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Survey Status, ROPs & SOM

- Requirements of Participation (ROPs) Phase One implemented as of November 28, 2016

- New State Operations Manual (SOM) for Phases One and Two published June 30, 2017, effective November 28, 2017

- New SOM now affecting interpretation of Phase One ROPs
Survey Status, ROPs & SOM

• Introduction of new tags numbers (Crosswalk)

• Surveyors trained on “new” survey process
  ▪ New survey forms continue to be generated

• November 28, 2017 – Phase Two implementation

• November 28, 2019 – Phase Three implementation
New SOM and Enforcement Delay

- S&C: 17-36-NH issued June 30, 2017

- Imposes a moratorium on imposing Civil Money Penalties (CMPs), Denial of Payment for New Admissions (DPNA) or termination for failure to implement certain Phase Two provisions for one year
  - Exact regulations to be determined

- CMS also considering holding the 5-Star ratings constant for one year during the moratorium
Revision to CMP Policies and Analytic Tool

• CMS S&C: 17-37-NH (eff date July 17, 2017)
  - Per instance CMP for all past noncompliance
  - Per instance CMP is default for noncompliance that existed before the survey and is ongoing (except IJ w/ actual harm; abuse with actual harm; repeat tag at s/s “G” or higher; s/s H or I)

• Facilities with good survey history may avoid daily CMP if G or J involves a singular event
Revision to CMP Policies and Analytic Tool

- Like under previous tool, facilities with repeats, pattern of G or above, or with more than five deficiencies will receive higher fines.

- Regional Office cannot adjust a penalty more than 35% without Central Office’s approval.

- If fine >$250,000, Central Office must approve.

- Hardship request must be timely.
New Computer-Based Survey Process

• Three parts to new survey process:

  ▪ Initial pool process: (70% computer driven–MDS)
  ▪ Sample selection
  ▪ Investigation: Observations, interviews, mandatory facility tasks, critical element pathways, record review
Mandatory Survey Tasks

- Dining
- Infection control
- SNF Beneficiary Protection Notification review
- Resident Council meeting
- Kitchen
- Medication administration
- Medication storage
- Sufficient and competent nurse staffing
- QAA/QAPI
Critical Element Pathways

Beneficiary Notice
Dining
Infection Prevention
Control and Immunization
Kitchen
Med Admin
Resident Council
QAA and QAPI
Abuse
Environment
Sufficient and Competent Staff

Personal Funds
Activities
Activities of Daily Living
Behavioral-Emotional
Urinary Catheter or UTI
Comm-Sensory
Dental
Dialysis
General
Hospice and End of Life
Death
Critical Element Pathways

Nutrition
Pain Management
Physical Restraints
Pressure Ulcer
Rehab and Restorative
Respiratory Care
Unnecessary Medications
Medication Storage
PASARR
Extended Survey

Hydration
Tube Feeding
Positioning, Mobility, ROM
Hospitalization
Bladder & Bowel Incontinence
Accidents
Neglect
Resident Assessment
Discharge
Dementia Care

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
Things to Review Now

- Admission Processes
  - Handling responsibility for lost items
  - Communicating visitation policy up front
  - Identifying special characteristics and limitations of the facility and abiding by them in admission procedures

- Grievances and Resident Council
  - Complaints vs. Communication
  - Written Grievances Decisions
  - Facility response to resident council documented/communicated?
Things to Review Now

- Changing discharge forms and practices (including bed holds)
  - Hospital transfers – Need to provide notice and appeal rights (Guidance says up to 24 hours for emergencies/up to a month for Ombudsman copy)
  - Bed hold information necessary at admission and at time of transfer
  - Private pay failure to hold bed will not allow facility to treat return as a new admission
Things to Review Now

- Abuse policies changed to include new time frames, new definitions and reference to restraints
  - Have aides been trained on dementia management? Resident catastrophic reactions (as part of abuse prevention)?
  - Do “structures” of facility promote neglect?
  - Number of tags expands from 3 to 10
  - Misappropriation: Remember drug diversions
Things to Review Now

- How resident personal alarms will be treated
- Understanding the authority and limits or authority of Guardian, Powers of Attorney, Resident Representatives
CMS Surveyor Training

• “A review of sufficient and competent nurse staffing will be conducted on every survey. This task is required to be investigated on every survey since surveyors are always considering whether staffing issues can be linked to resident complaints, or quality of life (QOL) and care (QOC) concerns. In addition, Phase 2 of the new rule puts a lot of emphasis not only on sufficient numbers of staff, but also the competence of staff.”
Focus on Sufficient Competent Staff and Resident-Centered Care

- Quality issues trigger many questions about staffing: Sufficiency, competency, evaluations
- Was the issue the subject of QA and PI?
- Are the care plans individualized? (Automatic “F” SQC in Region V if just the typical E record)
- Does everyone on the team know and understand the residents’ care needs consistent with their roles
- Does the resident have a “voice”
Facility Assessment

- Facility Assessment ("FA") = Business Plan

- FA contains a description of:
  - Resident population and care required
  - Staff competence (including outside contractors and volunteers consistent with their roles)
  - Physical environment and equipment
  - Ethnic, cultural and religion considerations
Facility Assessment

- Type of services provided
- Contracts with third parties to provide services or equipment during normal operations and emergencies
- Health information technology resources
- Facility and community-based risk assessment using an all-hazards approach (e.g. emergency preparedness plan)
Facility Assessment Is Integrated Throughout the ROPs

- Examples:
  - Sufficient staff
  - Specialized Training
  - Neglect Guidance references “structures” (or lack thereof) that promote neglect
  - Admission Policy – Limitations and Special Characteristics
  - QAPI should be tailored to services and population identified in the Facility Assessment

Compliance Programs
When Do You Have To Have This Completed?

- By November 28, 2017
- CMS Tool (See Attachment)
- Will need to be produced in the Entrance Conference (See Entrance Worksheet Attached)
- Must review and update annually and any time “substantial change” indicates
Who Should Be Involved In Designing?

- Representative from Governing Body
- Administrator
- Medical Director
- DON
- Consider: Resident or Family Council President, other department heads
- Note: The Assessment *must* be conducted at the facility level, not the corporate level
Facility Assessment Must Coordinate With Admissions

- Communication between disciplines in all things
- Facility Assessment should prevent errors = risk management tool
- Will be used as a club if not coordinated
  - Tort cases
  - Discharge cases
  - Surveys
Quality Assurance and Performance Improvement (QAPI)

- Starting November 28, 2017, you will need to produce your QAPI plan to surveyors for review.
- Guidance says surveyors are not supposed to review QAPI/QAA documents until the end of the survey.
- Draft Entrance Worksheet indicates surveyors will request the QAPI Plan on entrance.
- Guidance directs surveyors to review QAPI plan and QA activities anytime there is a SQC or “E” or higher.
Quality Assurance and Performance Improvement Plan (QAPI)

- Monitoring – Must develop written policies for feedback, data collection and monitoring, including adverse event monitoring.
- Performance Improvement (PI) – Must develop policies that address the systemic approach used, how corrective actions will be developed and how facility will monitor PI activities.
- Program Activities – Must set priorities for PI activities (e.g., high-risk, high-volume, etc.), and track and analyze medical errors and adverse events.
Responsibility of Governing Body

- Ensuring QAPI Program exists and is operational
- Ensuring adequate resources to support the Program
- Ensuring Program sets priorities that reflect resident and staff input
- Ensuring that corrective action is taken to address gaps in systems
- Outlining clear expectations for resident safety, quality, rights, choice and respect
Duties of QA Committee

- Reports to Governing Body
- Meets at least quarterly
- Develops and implements appropriate plans of action to correct quality deficiencies; and
- Regularly reviews and analyzes data, including data collected by QAPI Program and drug regime reviews, and acts on the data
Is QA Information Protected?

- Yes and No
- Surveyor may not require disclosure of the records of such Committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.
Is QA Information Privileged?

- Good faith attempts by the Committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
- Note: Regulation does not mention citations; however, Guidance says:
  - “Information gleaned from disclosure of QAA Committee documents will not be used to cite new issues . . .”
Is QA Information Privileged?

- Guidance also says:
  - “Incident and accident reports, wound logs or other adverse event logs are not protected from disclosure”

- If a facility refuses to provide requested information, it could lead to citation and possible enforcement
Is QA Information Privileged?

- The facts considered are not privileged; analysis of the facts is privileged
- QA policies and procedures detail how Committee identifies issues, develops and implements action plans
- QA materials should be:
  - Clearly marked/labeled & kept separate
  - Only circulated and accessed by QA Committee members
  - Query: = Are your consultants members of the QA Committee??
Why Does Privilege Matter?

- Survey Citations
- Tort Cases
- Media Requests
- Family Requests
- Other Government Investigations
What Will Surveyors Look For?

- Initially, evidence that Committee meets quarterly, that it is properly constituted and that staff (at all levels) are aware of its existence and how to identify and refer QA concerns to the Committee.

- If quality issues are identified, surveyors will want to see whether same issue was identified and whether an action plan was developed and facility was making good faith efforts to address the issue. If so, the QA tag should not be cited.
What Surveyors Can And Cannot Do?

- Should not look at QA until conclusion of survey
- Can’t ask to see QA minutes in general in absence of specific quality issue they have identified
- Can’t cite new deficiencies or expand the survey based on the specific information they review
- Can seek penalties if facility does not cooperate with their request as to a particular quality issue
- Query: Can surveyors generally ask to see all QA minutes at the conclusion of the survey where they have identified multiple quality issues?
Prepare Now

- Start your facility assessment ASAP
- Review staffing competency and evaluation processes
- Print the CE Pathways and distribute to appropriate team members
- Talk to residents, families and staff
- Forewarned is forearmed!
Links to Key Documents

- **New SOM:** [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf)

Links to Key Documents

- CMS S&C: 17-37-NH

- Sample Facility Assessment Tool:
  http://qioprogram.org/sites/default/files/editors/141/Facility_Assessment_2017_08_18_Final.docx
Links to Key Documents

Questions

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