

Responding to Regulatory Requirements & Frequently Cited Deficiencies in Long Term Care



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Objectives



1. To provide an overview of the Regulatory Process.
2. To understand & apply the CFR+Code of Federal Regulations
3. To prevent deficiencies & understand the Scope and Severity Grid
4. To be familiar with frequently cited deficiencies & ways to prevent them
5. To understand the concept of Resident Centered Care+& Survey Readiness+at the same time!

2

What Do We Need To Know?

1. Long Term Care/Skilled Nursing Facilities are governed, **regulated** & **overseen** by many agencies!

*CMS: Centers for Medicare/Medicaid Services
Code of Federal Regulations
(www.cms.gov)



*New Jersey State Department of Health & Senior Services



New Jersey Administrative Code (NJAC)
(www.state.nj.us)

3

What Do We Need To Know?

*Title 42 of Public Health Code



*Office of the Attorney General/Law and Public Safety

(www.nj.gov/lps)



*Occupational Safety & Health Administration

→Protects the Health & Safety of the Healthcare Worker

(www.osha.gov)



What Do We Need To Know?

*HHS Office of the Inspector General

→ Coordinates all federal agencies, provides publications & reports regarding nursing home inspections.



→ Provides regulations to other authorities:

- ♦♦Fraud & Abuse Law
- ♦♦CMS

(www.oig.hhs.gov)

5

Other Helpful Websites:

*Centers for Disease Control

(www.cdc.gov)



*The Compliance Store

(www.cpl-store.com)




*American Association of Nurse Assessment Coordinators

(www.aanac.org)



6

**Overview
Of
The
Regulatory
Process**




7

What Do We Need to Know ?

Definitions/Acronyms

- “F-Tag” – “CFR”** code of Federal regulations
 - There are 183 F-Tags
 - F means Federal-Tag
 - Tags start with F150 Residents Rights ends with F522 Disclosure of Ownership
- “SOM”**- State Operation Manual; all of the above tags can be found in this manual as well as survey documents
- “SNF”**- Skilled Nursing Facility or NF which meets the requirements of the Social Security Act


A skilled nursing facility is defined as an institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement with one or more hospitals



8

What Do We Need to Know ?

Definitions/Acronyms (cont’d.)

- LSC**- Life Safety Code, adapted from the NFPA National Fire Protection Agency- this code is utilized as part of the survey process for compliance with Disaster Plans, Building codes, Fire Prevention, etc.
 
- “K-Tag”** Springs off of the LSC and NFPA and correlates with requirements of the building code. K-Tags are part of the survey process, and can be cited using scope and severity.


9

What Do We Need to Know ?

Definitions/Acronyms (cont'd.)


- 6. **Deficiency**- failure to meet a participation requirement specified in the Social Security Act or in 42 CFR Part 483, Subpart B
- 7. **Dually Participating Facility**- a facility that has a provider agreement for both medicare and medicaid
- 8. **Immediate Family**- husband or wife, natural or adopted parent, child, sibling, step parent, step child, step brother, step sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild





What Do We Need to Know ?

Definitions/Acronyms (cont'd.)



- 9. **Immediate Jeopardy (IJ)**- a situation in which the facility's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm or death to a Resident. (see appendix (cms.gov))
- 10. **Neglect**- failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- 11. **Abuse**- the willful inflictions of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Key Point: The Public Health Code 2803d does not recognize the word willful in their definition.

11

What Do We Need to Know ?

Definitions/Acronyms (con't)

- 12. **Misappropriation of Resident Property** the deliberate misplacement, exploitation, or wrongful temporary use of a Resident's belongings or money without the Resident's consent.



- 13. **Non-Compliance**- any deficiency that causes a facility to not be in substantial compliance.
- 14. **Substantial Compliance**- means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to Resident's health or safety than the potential for causing minimal harm.

What Do We Need to Know ?

Definitions/Acronyms (cont'd.)

15. **Sub-Standard Quality of Care**- one or more deficiencies related to participation requirements under (483.13) Resident behavior and facility practices, (483.15) Quality of Life, or (483.25) Quality of Care; which constitute either immediate jeopardy to Resident health or safety, a pattern of or widespread actual harm that is not immediate jeopardy, or a wide spread potential for more than minimal harm, but less than immediate jeopardy with no actual harm.

16. **Enforcement Action**- The process of imposing one or more of the following remedies:

- termination of provider agreement
- denial of participation
- denial of payment (DOPNA)
- temporary manager
- civil money penalty
- state monitoring
- Directed Plan of Correction
- Directed Inservice Training
- transfer of Residents
- closure of facility
- other CMS approved/state remedies





Who Does What?

1. DOH is contracted by CMS to provide the Survey Process
2. DOH surveys facilities, however, it is a Federal Survey process that is utilized
3. CMS can also provide Regulatory Surveys:
 1. To monitor performance by the DOH
 2. To respond to complaints, and or concerns triggered by numerous sources


14

I. Survey Cycle

- Surveys are done to ascertain compliance with Federal and State codes (called conditions of participation)
- Survey cycle can be 9-15 months, but must be done annually
- Facilities should adopt the concept of being **Survey Ready+everyday!**



II. Types of Survey:




A. Standard Survey- periodic resident centered inspection which gathers information about the quality of service provided in a facility to determine compliance with the requirements of participation. Usually done annually.

B. Abbreviated Standard Survey- Other than a standard survey, resident centered on Facility compliance. May result from a compliant, change of ownership, management, DNS or any other indicator

C. Extended Survey- A survey that evaluates additional participation requirements subsequent to finding Substantial Quality of Care during a standard survey

16



. Types of Survey

D. Partial Extended Survey- A survey that evaluates additional participation requirements subsequent to finding Substantial Quality of Care during an Abbreviated Survey

E. Validation Survey- (commonly known as Comparative Survey) usually conducted within 2 month following a standard, abbreviate, partial extended, extended for the purpose of monitoring state agency performance (this is usually a Federal Survey)


F. Other- The Survey Agency (State or Federal) may conduct a survey as frequently as necessary i.e. to confirm the facility corrected deficiencies

17

What Do We Need To Know Con't?


How are Deficiencies Cited?

*The Scope and Severity Grid is used in all states!



SCOPE: number of residents or staff involved in a deficient practice.

SEVERITY: level of harm or outcome of the deficient practice.



Scope and Severity Grid

Scope Levels: Isolated, Patterned or Widespread levels

Severity Levels: (1) No actual harm (2) No actual harm with potential for more than minimal harm (3) Actual harm (that is not immediate jeopardy) (4) Immediate Jeopardy

4	J	K	L
3	G	H	I
2	D	E	F <small>(Substandard QOC)</small>
1	A	B	C

ISOLATED PATTERNED WIDESPREAD



OVERVIEW OF FREQUENTLY – CITED F-TAGS & COMPLIANCE TIPS


Involved F-Tags

- F279 – 284 Care Planning
- F221 Restraints
- F223 – 226 Abuse Protocols
- F309 Quality of Care/
Pain Management
- F314 Pressure Sores
- F323 Hazards/accidents
- F441 Infection Control
- Of mention: F252 Environment
F253 Housekeeping






F279 ó 284 Care Planning

- o Among the top 10 deficiencies cited in all Facilities! Can be a Domino effect for other deficiencies.
- o Frequent deficient practice includes:
 - * Not developing a plan/Plan not specific or individualized
 - * Not revising the plan
 - * Not implementing the plan
 - * Not interdisciplinary
 - * Not evaluating the plan
 - * Goals not measurable
 - * Not developing a discharge plan (F283/F284)
 - * Not implementing a discharge plan to Resident or Family
 - * Care Plan **NOT** compatible with %CAA§ (Care Area Assessments)



22


Compliance Tips ó Care Planning

- *Care Plan deficiencies are the most preventative if your team follows guidelines for compliance!
- *Develop the Philosophy that Care Planning begins on day of admission and ongoing
- *Develop Care Plan concepts and assignments in your morning meeting.
- *Utilize the 24 hour report as a means of CCP communications to other disciplines.

23

Compliance Tips ó Care Planning




- o Make it a **mandatory** policy that all department heads and key care givers read and respond to the 24 hour report:
 - * Same should be done at morning meeting (CCP/QA)
 - * Concentration should be on quality care issues
 - * Minutes and attendance should be taken for validation
 - * Assignment for follow-up and care planning should be done at the meeting or via 24 hour report shift → shift
 - * Have disciplines sign the 24 hour report as well as morning meeting attendance for validation and awareness or develop %Morning Meeting+report form

QA/CCP

Morning Meeting: Date _____

Attendance: _____


Potential Quality Issue	Action Plan	Assigned Discipline	Outcome
331 John Smith: Developed new stage II P/S on left buttock, and lost 2 lbs.	<ol style="list-style-type: none"> 1. Medical work up including serum albumin 2. Dietary evaluation 3. To be seen by wound care team 3/5/09 	RN/MD RD Wound Care Nurse	



Compliance Tips 6

Care Planning


- o Include CCP Review in all Quality of Care audits as part of overall QA for compliance.
- o Care Plan Policies and Protocols should be part of overall orientation to involved disciplines on initial hire and throughout the year! Inservice should concentrate on revision of the plan!
- o Consultants should be part of the CCP team including overall QA or documentation:
 - * Pharmacy Consultant . review CCPs as part of overall review.
 - * Infection Control . compliance and plans for infection
 - * Psychologist . care plan interventions in case notes or on CCR



Compliance Tips 6


Care Planning

- o Caregivers and staff should have the philosophy that if the Resident issue is important enough to write a note, then a CCP should be considered, or at least reviewed. This concept will ensure Care Plan compliance!



Compliance with these concepts will prevent the domino effect of double deficiencies.


(i.e. F309 / F282 and F323/ F279)



F221 Restraints


- o Facilities still struggle with compliance in understanding requirements for siderails!
- o Regulations were revised 10/10/00 and has a distinct part for siderail compliance.
- o All involved members of the interdisciplinary team should be aware of Regulatory requirements!
- o All involved team members should be part of the decision making for restraint use!

28



F221 Restraints

- o Frequent deficient practice includes:
 - ★ No evaluation process for using siderails/restraints (team decision)
 - ★ No alternatives tried or documented
 - ★ No medical symptom identified
 - ★ No evidence of reduction through the CCP process
 - ★ No Care Plan for restraints
 - ★ Not informing significant other of risks/benefits/potential negative outcomes
 - ★ No evaluation of continued need (i.e. quarterly/episodically)




Compliance Tips 6 Restraints

- o Develop a Restraint Committee as a liaison to CCP team. The Committee or Rehab should assess Residents need for Restraint and evaluate the medical symptom.
- o Develop an assessment tool to assess need for siderail/restraint. Same should differentiate or define Restraint from assistive device:
 - ★ Do assessment on admission/quarterly to justify continued need
- o Develop a bed mobility assessment to validate siderail decisions and medical symptom. This assessment should start on admission.
- o Develop a Sleep Monitoring Assessment


to assess risk factors & validate siderail considerations

30



Compliance Tips 6 Restraints


- o All Restraint use including siderails should have an individualized and specific care plan. The plan should state the Restraint use as the problem and the goal would be for reduction.
- o Restraint use should be evaluated quarterly/episodically and when appropriate monthly! The evaluation should include justification of continued need or validation of discontinuance.
- o All Restraints should be tracked monthly for quality assurance and restraint reduction.
- o Policies should include directives for restraint initiation/evaluation, restraint reduction and QA tracking.



31

F223-F 226 Abuse/Neglect Staff Treatment of Residents

- o Among the top 10 deficiencies cited!
- o Frequent deficient practice includes:
 - * Not having a specific policy and procedure to prevent abuse/neglect, or inadequate policy, lack of implementation
 - * Investigation not complete and thorough/no evidence or witness statements
 - * No conclusion statement to rule out abuse/neglect.
 - * Inadequate plans of care to prevent abuse:
 - * No Behavior Management
 - * No Risk Assessment
 - * No Care Plan
 - * Not reporting incidents to Department of Health
 - * Facility not checking employee background with Nurse Aide Registry prior to employment. (CHBC)
 - * Not investigating potential issues relative to abuse/neglect i.e. grievances, medical events, lost property, Resident altercations






32

Compliance Tips 6 Abuse/Neglect

- o Develop a Policy/Procedure that includes all seven elements of Abuse Prevention:

1) Screening	5) Investigation
2) Training	6) Protection
3) Prevention	7) Reporting
4) Identification	
- o Inservice all staff on orientation and throughout the year on ABUSE Policies. Provide inservice education if statistics increase i.e. Accidents/Resident behavioral issues
- o Develop a Behavior Management Program.
- o All perspective employees must be screened prior to hire (validate same)
 - * Develop a tracking system for same.







Compliance Tips δ Abuse

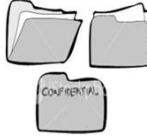

Investigate everything that could come under the δ Abuse umbrella:

- ϵ Accidents/grievances/elopements/medical events/choking/pressure sores/medication errors/misappropriation of property etcí ...
- ★ Facility may want to keep Resident to Resident events in a separate book for tracking and QA
- ★ Investigation should start the moment the event occurs!
- ★ Investigation should include a summary of the precipitating events or timeline, and validation that adequate supervision was provided as per F323
- ★ Investigation must include a conclusion statement to R/O or substantiate abuse/neglect
- ★ Investigation must have evidence to support conclusion.




Compliance Tips δ Abuse

- o Facility should notify the Department of Health timely (within 5 working days) if %abuse+suspected or known
- ★ Develop a DOH log to track reported cases
- ★ Create a file of each case including all supportive documentation
- o Staff should understand the intent of these regulations including:
 - ★ Public Health Code 2803d
 - ★ Definitions of %abuse+
 - ★ Protocol for reporting
 - ★ Protocol for investigation


F309 Quality of Care

- o Among the top 10 deficiencies cited . usually a harm level, usually will have a domino effect on other F-tags.
- o Frequent deficient practice includes (but is not limited to):
 - ★ Decline in Resident function which was avoidable
 - ★ Not following MD orders (i.e. treatments, medications)
 - ★ CPR / DNR issues
 - ★ Resident not receiving appropriate care resulting in decline/harm (i.e. no pain assessment or medication for pain)
 - ★ **Medication errors and Physician errors**
 - ★ **Lab Errors: Anticoagulant Therapy
Glucose Monitoring**



Compliance Tips

Quality of Care



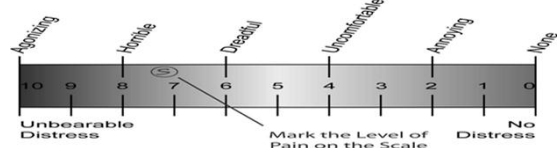
- Have effective supervision for all shifts!
- Establish a morning meeting to review 24 hour reports
- Investigate all/any Quality of Care issues immediately!
- Investigations should always be in writing, include summary of findings and corrective actions!
- Assign follow-up and responsibility to Resident issues at morning meeting.
- Have attendance and minutes to all morning meetings for QA/validation and follow-up

37

Compliance Tips

Quality of Care

- Do pain assessments on admission, continue to review quarterly/episodically/significant change
- Document **Pain Level** using the 1-10 scale prior to medication & post medication for validation of effectiveness
- Utilize a Coumadin flow sheet to track PT/INRs & MD medication changes
- Utilize coverage directly on the medex





Task Typing

Date 5/17/06 Start 9:45 am End _____

Compliance Tips

Quality of Care

- If frequency of Quality Issues+ develop, then respond with full house Compliance review, for example: Develop an action plan including:
 - ★ Policy Reviews
 - ★ Chart Reviews
 - ★ Audits
 - ★ Inservice as needed
- Involve Medical Director in Quality of Care issues and his/her response for correction:
 - ★ May require medical review
 - ★ May require assessment and documentation for corrective action validation

39

F314 Pressure Sores

- o Involves use of Investigative Protocols.
- o Among the top 10 deficiencies cited . . usually a harm level!
- o Frequent deficient practice identified includes the following:
 - * Resident develops pressure sore when same was avoidable
 - * No system for risk assessment
 - * No Care Plan for preventing pressure sore
 - * Pressure sore worsens/deteriorates without supporting documentation

F314-Pressure Sores

- o Frequent deficient practice continued:
- *No supportive documentation by MD/Dietary . . other disciplines, no wound flow sheets, no wound bed description
- *Treatment not done according to MD orders or breach of Infection Control practice
- *No Physician assessment including:
 - Monitoring response to healing
 - Establish baseline labs and need for protein replacement
 - Documentation of initial assessment for new pressure sores
 - Supportive note to show that pressure sore was unavoidable

41

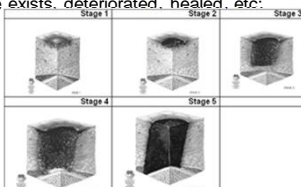
Compliance Tips δ Pressure Sores

- o Establish a policy/procedure for pressure sore prevention and intervention.
- o Develop a pressure sore risk assessment tool:
 - * Same should be done on admission, quarterly and change of condition
 - * Document on admission the appearance of pressure sores including size/stage/wound bed appearance
- o Develop an individualized Plan of Care including: (LxWxD)
 - * Plan for existing pressure sores
 - * Plan for preventing additional pressure sores
 - * Plan must include appropriate disciplines
- o Weekly rounds should be done, Physician involvement and documentation should be monitored for validation and QA during rounds!

42

Compliance Tips ◊ Pressure Sores

- Pressure sore statistics should be done weekly/monthly and responded to from a QA perspective (unit and house)
- All newly developed sores should be investigated for compliance and facility protocols!
- Dietitian should do a nutritional assessment on all Residents with new breakdown. RD must recalculate needs for compliance!
- Facility should develop a communication system to alert involved disciplines that a pressure sore exists, deteriorated, healed, etc.:
 - ★ 24 hour report
 - ★ Voicemail or email
 - ★ NCR communication forms





Compliance Tips ◊ Pressure Sores


- Families/significant others must be notified if pressure sores develop. (F157 Notification of Change)
- Physician should document monthly and as needed on status of pressure sore. (F386)
- OT should be involved in positioning. (F314)
- CNA Plan must have documentation of site and preventive plans to ensure implementation



F323 Accidents

- Among the top 10 deficiencies cited and since regulation was revised in August of 2007!
- Easy for surveyors to cite.
- Usually a harm level!
- Can have a domino effect with F279 / F282 (Care Plans) and F223 / F225 (Abuse) and F309 Quality of Care!






F323 Accidents

- o Frequent deficient practice includes: * No Risk Assessment
 - * Not following/implementing Plan of Care to prevent accidents. Not identifying hazards in the facility
 - * Not providing adequate supervision to Resident which may result in accident/elopement/medical event.
 - * Not revising the Plan of Care to prevent accidents
 - * Not conducting a complete and thorough investigation with a conclusion statement
 - * CNA/Care givers not aware of Resident risk factors for accidents, and/or not following the plan of care
 - * No identification of risk factors/hazards
 - * No attempt for facility to repair/replace equipment that could create hazards i.e. call bell system (F463)

46



Compliance Tips Accidents

- o Facility should have a policy/procedure for accident prevention and intervention (i.e. Falling Star Program)
- o Develop a risk assessment that identifies risk on admission, quarterly or with change of condition:
- o **Elopement Risk** **Fall Risk** **Wandering/Behaviors**
- o Implement a Rehab Nursing program for high risk Residents after review by PT/OT to prevent falls
- o Develop individualized Plans of Care and evaluate progress of plan . include CNAs in the plan!!


47

Compliance Tips


. Accidents

*Investigate all accidents/hazardous incidents and summarize findings:

- * Obtain statements
- * Rule out abuse(within 5 working days)
- * Develop corrective plans



- o Review Residents with Accidents at morning meeting
- o Have monthly accident/incidents statistics by unit/house that looks at:
 - * Type of accident; Include Resident to Resident Issues
 - * Time of accident
 - * Location of accident



* **All statistics should be analyzed!**

F333 Medication Errors

Frequent Deficient practice includes:

- *Transcription Errors
- *Medication not available or omitted
- *Wrong does Given!
- *Wrong resident/Wrong medication
- *Expired meds found in cart or in fridge including (otc,vaccines)
- *Poor infection control during medication administration:
 - Handwashing/GT Med Pass
 - Glove Use
 - Eye Drops/Patches



49

Compliance Tips:

1. Review Medication

Policies & Policy for administration:

- *On Orientation
- *Inservice Education Program
- *Whenever a significant Med Error is noted!

2. Consider providing a Medication Exam to new hire nurses to assess competency & prevent errors!

- *Have policy for Medication Error Criteria



50

Compliance Tips Con't:


3. Be **AGGRESSIVE** in

Quality Assurance Monitoring: (in addition to Pharmacy Consultant)

- *Medication Pass Audits
- *Medication Pass Competency
- *Physician's Order Review & Audit
- *Review of Response to Lab Values by nursing & notification to physician



51



Compliance Tips Con't:


- *Audit MD documentation for compliance with regulatory process including:
 - *Medication Effectiveness
 - *Justification of continued need
 - *Medication Tolerance
 - *Diagnosis for Medication
 - *Medical Director Chart audits for compliance

52

Compliance Tips Con't:

If a Medication Error is detected, consider the following:

- a. Assessment of Resident
- b. Notification to MD
- c. MD Evaluation
- d. Complete Med Error Form
- e. Do a complete & thorough investigation as per F223




53

F441 Infection Control

- o Among the top 10 deficiencies & usually has a domino effect to other deficiencies!
- o Can be cited in multiple ways.
- o Frequent deficient practice
- o includes:
 - * Issues with **handwashing**
 - * Not following appropriate procedure for dressing change
 - * ~~Hands~~ Hands on care issues, i.e. suctioning and trach care, GT handling/Foley catheter, sterile technique and blood glucose monitoring

START →






HAND WASHING STEPS

1. Wet hands
2. Soap (20 seconds)
3. Scrub backs of hands, wrists, between fingers, under fingernails.
4. Rinse
5. Towel dry
6. Turn off taps with towel

54

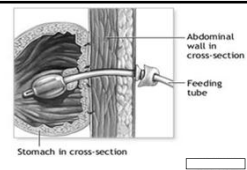
F441 Infection Control

- o Frequent deficient practices continued:
 - * Handling of Regulated waste/linen
 - * Improper handling of Residents on precautions
 - * Non specific Care Plan for infection control issues . i.e. CNA unaware of precautions
 - * Environment and sanitation issues (cross reference to F371)
 - * No PPD/Pneumovax/Influenza Program (F334) including no validation of education for influenza and pneumovax

55


Compliance Tips 6 Infection Control




- o Develop Infection Control Policies that address a multiple of issues:
 - Handwashing, dressing technique, medication administration, respiratory care, gastrostomy tube care
- o Develop policies for PPD/Pneumovax and Influenza that are compatible with OSHA/CDC guidelines and F334 including VIS and plans for education to Resident and/or Family
- o Utilize an Infection Preventionist as per F441 to develop linelists, monitor facility acquired infections and enforce IC policies and Quality Assurance

56

Compliance Tips 6 Infection Control



- o Incorporate IC audits during Med pass, Hands on Care, Observations, Linen Handling, dressing observations
- o Inservice all applicable staff on Infection Control protocols . include housekeeping and maintenance as well as nursing
- o Incorporate IC compliance during meal observations and daily rounds




Compliance Tips 6

Lastly:

LISTEN TO YOUR RESIDENTS!

LISTEN TO YOUR STAFF!

PROVIDE A CONCEPT
OF
RESIDENT CENTERED CARE!



58



REMEMBER:

QUALITY OF CARE

Plus

QUALITY OF LIFE

=

COMPLIANCE!!!

Thank You!

