issue 18, April 6, 2018

Reviewing the Top Six Citations May Help You Avoid Them

We continue to monitor the Florida surveys results under the new survey process. The following information about recent surveys can help you ensure you are addressing the areas that are being cited by surveyors.

On March 28, 2018, the Centers for Medicaid and Medicare Services (CMS) posted survey results for the period January 11 - February 1, 2018. Fifty percent (50%) of facilities surveyed were cited under F880 and 30 percent for F812. In total, there were 36 surveys posted with the following top six (6) citations as listed below:

- F880 - Provide and implement an infection prevention and control program;
  - 18 facilities cited with S/S of 10 D, 6 E, 2 F.
- F812 - Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards;
  - 11 facilities cited with S/S of 2 D, 2 E, 7 F.
- F550 - Honor the resident's right to a dignified existence, self-determination, communication and to exercise his or her rights;
  - 9 facilities cited with S/S of 1 B, 5 D, 3 E.
- F656 - Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured;
  - 8 facilities cited with S/S of 7 D, 1 E.
- F584 - Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely;
  - 6 facilities cited with S/S of D 3, E 3.
- F684 - Provide appropriate treatment and care according to orders, resident's preferences and goals;
  - 6 facilities cited with S/S of 6 D.

We are committed to helping our members to have good surveys, so please do not hesitate to contact us with any questions or issues you may have.

REGULATORY – LeadingAge LINK, Volume 25, Issue 17, March 30, 2018

Residents' Beds Can Be Against the Wall

A resident can chose to have their bed against the wall. To be in compliance to with state regulations you must have a policy in place that addresses the placement of a bed, the resident or their representative must sign a statement indicating their understanding that the room will not be in compliance with the Florida building code and this statement must be included in the resident care plan.

This regulation is found in the ASPEN state regulation set N0035, rule 400.23(2)(a) - Bed Placement in Nursing Homes. The following is the interpretive guideline for surveyors:

> *At admission was the resident presented with a room that meets the requirements of the building code? Did the resident/resident representative request the bed be moved? If so, did the resident/representative sign a statement indicating their understanding the room will not be in compliance with the Florida Building Code. Is the statement included in the residents care plan? Does the bed change infringe on the roommate, if applicable? Do the facility policies outline their procedures should a resident/resident representative request the bed be moved?*

At LeadingAge Florida, we are committed to helping all our members have a good survey. Please do not hesitate to contact us for assistance.

REGULATORY – LeadingAge LINK, Volume 25, Issue 16, March 23, 2018

Summary of Citations from Completed Surveys

Below is a summary of citations resulting from surveys from November 28, 2017 - January 10, 2018. These deficiencies represent surveys from 50 facilities.

- F880 – 20 facilities were cited for failure to provide and implement an infection prevention and control program.
- F656 – 16 facilities were cited for failure to develop and implement a complete care plan that meets all the resident needs.
- F812 – 10 facilities were cited for failure to procure food from an approved source, and to store/prepare and serve in sanitary conditions.
- F641 – 10 facilities were cited for failure to ensure each resident receives an accurate assessment.
- F761 – 10 facilities were cited for failure to ensure drugs and biologicals used in a facility are labeled in accordance with currently acceptable professional principles.
- F657 – Eight (8) facilities were cited for failure to develop the care plan within seven (7) days of the comprehensive assessment.
- F684 – Eight (8) facilities were cited for failure to provide appropriate treatment and care according to orders, resident preference.
- F757 – Seven (7) facilities were cited for failure to ensure that each resident's drug regimen be free from unnecessary drugs.
- F758 – Seven (7) facilities were cited for failure to implement gradual dose reductions and non-pharmacological interventions.

REGULATORY – LeadingAge LINK, Volume 25, Issue 15, March 15, 2018

Number 1 Reported Deficiency: Infection Control

From November 28, 2017, through January 10, 2018, the number one cited deficiency was Infection Control. Most of these deficiencies were one or two observations, not showing to be patterns. In summation:

• Seven (7) facilities were cited for failure to implement appropriate use of personal protective equipment;
• Four (4) facilities were cited for improper use of gloves and for not using proper hand-washing hygiene;
• Three (3) facilities were cited for failure to implement a Legionella water management program;
• Three (3) facilities were cited for improperly folding clean laundry/clean laundry touching floor;
• One (1) facility was cited for failure to clean a glucometer; and
• One (1) facility was cited for having a cell phone and water bottle stored on a table next to bags of clean laundry.

Educating your staffs on infection control continues to be a very high priority. As you prepare for your survey, keep this in mind and do not hesitate to let us know if we can assist you.

REGULATORY – LeadingAge LINK, Volume 25, Issue 13, March 3, 2018

Avoiding One-Time Deficiency Observations

I have been following the surveys conducted by AHCA since the new survey process began November 2017. Most of the deficiencies have been one time observations. With surveyors on the units up 150 hours observing care how can you avoid these one-time incidents?

Examples of one-time observations that are bringing deficiencies include the following:

1. Heels not floated - failure to carry out care plan interventions.
2. Taking the pulse in public - privacy violation.
3. One resident needing nail care - ADL issue.
4. One resident without an update to the care plan after a fall - care plan issue.
5. Diagnosis of UTI not on the MDS - inaccurate MDSs.
6. Lint in the dryer - failure to maintain equipment in working order.

And the list goes on.

My very best advice to avoid these one-time observation deficiencies is to ensure the resident care plan is carried out at all times. For CNAs to carry out care plan interventions, they must know the interventions. For CNAs to know the care plans they must have an easily understood, updated care plan that indicates the resident interventions. It is important to have consistent staffing to stabilize CNAs to residents so they know the many interventions unique to residents.

And, remember the surveyors are only talking to the front line staff (CNAs and nurses) not administrative staff.

The second most important way to prevent these one-time observations from happening is ROUNDING. All administrative staff should round - administrators, director of nurses, unit managers, social workers and maintenance directors. Observations should be made during these rounds with immediate staff corrections and teaching to correct any issues noted. Rounds should include every room, every resident, all meals.

The last recommendation is that every day should be considered a survey day. Compliance with regulations should be *every day* and not just when surveyors are in the facility.

REGULATORY – LeadingAge LINK, Volume 25, Issue 11, February 23, 2018

Survey Reminders from the Recent Workshop

On Tuesday, February 20, LeadingAge Florida hosted a workshop at one of our member's facility - Mayflower. The topic was "Using the New Survey Process for a Deficiency-free Survey."

There was very good discussion among our member facilities, as they discussed their experiences with recent surveys. Listed are some of their survey reminders that can help you to have a good survey.

1. Surveyors are requesting you separate your federal emergency preparedness plan and your state CEMP (Comprehensive Emergency Management Plan).

2. Remember to include the 1035 waiver in your federal emergency preparedness plan.

3. Ensure that any caulking work is performed by a certified person/vendor.

4. The mandatory survey tasks include kitchen observation, dining observation, resident council meeting, SNF beneficiary notification review, medication administration observation, medication storage, sufficient and competent nurse staffing, and QAA/QAPI plan review. All of the surveyor forms for these tasks are available to you to assess your own compliance.

5. In addition to the mandatory surveyor task, there are 28 surveyor critical pathways covering clinical areas. These also are available for your use to assess compliance.

6. You must have a system to ensure you are monitoring and evaluating for clusters or outbreaks of staff illness.

7. Surveyors have been asking about your plans for responding to an active shooter.

8. Remember that wheelchairs used to transport residents should have footrests. One member shared that their facility uses bags on the backs of wheelchairs to store the footrests.

It is always good to be with our members, listening to their experiences and recommendations for other members. Information sharing can help to ensure you have a good survey process.

REGULATORY – LeadingAge LINK, Volume 25, Issue 11, February 16, 2018

Another Change

There is another change from CMS involving the facility advanced beneficiary notice of non-coverage (SNFABN). Skilled Nursing Facilities (SNFs) must issue a liability notice to Original fee-for-service (FFS) Medicare beneficiaries before the SNF provides:

- An item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary or is custodial care.

CMS has released a newly revised Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) along with newly developed, concise and separate instructions for form completion. The revised SNFABN has the requirements from the Denial Letters and looks similar to the ABN with 3 different options for Original FFS Medicare beneficiaries to choose from. CMS has discontinued the 5 SNF Denial Letters and the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF). Since the NEMB-SNF was used as a voluntary notice for care that is never covered by Medicare, they will continue to encourage providers to issue the revised SNFABN in this voluntary capacity. The revised SNFABN will be mandatory for use on May 7, 2018. During the interim, you may continue to use the old version of the SNFABN, the Denial Letters or the NEMB-SNF; however, it is recommended that the revised SNFABN be used as soon as possible.

For Part A items and services: SNFs must use the newly revised SNFABN as the liability notice.

For Part B items and services: SNFs must use the Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131. The ABN and information on this notice can be found at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

To download the notice and accompanying instructions, please click on the link below.

SNF ABN 2018 (CMS-10055) [DOCX, 27KB]

REGULATORY – LeadingAge LINK, Volume 25, Issue 9, February 9, 2018

F-Tags, K-Tags and, now, E-Tags

There are F-tags, K-tags and, now, there are E-tags. E-tags are given for failure to develop an emergency preparedness plan that meets the federal requirements.

In September 2016, the Centers for Medicare and Medicaid Services (CMS) released new emergency preparedness requirements for 17 different types of health care providers including long-term care. The rules were published in the Federal Register September 16, 2016 (Federal Register Vol. 81, No. 180). The advanced copy of Appendix Z, Emergency Preparedness Final Rule Interpretative Guidelines and Survey Procedures was published on June 2, 2017, in S&C 17-29-ALL. The rules became effective on November 15, 2016, and have an implementation date of November 15, 2017.

The new rule requires providers to demonstrate that they conduct risk assessments; identify potential hazards via an all hazard approach; write a detailed emergency preparedness plan; revise and establish policies and procedures; and train and test the emergency preparedness plan with facility staff and partners in the community.

The CMS final rule outlines four core elements of an Emergency Preparedness Program:

- **Risk Assessment and Emergency Planning**: Develop an emergency preparedness plan based on facility and community risk assessments and utilizing an all hazards approach - addressing patient populations, services offered for continuity of operations and succession plans.

- **Policies and Procedures**: Develop emergency preparedness policies and procedures based on risk assessment, communication plan and the emergency plan – while coordinated with the facility assessment. Need to address subsistence needs, resident tracking, evacuation process and shelter in place, protection of medical information and documentation, and arrangements with other community providers in the event of an evacuation or resident transfer.

- **Communication Plan**: Develop an emergency preparedness plan which addresses a comprehensive communication plan that complies with federal, state and local laws; the communication plan must include contact information for relevant partners, processes for the exchange of resident information and primary and alternate means of communication.

- **Training and Testing**: Develop an emergency preparedness training and testing program based on the risk assessment, communication plan and emergency plan; annual training for all staff on all emergency preparedness policies and procedures; conduct and participate in two annual exercises – one of which must be a full-scale community-based exercise.

LeadingAge has developed an excellent toolkit to walk you through the four core elements, providing you with definitions, templates, best practices and additional resource sites to help you produce plans for your unique risks. This information will be covered during the workshop **"Lessons Learned: Updates on New Survey Process"** to be held on February 20, 2018, in Winter Park, FL.

Resource List:

- Implementation Guide
- Overview
- Risk Assessment and Planning
- Sample Emergency Plan
- Policies and Procedures
- Incident Command System
- Communication
- Training and Testing
- Training Plan
- Powerpoint
- CMS NFPA Crosswalk
- Toolkit Resources
- Tags for Post Acute-Care

REGULATORY – LeadingAge LINK, Volume 25, Issue 8, February 2, 2018

My View: Observations Regarding the New Survey Process

Recently, I visited a facility and "played surveyor." Yes, you read that correctly. I pretended to be a survey using the new process to see how the facility would fair. While I won't reveal the location of the facility, nor its name and its results, what I will do is share with you my observations so that you have as much information as possible prior to your survey.

Observation 1: At the onset of the process, surveyors will have a lot of information about your residents, such as knowing which residents have fallen within the last 90 days and if the fall resulted in injuries; all residents with an in-house pressure sore; and/or residents with excessive weight loss, and other information.

Observation 2: Surveyors can very quickly look at your care plans and, since they are spending so much time on the units, they will surely identify your failure to carry out care plan interventions.

Observation 3: Further, spending so much time on the units also gives the surveyors many opportunities to observe infection control issues, if there are any issues present.

Observation 4: As the surveyors are interviewing most residents, they can identify any issues regarding food, staff answering call lights and how resident are treated by the staff.

Observation 5: By meeting with the resident council and reviewing resident council minutes, surveyors are able to confirm any patterns of care issues.

Observation 5: Surveyors can quickly follow residents who are identified as smokers and, conversely, identify smokers who were not properly identified, as required in the new process.

Now, keeping these observations in mind, here are my recommendations for you to have a good survey.

- **Recommendation 1**: Care plans, care plans, care plans. This isn't anything new; however, I believe having a good care plan and following them is more important than ever in the new survey process. Not only should your plan address identifying resident problems and having appropriate interventions, but also it you should properly use the interventions identified in the plan. I cannot emphasize enough that surveyors will follow up to determine you are using your care plan.
- **Recommendation 2**: I have said this in prior articles and at trainings, and will say it again. I strongly recommend that you gather all the required survey material, such as the matrix, Casper report, entrance conference material, etc. Once compiled, review it as if you were a surveyor to identify any issues and see what can be corrected prior to your survey. For those that cannot be corrected, make a note so that you can let the surveyor know you have identified it as an issue that needs addressing.
- **Recommendation 3** (and this is not a shameless plug): Register to attend the training on February 20 in Orlando. During this workshop, we will discuss strategies to ensure that your facility is in compliance and has an outstanding survey.

REGULATORY – LeadingAge LINK, Volume 25, Issue 7, January 26, 2018

Avoiding the Dietary Deficiency

Why do so many facilities get cited for F812 Food Procurement, Store/Prepare/Serve - Sanitary (formerly 371)? More importantly, how can you avoid this deficiency during your survey?

The answer to avoiding this deficiency is three-fold: rounding, follow up and consistent implementation of systems. During your annual survey, one of the first things the survey team will do is to send a surveyor into the kitchen. In my experience, the surveyor's findings that stem from the kitchen can help to set the tone for the rest of your survey.

Everyday, someone should round in the kitchen with a critical eye toward compliance to ensure adherence to the following list:

- Temperature log for the dishwasher is maintained and reflects correct temperatures for both the wash and rinse cycles;
- Temperature logs for the refrigerators and freezers are maintained and reflect correct temperatures for both;
- All opened items in the refrigerators and freezers are properly labeled and dated;
- There is hot water, soap, paper towels and a step-on garbage can at each hand sink;
- All pots and pans are free from dents and damage;
- The kitchen is VERY clean, including all appliances, large and small, inside drawers and under hoods;
- Towels are not lying on the countertops (they all should be in the sanitizing buckets);
- All staff with facial hair (beards or mustaches) are wearing proper protective covers; and
- All staff are wearing hairnets when they are in the kitchen.

By rounding the kitchen each day, and educating and correcting staff about compliance, you can avoid being cited for noncompliance with F812.

REGULATORY – LeadingAge LINK, Volume 25, Issue 6, January 19, 2018

'Flu-Avoidance 101': It's an Excellent Time to Stress Infection Control

Since the 2018 cold and flu season is in full swing, this is an excellent time to stress to your staff (and residents) the importance of infection control measures. Every day, the national news is reporting on the current flu epidemic; your staff should be highly motivated to avoid getting sick and, thereby, getting residents sick.

Not only will infection control techniques help to prevent the spreading of illnesses among staff and residents, but also can keep your community from receiving an F880 (formally F441) citation. Techniques that can help with infection control include the following:

- Using protective gear (gloves, masks, gowns, etc.) appropriately;
- Tracking all residents with signs and symptoms of infections;
- Looking for patterns and ways to prevent the spreading of identified infections;
- Covering trash receptacles (including those on med carts);
- Requesting that family members NOT visit if they have any signs and/or symptoms of an infection;
- Teaching residents good infection control techniques (proper sneezing etiquette and disposal);
- Making daily infection control rounds on all shifts looking for issues with infection control; and
- HANDWASHING! The Centers for Disease Control (CDC) is reminding EVERYONE that handwashing is the best defense against spreading germs and infection, and getting sick.

The infection control deficiency continues to be one of the top deficiencies cited by surveyors. Remember, older adults are more susceptible to infections, so diligence and attention to infection control measures can help them avoid the flu and you avoid an F880 citation.

REGULATORY – LeadingAge LINK, Volume 25, Issue 6, January 12, 2018

Collecting Information Ahead of Time Can Lead to a Good Survey

As you all know, your facilities are required to have an Infection Prevention and Control Program to help prevent the proliferation and transmission of communicable diseases and infections. Additionally, the Centers for Medicaid and Medicare Services (CMS) require that facilities develop and adhere to policies and procedures to help reduce the risk and spread of Legionella and other opportunistic pathogens by inhibiting microbial growth in building water systems.

Surveyors will review your policies, procedures and reports that document water management implementation results to verify that facilities did, in fact, conduct a risk assessment to identify where Legionella and other opportunistic waterborne pathogens may possibly grow and spread in a facility's water system. Specifically, they want to confirm that you are using a water management program that considers the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) industry standard and the national Centers for Disease Control (CDC) toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.

The survey and certification memo outlining the requirement will be helpful to you, as well as the CDC toolkit. LeadingAge Florida is valuable resource to you as you prepare for your survey; please do not hesitate to contact us to assist.

REGULATORY – LeadingAge LINK, Volume 25, Issue 5, January 5, 2018

Collecting Information Ahead of Time Can Lead to a Good Survey

One way to help your facility have a good survey is to compile and have ready all the information surveyors will request at the entrance conference upon arrival. Preparing the requested material early will give you time to review the material to determine if you are in compliance with Phase I and Phase II regulations.

You can use the Entrance Conference Worksheet as a checklist when gathering the information. This will help to ensure you have everything you need to provide to the surveyors and that there are no missing or incomplete documents. If there are items missing, you will know ahead of time and can address it prior to surveyors receiving the material.

Additionally, there are two forms you need to complete for the surveyors: (1) Beneficiary Notice - Residents Discharged Within the Last Six Months, and (2) Electronic Health Record (EHR) Information.

Of course, the list of residents discharged will need to be completed on the first day of the survey. Just make sure you know how you can quickly obtain the list.

The second form can be completed in advance of the survey, as this information shouldn't change. This form helps the surveyors identify where to find information, so it needs to be very specific, making it easy for surveyors to find what they need regarding residents' care and treatment.

At LeadingAge Florida, we are committed to helping all our members have a good survey. Please do not hesitate to contact us so that we can assist you. Let us know if we can help you.

REGULATORY – LeadingAge LINK, Volume 25, Issue 4, December 22, 2017

Want a Good Survey? Know and Comply with the Regulations

The best way to have a good survey is to be in compliance with the regulations. The best way to be in compliance with the regulations is to know the regulations. And, not just the administrative staff should know the regulations. From janitorial staff to activity staff and medical staff - ALL staff should know the regulations.

Sometimes, I think we focus more on the actual survey than we do on the regulations. In my experience, if you know and are in compliance with the regulations, you don't have to worry about survey. If you are cited for something with which you believe you are in compliance, I recommend you commence the Information Dispute Resolution (IDR) process regarding the deficiency citation.

While many members fear submitting an IDR, I don't think you should fear the process if you are in compliance with the regulations. We can help you with the IDR process, and I believe submitting an IDR for deficiencies you feel are not warranted will, in fact, improve the survey process. We are committed to helping all members to have excellent surveys.

Teaching your staff--all staff--the regulations is an ongoing process. With more than 500 regulations and up to hundreds of staff in a facility, it is a continuous process to teach staff the regulations. Remember to teach not just what to do, but also why they are asked to do it.

To all LeadingAge Florida members, Happy Holidays, and I look forward to seeing you at our trainings in the New Year.

REGULATORY – LeadingAge LINK, Volume 25, Issue 3, December 15, 2017

Updates on the New Survey Process

In the last several newsletters, I have discussed the new survey process. Continuing with this subject, providers who had their surveys last week report that there are noticeable differences between the former process and the new one. Most noticeable, surveyors are on the units for the majority of the survey; they are interviewing every resident or the resident's representative.

This being the case, my recommendation is for providers to teach all staff to keep their eyes focused on compliance as they are continuously observing residents and the environment they are in. Specifically, ensure compliance with infection control (all staff), positioning of residents, timely meeting residents' needs, cleanliness of the environment, and safety of residents (for example, ensuring med carts are locked and doors are secure, etc.). In addition, teach all staff to immediately correct any noncompliance they observe.

Secondly, remember the state tags. Surveyors can and are citing violations of state regulations. They are asking for your policies on care planning. By way of reminder, this requirement is found under 59A-4.106(4)(v) and referenced in ASPEN ST-N0041, Facility Policy Component.

Each facility shall maintain policies and procedures in the following areas: (a) activities; (b) advance directives; (c) consultant services; (d) death of residents in the facility; (e) dental services; (f) staff education, including HIV/AIDS training, as required by section 381.0035, F.S.; (g) diagnostic services; (h) dietary services; (i) disaster preparedness; (j) fire prevention and control; (k) housekeeping; (l) infection control; (m) laundry service; (n) loss of power, water, air conditioning or heating; (o) medical director/consultant services; (p) medical records; (q) mental health; (r) nursing services; (s) pastoral services; (t) pharmacy services; (u) podiatry services; (v) resident care planning; (w) resident identification; (x) resident's rights; (y) safety awareness; (z) social services; (aa) specialized rehabilitative and restorative services; (bb) therapeutic spa services, if offered; (cc) volunteer services; and (dd) the reporting of accidents or unusual incidents involving any resident, staff member, volunteer or visitor.

Let us know if you have any questions. We are here to help.

REGULATORY – LeadingAge LINK, Volume 25, Issue 2, December 8, 2017

New Survey Process Has Begun

This week, surveyors have begun using the new survey process. If you haven't already, I recommend that you download and print the survey forms located at the links below. If you ordered the Long-Term Care Regulatory Phase 11 book, it DOES NOT contain the new survey process nor the forms.

- LTC Survey Entrance Conference and Provider Matrix - Updated 11/08/2017 [ZIP, 433KB]
- LTC Survey Pathways - Updated 11/08/2017 [ZIP, 2MB]
- LTCSP Procedure Guide [PDF, 1MB]

We are monitoring the surveys of LeadingAge Florida members who are being surveyed with the process this week. One noticeable change is that the surveyors are definitely spending more time on the units, and they are interviewing all residents who are able to participate in the interview process. Additionally, the kitchen initial tour continues to be very important.

We will continue to monitor the new survey process. If you have any questions proir to, during or following your survey, do not hesitate to reach out to me.

REGULATORY - LeadingAge LINK, Volume 25 Issue 1, December 1, 2017

QUARTERLY QUALITY MEASURES AND CONFIDENTIAL FEEDBACK REPORTS

Have you ever wondered how CMS calculates your quarterly quality measures and where they get the information?

Did you know you can get a report that identifies the residents who were included in each of the quality measures?

There are two reports stored in your facility's shared folder in CASPER. These are the **Public Reporting Preview** and **Public Reporting Resident Report**, both of which contain your quality measures as well as the list of residents used to determine the measure. There is a slight difference for the resident names that are displayed in the influenza and pneumococcal vaccinations reports, as CMS only lists residents who did not receive the vaccination, rather than those who did.

The most current public reporting preview and public reporting resident reports were automatically loaded into your facility's shared folder on October 9, 2017. The shared folders where the reports are stored are named as follows: two-character state code, LTC, and your facility ID (FL LTC 95013). The facility ID on the folder is the same ID that is included in the XML records that are submitted to the ASAP system.

These reports are only available in CASPER for a period of 60-days, so it is recommended that you download and save the reports each quarter. They can be used for reference purposes in case there is a need to identify the residents who were included in the measure. For more information on these reports, register to participate in a webinar conducted by CMS next week.
