Mid-Year Update on Requirements of Participation and the New Long Term Care Survey Process

By

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It is hard to believe that almost 8 months have passed since the Phase II nursing facility regulations went into effect and the new survey process was initiated. This article will discuss a few insights that have been noted since these changes were put into place.

First, let's discuss the new survey process. We have had feedback from providers that they like the process, and feel it is going well. Surveyors, for the most part, also like the process. A few surveyors, who, like me, prefer to have physical paper and a clipboard in hand, are not as thrilled about the totally computerized process. But, we will have to be dragged kicking and screaming into the computer age whether we like it or not, as that is where the world is going.

There has been one unanticipated outcome since the new survey process has been initiated. Initial feedback from CMS on average numbers of deficiencies per survey show that Kentucky averages have significantly decreased in surveys conducted under the new process versus under the old process. While providers may welcome this change, it is something that we need to evaluate to determine what may be contributing to this outcome. There may be additional training needs for surveyors related to how to use the automated process effectively or there may be the need to evaluate on-site hours or survey team numbers. While we certainly are never looking for reasons to cite more deficiencies as we are already overwhelmed with the workload we do have, if there are clear violations of regulatory requirements, it is our job and duty to cite them. I am sure that each of you in the provider community can understand and appreciate that we all have our individual jobs that we strive to do to the best of our ability, and can understand why we need to evaluate and address this significant change in citation rates under the new survey process.

In addition, as part of a new Training/QI initiative that we have begun in our agency, we are trying to have more trainer and manager participation on-site during surveys in facilities to work with our newer surveyors and also the more seasoned ones to provide training and assistance to the surveyors. Hopefully this will improve quality, consistency, and efficiency in the survey process. So, if you see a trainer, manager, assistant director, etc. on-site with the survey team, please do not panic or think it is because there is something happening in your facility that we are concerned about. These persons are simply there to assist with surveyor training and to see how we can improve things on our part, just as you would do with your Quality Improvement program. CMS is also providing training to states and their surveyors on the new process, and they may be going on-site with our surveyors on occasion to provide this training and consultation. So, it is also possible a CMS surveyor/trainer will be with a team in

your facility. Once again, if your facility is chosen as one where a CMS person will be with the team, it has nothing to do with anything your facility has done or not done. It is simply a component of scheduling, location, and staff availability.

Regarding the changes to the abuse/neglect regulations, reports that have been run since the new regulations went into effect do not show increased or large numbers of deficiencies cited under this category. I know these regulatory changes were a major concern to providers because of the impact abuse/neglect deficiencies can have on liability insurance, as well as the fact that no facility wants to have abuse/neglect deficiencies written on the Statement of Deficiencies, which becomes a public document.

Having said that, there are a couple of areas in the F600 to F610 tags that seem to be cited more frequently. The first is the requirement to have policies and procedures for an effective abuse prevention program and to implement those policies. Please review the Interpretive Guidance at F607, and you will find a great deal of excellent information to include in your policies related to the 7 Key Components of an Effective Abuse Prevention Program. If your policies need to be revised and beefed up to be more comprehensive, that would be a helpful step to take. Secondly, it is vital to ensure that staff are trained on and understand how to IMPLEMENT the policies. We have noted that the deficient practice often is related to the failure of staff to implement what the facility policy says should be done.

The second area that seems to be cited more frequently related to abuse/neglect is the failure to conduct a THOROUGH investigation and to take appropriate action and make any needed changes based on the information and possible root causes or contributing factors that were found during the investigation. It is not enough to just investigate and fire the alleged perpetrator; it is also important to ensure that any other contributing factors are addressed. Also, we have often seen that, while oriented residents and staff are interviewed to determine if they have observed any abuse or neglect, residents who are not interviewable are not assessed for physical signs of abuse/neglect or any psychosocial or behavioral changes that might be indications of abuse/neglect.

Another area that has been and continues to be a major focus for CMS is Transfer and Discharge. As you know, CMS now requires us to notify them of transfer and discharge deficiencies that meet certain requirements, even if only cited at a "D" scope and severity. While we do not have a large number of deficiencies in this area, some of the issues we have seen are failure of the physician to document the reasons for the facility-initiated discharge at the time of the discharge. There have also been issues noted with failure to accurately differentiate between facility-initiated and resident-initiated discharges.

Please read the interpretive guidance at the Transfer and Discharge regulations, where there is a very clear definition of what constitutes a resident-initiated discharge. The resident/representative has to be the one to initiate the request for the discharge, and this should be clearly documented in the record with appropriate discharge planning completed to

the extent possible. It has been said, and I believe it is accurate, that there are very few situations where it is actually a resident-initiated discharge. Just because a resident agrees to a facility's desire to discharge them somewhere else does not make it a resident-INITIATED discharge. Please read the information at the transfer/discharge regulations to ensure your facility has all the required documentation in the medical record whether it is a facility-initiated or resident-initiated discharge. Surveyors are being trained to look for this documentation and not just at the discharge notice.

It appears that most facilities do have a fairly clear understanding now of the requirement to send discharge notices to the state LTC Ombudsman at the time the notice is provided to the resident/representative. Of course, transfer notices such as when sending the resident to the hospital for urgent care and where the resident is expected to return to the facility, can be batched and sent to the Ombudsman at routine intervals such as monthly. It should be noted that if a resident is discharged from the facility while in the hospital, the notice MUST be sent to the Ombudsman at the same time as given to the resident. Lastly, please check your transfer and discharge notices to make sure they contain all the required information listed at F623.

The new regulatory requirements regarding the use of side rails have had a few areas of confusion. If a resident is determined to need/want side rails, the facility must obtain informed consent AND must be able to provide evidence that informed consent was obtained. The regulations do not explicitly state that written informed consent must be obtained. However, it would be fairly difficult to have evidence of informed consent without having something in writing. Just something to ponder when looking at your facility's procedures for obtaining informed consent.

Also, we continue to get questions about are all side rails automatically considered restraints. The answer is no. It is a restraint if it restricts the resident's voluntary movement or ability to get out of bed or move around the room, and the resident cannot easily lower the side rail without staff assistance. If a side rail meets the definition of a restraint, this does not preclude its use, but there must be appropriate assessment, care planning, alternatives attempted, etc., as you would do with any restraint.

Lastly, please be sure you are posting your daily staffing in a place visible to residents and visitors. We are seeing fairly frequently that this is not being done in accordance with the regulation (see below) and is not being maintained for a minimum of 18 months. Surveyors may ask to see the staffing postings for the last 18 months, and these postings should reflect the actual staff who worked, not just who was listed on the master schedule to work on that shift.

F732
§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.
§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.
§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.
§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

I hope this information has been helpful to you regarding some of the things we have noted and are seeing related to the new survey process and updated regulations. We will have future articles to keep you updated on trends or issues we see as time goes along. As always, please feel free to contact us if you have questions and we will do our best to answer them or find an answer for you.