RoPs Phase 3: Critical Information

August 30, 2022

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CMS released regulatory changes for nursing homes that will become effective on October 24, 2022. The QSO-22-19-NH memo released on June 29 reflects changes to Phase 2, guidance for Phase 3, and significant process changes to complaint and Facility Reported Incidents (FRIs) investigations. The updated State Operations Manual (SOM) Appendix PP will be discussed as well as what you need to know about the survey process changes. New Office of Inspector General (OIG) audits occurring in Ohio, current survey trends, and additional federal focus areas will also be discussed. This session will provide a comprehensive overview of the new guidance and detail what facilities need to do to be compliant.

- Describe CMS' recent Requirements of Participation changes including the changes to Phase 2, surveyor guidance for phase 3, and survey process changes including self-reported incidents changes.
- Identify steps to be implemented for facilities to be in compliance with the changes to the State Operations Manual (SOM) Appendix PP, arbitration agreements, and CMS focus areas.

OIG Audits

- Life Safety Code, Emergency Preparedness, and Infection Control audits began in Ohio the week of August 22nd.
- OIG notified Ohio Department of Health the prior week that these audits were an audit of the state agency.
- There will be 18 facilities selected in Ohio.
- ODH will receive an OIG report once all 18 facility audits have been completed.

OIG LSC & EP Audits

- In 2018, the OIG conducted audits in 8 states to assess compliance with CMS's new life safety and emergency preparedness requirements.
  - 2,233 areas of noncompliance with life safety and emergency preparedness requirements at 150 of the 154 nursing homes visited across these eight states
  - Specifically, the OIG found 1,094 areas of noncompliance with life safety requirements, including noncompliance with requirements for building exits, fire barriers, and smoke partitions (416 deficiencies); fire detection and suppression systems (268 deficiencies); resident call systems (4 deficiencies); carbon monoxide detectors (12 deficiencies); hazardous storage areas (124 deficiencies); smoking policies and fire drills (107 deficiencies); and elevator and electrical equipment testing and maintenance (163 deficiencies).

https://oig.hhs.gov/oas/reports/region2/22101010.pdf

OIG LSC & EP Audits

- In addition, the OIG found 1,139 areas of noncompliance with emergency preparedness requirements throughout the eight states, including noncompliance with requirements for emergency plans (229 deficiencies); emergency supplies and power (140 deficiencies); plans for evacuations, sheltering in place, and tracking residents and staff (194 deficiencies); emergency communications plans (331 deficiencies), and emergency plan training and testing (245 deficiencies).

OIG IPC & EP Audits

- Beginning in 2021, the OIG conducted a series of audits in ten states to assess compliance with infection prevention and control emergency preparedness. Upon reviewing these states, 39 nursing homes had not provided a plan of correction for the infection prevention and control deficiencies as of March 26, 2020. The OIG contacted the 39 nursing homes and requested that they provide the documentation related to infection prevention and control and emergency preparedness program policies and procedures that were in effect from January 1, 2019, through May 31, 2020. This documentation included, but was not limited to, the nursing homes' IPCP policies and procedures, information regarding the infection preventionist position, quality assessment and assurance committees (QAAC), training, all-hazards risk assessments, and emergency preparedness policies and procedures.

https://oig.hhs.gov/oas/reports/region1/12000005.pdf

OIG IPC & EP Audits

- The OIG identified possible deficiencies were related to: (1) the designation of an infection preventionist who met Federal regulations, (2) conducting QAAC meetings at least quarterly, (3) infection preventionist attendance at the QAAC meetings, (4) policies and procedures regarding reporting possible incidents of communicable diseases and infections, (5) annual review of the IPCP, and (6) training. The OIG also found 18 instances at 18 nursing homes of possible noncompliance with emergency preparedness requirements related to all-hazards risk assessments and strategies to address emerging infectious diseases. The OIG auditors provided the findings to the state agencies whom they noted may conduct a follow up review at the selected nursing homes to determine whether a deficiency exists for each condition identified in this report.

What to expect

- Entrance conference
- Checklist
- LSC round
- Policies
- Documentation
- Exit with worksheet
- POC

- Waivers (if applicable)
- Generator Logs
  - Weekly Inspections
  - Monthly Load Tests
  - Annual Fuel Quality Test (diesel/fuel oil generators)
  - Vendor Service Records
- Kitchen Hood Extinguishing System Maintenance Records (semi-annual)
- Fire Alarm System Testing and Maintenance Records (semi-annual)
- Sprinkler System Testing and Maintenance Records (quarterly)
- Electrical Equipment Testing Records
- Building Oxygen System Testing/Inspection Records (if applicable)
- Fire Drill Logs
- Elevator Maintenance/ Inspection Records (monthly)
- Smoking Policy – For Residents, Staff, and Visitors
- All Hazards Risk Assessment
- Communication Plan
- Evacuation Plan
- Shelter in Place Plan
- Volunteer Plan
- Fire Alarm/ Sprinkler System Out of Service Policy/Procedures

- Orientation Program for Disaster Preparedness Training Program
- Annual Disaster Preparedness Training Program
- Documentation of Disaster Preparedness Training Completion for all Employees
- Disaster Drills/Events in the past 12 months
- Infection Prevention and Control Program
  - Infection Preventionist Information
- Antibiotic Stewardship Program
- Influenza/Pneumococcal Policies and Procedures
  - Immunization
- COVID-19 Policies and Procedures
  - Vaccination
  - COVID-19 Reporting
  - COVID-19 Testing
- Most recent COVID-19 Report
- Most recent notification of a confirmed COVID-19 infection
- Reports on COVID-19, Influenza, and Pneumococcal vaccination status of residents
- Report of COVID-19 vaccination status of staff
- Outbreak Response Plan

CMS RoP Updates

Effective 10/24/22

Training resources for state survey agencies were made available when the announcement was posted, and are available at the following links:

- QSO-22-19-NH (PDF)
- Appendix PP Guidance to Surveyor for Long Term Care Facilities (PDF)
- SOM Chapter 5 - Complaint Procedures (PDF)
- SOM Exhibit 23 - ACTS Required Field (PDF)
- SOM Exhibit 358- Sample Form for Facility Reported Incidents (PDF)
- SOM Exhibit 359- Follow-up Investigation Report (PDF)
- Psychosocial Outcome Severity Guide (PDF)
- Fact Sheet

CMS RoP Phase 3

- Surveyor Training - Long Term Care Regulatory and Interpretive Guidance and Psychosocial Severity Guide Updates – June 2022 (LTCRIGPSG)
  - https://qsep.cms.gov/welcome.aspx
- 7/26 LeadingAge Nursing Home Network - We'll hear from CDC on the new enhanced barrier precautions guidance, plus policy updates from LeadingAge, and member feedback. https://leadingage.org/networks
- LeadingAge Virtual Update in the Hub on RoPs 3 Compliance. On Tuesday, August 2 from 2:00 – 3:00 PM ET. https://learninghub.leadingage.org/courses/rops-compliance-update

RoP's Phase 2 Updates

CMS is revising the Phase 2 guidance to enhance quality and oversight in certain areas, such as abuse and neglect, admission, transfer, and discharge, and improving care for individuals with mental health or substance use disorder needs. Guidance was added to incorporate the use of Payroll Based Journal (PBJ) staffing data submitted by providers to help inform surveyors of potential staffing concerns. Revisions also were made to clarify expectations for ensuring visitation can occur while preventing community-associated infection or the spread of communicable disease; as well as to assist in the investigation of situations where practitioners or facilities may have inaccurately diagnosed and/or coded a resident with schizophrenia. Additional clarifications are incorporated into the regulatory groups of Quality of Life and Quality of Care, Food and Nutrition Services, and Physical Environment. Lastly, CMS has made minor technical corrections, and changes, such as updated references and web links.

F557 Respect and Dignity

Facility staff searching a resident's body or personal possessions without the resident's or, if applicable, the resident's representative's consent. It is important for facility staff to have knowledge of signs, symptoms, and triggers of possible illegal substance use; such as changes in resident behavior, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. This may include asking residents, who appear to have used an illegal substance (e.g., cocaine, hallucinogens, heroin), whether or not they possess or have used an illegal substance. If the facility determines through observation that a resident may have access to illegal substances that they have brought into the facility or secured from an outside source, the facility should not act as an arm of law enforcement. Rather, in accordance with state laws, these cases may warrant a referral to local law enforcement. To protect the health and safety of residents, facilities may need to provide additional monitoring and supervision.

F557 Respect and Dignity

If facility staff identify items or substances that pose risks to residents' health and safety and are in plain view, they may confiscate them. But, facility staff should not conduct searches of a resident or their personal belongings, unless the resident, or resident representative agrees to a voluntary search and understands the reason for the search. For concerns related to the identification of risk and the provision of supervision to prevent accidental overdose, investigate potential non-compliance at F689, §483.25(d) – Accidents. For concerns related to the behavioral health services that are provided, investigate potential non-compliance at F740, §483.40 – Behavioral Health Services.

F561 Self-determination

- If a facility changes its policy to prohibit smoking (including electronic cigarettes), it should allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents. The smoking area may be an outside area provided that residents remain safe. Residents admitted after the facility changes its policy must be informed of this policy at admission. (See §483.10(g)(1) and
- §483.10(g)(16)) For further explanation of safety concerns, refer to §483.25(d), F689. For information on smoking policies, refer to §483.90(i)(5), F926.

F563 Visitation

- Reasonable clinical and safety restriction
  - CDC guidelines, and/or local health department recommendations
    - Offering alternatives, signage, hand hygiene, safety with current infections, LHD
    - Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.
  - History of bringing in illegal substance
    - Knowledge of signs, symptoms, and triggers of possible illegal substance
    - Involve local law enforcement

- F-582 Beneficiary Notices
  - Notice of Medicare Non-Coverage (NOMNC)
  - Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)
- F-584 Safe Environment - fire danger addressed in the life safety code survey - reference Appendix I in the SOM
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_i_lsc.pdf

F-600 Abuse

- **Resident to Resident Abuse of Any Type** A resident to resident altercation should be reviewed as a potential situation of abuse. The surveyor should not assume that every resident-to-resident altercation results in abuse. For example, infrequent arguments or disagreements that occur during the course of normal social interactions (e.g., dinner table discussions) would not constitute abuse. The surveyor must determine whether the incident would meet the definition of abuse.
- Prior to citing a deficiency as past-noncompliance, surveyors should investigate each instance thoroughly to determine if the facility took all the appropriate actions to correct the noncompliance and determine the date on which the facility had returned to substantial compliance.

F-600 Abuse

- When a facility has identified abuse, the facility must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. Facilities that take immediate action to correct any issues can reduce the risk of further harm continuing or occurring to other residents, thereby potentially preventing the scope and severity of the deficiency from increasing. Failure to take steps could result in findings of current noncompliance and increased enforcement action, including, but are not limited to, the following:
- Taking steps to prevent further potential abuse [See F600, 483.12(a) and F610-§ 483.12(c)(3)];
- Reporting the alleged violation and investigation within required timeframes [See F609-§ 483.12(c)(1) and (c)(4)];
- Conducting a thorough investigation of the alleged violation [See F610 – § 483.12(c)(2)];
- Taking appropriate corrective action [See F610 –§ 483.12(c)(4)]; and
- The facility must revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse [See Tag F656-§483.21(b)].

F-600 Abuse

- Noncompliance at tags such as F686 and F689, do not automatically indicate noncompliance at F600 for neglect.
- Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;
- If Tag F600 is cited for abuse, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from [Type(s) of abuse: mental abuse/verbal abuse/physical abuse/sexual abuse/deprivation of goods and services] by [Perpetrator type: staff/a resident/a visitor]…."

F-600 Abuse

- As the Psychosocial Outcome Severity Guide, located in the Nursing Home Survey Resources Folder, describes, to apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in the resident's similar situation to suffer as a result of the noncompliance). Generally, when applying the reasonable person concept, the survey team should consider the following as it determines the outcome to the resident, which include, but is not limited to:
  - The resident may consider the facility to be their "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.
  - The resident trusts and relies on facility staff to meet his/her needs.
  - The resident may be frail and vulnerable.

F-600 Abuse

- Determining the severity of psychosocial outcomes for abuse can present unique challenges to surveyors. Given that the psychosocial outcome of abuse may not be apparent at the time of the survey, it is important for the survey team to apply the reasonable person concept in evaluating the severity of psychosocial outcomes. It is important for the surveyor to gather and document any information that identifies any psychosocial outcomes resulting from the noncompliance; for abuse, surveyors should also consider that the psychosocial outcome of abuse may not be apparent at the time of the survey. For example, a resident who was raped may demonstrate indifference to the incident at the time of the survey. In addition, residents may not be able to express themselves due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), not be able to recall what has occurred, or may not express outward signs nursing home residents of physical harm, pain, or mental anguish. However, when a nursing home resident is treated in any manner that does not uphold a resident’s sense of self-worth and individuality, it dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive situation for the resident(s).

F-600 Abuse

- There are situations that are likely to cause psychosocial harm which may sometimes take months or years to manifest and have long-term effects on the resident and his/her relationship with others. Therefore, during a survey, "Immediate Jeopardy" or "Actual Harm," may be supported when there is not an observed or documented negative psychosocial outcome, or a description of resident impact from the resident's representative or others who know the resident. Numerous situations involving abuse are likely to cause serious psychosocial harm (i.e. Immediate Jeopardy) to a resident who is a victim of these types of actions; these situations include, but are not limited to:

F-600 Abuse (Continued)

- Sexual assault (e.g., rape)
- Unwanted sexual touching
- Sexual harassment
- Any staff to resident physical, sexual, or mental/verbal abuse [NOTE: Sexual abuse does not include the rare situation where a nursing home employee has a pre-existing and consensual sexual relationship with an individual (i.e., spouse or partner) who is then admitted to the nursing home unless there are concerns about the relationship not being consensual]
- Staff posting or sharing demeaning or humiliating photographs or videos of nursing home residents
- When facility staff, as punishment, threaten to take away the resident's rights, privileges, or preferred activities, or withhold care from the resident
- Any resident to resident physical abuse that is likely to result in fear or anxiety

- F-600 Abuse
- According to the Social Security Act [Sections §§1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii)], every resident has the right to be free from mental or physical abuse. A reasonable person would not expect that they would be harmed in his/her own "home" or a health care facility and would experience a negative psychosocial outcome (e.g. fear, anxiety, anger, humiliation, a decline from former social patterns). In incidents in which one resident abuses another resident, if a reasonable person would likely suffer actual harm as a result of the incident, the incident should not be cited below Severity Level 3 (Actual Harm).
- NOTE: Surveyors should refer to the guidance related to physical, mental/verbal, and sexual abuse and deprivation of goods and services by staff.
- Added several severity level examples

Psychosocial Outcomes - IJ

- Anger, agitation, or distress that has caused aggression that can be manifested by self-directed responses.
- Crying, moaning, screaming, or combative behavior that is above the resident's baseline.
- Fear/anxiety that may be manifested as panic, immobilization, and/or agitated behavior(s) (e.g., trembling, cowering)

Psychosocial Outcomes – Level 3

- Decline from former social patterns that does not rise to a level of immediate jeopardy.
- Depressed mood that may be manifested by verbal and nonverbal symptoms, such as a change in psychomotor retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering) unrelated to medical diagnosis

Psychosocial Outcomes – Level 2

- Sadness, as reflected in facial expression and/or demeanor, or verbal/vocal disappointment.
- Feelings and/or complaints of discomfort or irritability.

How do you prove this?

Surveyor guidance – observation, interview, record review

F604 Respect and Dignity

- Current - For example, a bed rail is considered to be a restraint if the resident is not able to put the side rail down in the same manner as the staff.
- New - For example, a bed rail is considered to be a restraint if *the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently.*

RoP Phase 3

- F607 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.
- VIII. Coordination with QAPI:
- The facility must develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program under §483.75.
- Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action and tracking by the QAA Committee, at §483.75(g)(2).

This coordinated effort would allow the QAA Committee to determine:

- If a thorough investigation is conducted;
- Whether the resident is protected;
- Whether an analysis was conducted as to why the situation occurred;
- Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and
- Whether there is further need for systemic action such as:
- Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,
- Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about,
- Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions,
- Measures to verify the implementation of corrective actions and timeframes, and
- Tracking patterns of similar occurrences.

F608 will change to F607 Abuse Reporting

- **Note: Regulatory requirements §483.12(b(5)(ii)(iii) have been relocated to F607. Regulatory requirements for §483.12(b(5)(i)(A)(B) have been moved to F609.**
- For failures related to the development and implementation of policies and procedures to communicate and coordinate with the QAPI program situations of abuse, neglect, misappropriation of resident property, and exploitation, cite tag F607.
- For failures related to the QAA Committee's identification of quality deficiencies or its development and implementation of action plans to correct identified quality deficiencies, cite tag F867.

F609 Examples

ODH Reporting

- SOM Chapter 5 - Complaint Procedures (PDF)
- SOM Exhibit 23 - ACTS Required Field (PDF)
- SOM Exhibit 358- Sample Form for Facility Reported Incidents (PDF)
- SOM Exhibit 359- Follow-up Investigation Report (PDF)

F622 Transfer and Discharge

- Facility-initiated not necessarily noncompliance
- AMA to be thoroughly investigated
- Short-term admission discharged involuntary
- ER – facility-initiated transfer not discharge

Considerations

- Policy Update
- Form Updates
- Admission Packet
- Who does what - training

Assessment & Comprehensive Care Plans

- F641 Accuracy of Assessment – Dx of Schizophrenia
- F 656 - Comprehensive care plan are culturally-competent and trauma-informed.
- “Culture” is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world. Adopted from Substance Abuse and Mental Health Services Administration. Improving Cultural Competence. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. https://store.samhsa.gov/system/files/sma14-4849.pdf.

F656 Comprehensive Care Plans

Example: Dietary restrictions

- "Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities. US Department of Health and Human Services publication: A Blueprint for Advancing and Sustaining CLAS Policy and Practice at: https://www.thinkculturalhealth.hhs.gov/clas/blueprint.

F656 Comprehensive Care Plans

How do you assess?

- "Trauma-informed care" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Adapted from: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, https://store.samhsa.gov/system/files/sma14-4884.pdf.

F 686 Pressure Ulcer

- Pressure ulcer risk - upon admission, weekly for the first four weeks, and then quarterly (rather than monthly), or whenever there is a change in condition. This change reflects the current accepted standard of practice.

F687 Foot Care

- Facility staff must follow proper infection prevention practices for foot care equipment/devices, including but not limited to nail clippers, scalers, files, and burr tools. Facility staff must separate used or contaminated foot care equipment from clean equipment. Reusable medical devices (e.g., scalers, electronic nail file, and surgical instruments) that are used on one resident must be cleaned and reprocessed (disinfection or sterilization) for use according to manufacturer's instructions prior to use on another resident. If the manufacturer does not provide such instructions, the device may not be suitable for multi-patient use. Recommendations for the cleaning, disinfection, and sterilization of medical devices are available in CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 (available at: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html). Please see guidance at §483.80, Infection Control, for more information.

F689 Accidents

- ***Electronic cigarettes*** *– While electronic cigarettes (e-cigs), or vapor pens, are not considered smoking devices, and their heating element does not pose the same dangers of ignition as regular cigarettes, they are not without risk. A review of literature by the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and Federal Emergency Management Agency (FEMA) shows that as electronic cigarette use has increased, risks associated with their use have also increased. Risks and concerns include: • Potential health effects for the smoker, such as respiratory illness or lung injury which may present with symptoms of breathing difficulty, shortness of breath, chest pain, mild to moderate gastrointestinal illness, fever or fatigue; • Second-hand aerosol exposure; • Nicotine overdose by ingestion or contact with the skin; and • Explosion or fire caused by the battery.*

- Safety for Residents with Substance Use Disorder (SUD) Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home. Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents.
- Care planning interventions should address this risk by providing appropriate diversions for residents and encouraging residents to seek out facility staff to discuss their plan of care, including discharge planning, rather than leaving to seek out substances which could endanger the resident's health and/or safety. The facility should advise residents of the risks of leaving the facility to seek out substances and/or early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible.

- A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts.
- Staff should have knowledge of signs and symptoms of possible substance use such as: frequent leaves of absence with or without facility knowledge, odors, new needle marks, and changes in resident behavior such as unexplained drowsiness, slurred speech, lack of coordination, and mood changes, particularly after interaction with visitors or absences from the facility.
- Provide supportive services

- A resident's risk for overdoses should be assessed and care plan interventions noted.
- Facility staff should be prepared to address emergencies related to substance use by providing increased monitoring, maintaining and having knowledge of administering opioid reversal agents like naloxone, initiating CPR as appropriate, and contacting emergency medical services as soon as possible. The United States Surgeon General has recommended that naloxone be kept on hand where there is a risk for an opioid overdose. Information on safe naloxone administration may be found on this document developed by the Substance Abuse and Mental Health Administration (SAMHSA), https://store.samhsa.gov/system/files/sma18-4742.pdf.
- Bed rail references

F697 Pain Management

- "Medication Assisted Treatment” (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. (From the Substance Abuse and Mental Health Services Administration (SAMHSA)).
- "Opioid Use Disorder" (OUD) is a problematic pattern of opioid use leading to clinically significant impairment or distress. Additional criteria used to assess and diagnose OUD can be found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

F697 Pain Management

- Recognition of opioid epidemic
- Alternative approaches
- Lowest dose, shortest amount of time
- Long-acting opioids
- Dementia – immediate release
- Not combing opioids and benzodiazepines
- Resources listed

F699 Trauma-informed care

- Intent, definitions, guidance, deficiency examples
- Background, assessment, trauma, triggers, culture, cultural competencies, care planning, monitoring delivery of care and services,

Studies have shown that 70% of adults in the United States have experienced some type of traumatic event and there is a direct correlation between trauma and physical health conditions.

F699 Trauma-informed care

- Facilities should ask the resident about a history of trauma, observe the resident, use screening and assessment tools, and obtain social history/assessment.
- Cultural Responsiveness, Cultural Awareness, and Cultural Sensitivity
  - Facility assessment, avoiding stereotypes
- Care plan interventions: Communication, Food preparation, Clothing preferences, Physical contact or provision of care by a person of the opposite sex, Cultural etiquette (voice volume, eye contact)

Staffing

- Meet State standards and care needs
- Provide licensed nursing staff 24 hours a day, 7 days a week
- The Long Term Care Survey Process (LTCSP) software application will alert the surveyors of specific dates that require further investigation related to staffing. Surveyors are expected to verify infraction dates indicated on the PBJ staffing data report. If concerns were identified on this report, as well as from other sources, refer to the critical element pathway of Sufficient and Competent Staffing, and the surveyor probes

Staffing

- DON Full-time = 40 hours
- Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week.
- Facility assessment
- Surveyor Probes

F 729 - If concerns are identified with Nurse Aide Services at F725 and F726, review a minimum of five nurse aide personnel files including any specific staff members with whom concerns were identified

LTCSP updated to include PBJ data

- Excessively low weekend staffing
- 4 or more days with no RN (1 day = citation)
- 4 or more days with less than 24 hours of (1 day = citation)
- Licensed nursing staff
- 1 star staffing rating
- No data submitted for the last quarter

F740 Behavioral Health Services

- Substance Use Disorder
- Substance Abuse and Mental Health Services Administration SAMHSA
- PASARR
- Interventions & care planning
- Diagnosis
- Activities

Pharmacy Services

- Due to the life threatening risks associated with exposure to or ingestion of the patch, the Food and Drug Administration (FDA) and manufacturer instructions recommend consumers dispose of used fentanyl patches by folding the patch in half with the sticky sides together and flushing the patch down the sink or toilet.
- May use drug disposal products or systems
- Psychotropics should not increase based on antipsychotic usage
- Unnecessary medications
- Psychosocial harm

F 812 Food Service

- Food service staff must wear hairnets when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.
- Staff glove use is necessary when touching ready-to-eat foods or when serving residents who are on transmission-based precautions. Staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine, unless touching ready-to-eat food.
- Food should be covered when traveling a distance (i.e., down a hallway, to a different unit or floor).

F847 Arbitration Agreements

If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

F847 Arbitration Agreements

§483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement…

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(5)

The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). . .

Effective 9/16/2019.

Infection Control - Changes

- Definitions
- Covered individuals
- Facility assessment
- Objective methods of evaluation
- Water Management
- PPE
- Instructions to see the nurse before entering should be included in signage
- Citation examples
- Resources/references

- Foot Care
- IV
- Food service

Infection Control - Changes

- Infection Preventionist
- Responsibility for the Infection Prevention and Control Program (including the Antibiotic Stewardship Program)
  - Mandatory survey task
  - Feedback to prescribing practitioners
  - Adverse drug event
- Training, Qualifications, and Hours (part-time/facility assessment, onsite)
- Infection Prevention, Control & Immunizations Facility Task

Enhanced Barrier Precautions

- Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs)
  - https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html
- Added additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting.
- Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status).
- Expanded MDROs for which EBP applies.
- Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission.

Enhanced Barrier Precautions

Precautions	Applies to	PPE used for these situations	Required PPE	Room restriction
Enhanced Barrier Precautions	All residents with *any of the following*: • Infection or colonization with an MDRO *when Contact Precautions do not otherwise apply* • Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) *regardless of MDRO colonization status*	During high-contact resident care activities: • Dressing • Bathing/showering • Transferring • Providing hygiene • Changing linens • Changing briefs or assisting with toileting • Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator • Wound care: any skin opening requiring a dressing	Gloves and gown prior to the high-contact care activity (Change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	None

https://www.cdc.gov/hai/pdfs/containment/PPE-Nursing-Homes-Table-H.pdf

Enhanced Barrier Precautions

- Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities
  - https://www.cdc.gov/hicpac/pdf/EnhancedBarrierPrecautions-H.pdf
- Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes
  - https://www.cdc.gov/hai/containment/faqs.html
- Letters
  - https://www.cdc.gov/hai/pdfs/containment/Letter-Nursing-Home-Residents-Families-Friends-508.pdf
  - https://www.cdc.gov/hai/pdfs/containment/Letter-Nursing-Home-Staff-508.pdf

MMWR Report

- Summary of Guidance for Minimizing the Impact of COVID-19 on Individual Persons, Communities, and Health Care Systems — United States, August 19, 2022 / 71(33);1057-1064
- CDC Webpages: *CDC is reviewing this page to align with updated guidance*.
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

QAPI

- F866 Intent, definitions, guidance, program and documentation, program design and scope, governance and leadership, key elements of noncompliance
- Regulatory requirements §483.75(c) and §483.75(c)(1)-(4) have been relocated to F867.
- F867 §483.75(c) Program feedback, data systems and monitoring.
- Intent, definitions, guidance, feedback, data collection systems and monitoring, performance indicators, systemic analysis and actions, establishing priorities, medical errors and adverse events, corrective actions, PIP's, QAA, key elements of noncompliance

Compliance and Ethics

- LeadingAge Ohio Compliance Plan Template https://www.leadingageohio.org/aws/LAO/pt/sd/news_article/219836/_self/layout_details/false
- Publication of the OIG Compliance and Ethics Program Guidance for Nursing Facilities (2000): https://oig.hhs.gov/compliance/compliance-guidance/index.asp.
- OIG Supplemental Compliance Program Guidance for Nursing Facilities (2008): https://oig.hhs.gov/compliance/compliance-guidance/index.asp

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RoP Phase 3

- F882 Infection Preventionist
  - The amount of time required to fulfill the role must be at least part-time and should be determined by the facility assessment (at the facility)
- F940 Training Requirements
  - Based upon the outcome of a facility assessment, suggestions for additional training topics may include, but are not limited to, advance care planning, cultural competence, end-of-life care, geriatrics and gerontology (i.e., understanding of how human beings change as they grow older), substance abuse, working with young and middle-aged adults, grief and loss, interdisciplinary collaboration, person centered care, specialized rehabilitative therapy, trauma informed care, intellectual disability, mental disorder and quality of life and care.

RoP Phase 3

Training Requirements

- F941 Communication Training
- F942 Resident's Rights
- F944 QAPI
- F945 Infection Control
- F946 Compliance and Ethics
- F947 NA Training (reviews/weakness, 12-hr, competent, dementia, abuse)
- F949 Behavioral Health

F 919 Call System

- Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from–
- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities.
- Probes – issues, auditing working, loss of power

OH CY 2022 - ALL

F0884	Reporting - National Health Safety Network
F0880	Infection Prevention & Control
F0684	Quality of Care
F0689	Free of Accident Hazards/Supervision/Devices
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer
F0677	ADL Care Provided for Dependent Residents
F0812	Food Procurement, Store/Prepare/Serve Sanitary
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records
F0761	Label/Store Drugs and Biologicals
F0580	Notify of Changes (Injury/Decline/Room, etc.)

OH CY 2022 Standard Only

F0880	Infection Prevention & Control
F0812	Food Procurement, Store/Prepare/Serve Sanitary
F0684	Quality of Care
F0689	Free of Accident Hazards/Supervision/Devices
F0677	ADL Care Provided for Dependent Residents
F0761	Label/Store Drugs and Biologicals
F0657	Care Plan Timing and Revision
F0692	Nutrition/Hydration Status Maintenance
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer
F0656	Develop/Implement Comprehensive Care Plan

OH CY 2022 Complaint

F0880	Infection Prevention & Control
F0684	Quality of Care
F0689	Free of Accident Hazards/Supervision/Devices
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer
F0677	ADL Care Provided for Dependent Residents
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records
F0609	Reporting of Alleged Violations
F0580	Notify of Changes (Injury/Decline/Room, etc.)
F0610	Investigate/Prevent/Correct Alleged Violation
F0760	Residents are Free of Significant Med Errors

OH CY 2022 G or Higher

F0689	Free of Accident Hazards/Supervision/Devices
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer
F0880	Infection Prevention & Control
F0600	Free from Abuse and Neglect
F0684	Quality of Care
F0760	Residents are Free of Significant Med Errors
F0697	Pain Management
F0678	Cardio-Pulmonary Resuscitation (CPR)
F0888	COVID-19 Vaccination of Facility Staff
F0692	Nutrition/Hydration Status Maintenance


RESOURCES

https://www.cms.gov/newsroom/fact-sheets/updated-guidance-nursing-home-resident-health-and-safety

Abuse and Neglect	• Clarifies compliance, abuse reporting, including sample reporting templates, and provides examples of abuse that, because of the action itself, would be assigned to certain severity levels.
Admission, Transfer, and Discharge:	• Clarifies requirements related to facility-initiated discharges.
Mental Health/Substance Use Disorder (SUD):	• Addresses rights and behavioral health services for individuals with mental health needs and SUDs.
Nurse Staffing (Payroll-Based Journal):	• Uses payroll-based staffing data to trigger deeper investigations of sufficient staffing and added examples of noncompliance.
Resident Rights:	• Imports guidance related to visitation from memos issued related to COVID-19, and makes changes for additional clarity and technical corrections.
Pharmacy:	• Addresses unnecessary use of non-psychotropic drugs in addition to antipsychotics, and gradual dose reduction.

Potential Inaccurate Diagnosis and/or Assessment	• Addresses situations where practitioners or facilities may have inaccurately diagnosed/coded a resident with schizophrenia in the resident assessment instrument.
Infection Control:	• Requires facilities have a part-time Infection Preventionist. • While the requirement is to have *at least* a part-time IP, the IP must meet the needs of the facility. • The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. • IP role is critical to mitigating infectious diseases through an effective infection prevention and control program. • IP specialized Training is required and available.

Arbitration:	• Clarifies existing requirements for compliance when arbitration agreements are used by nursing homes to settle disputes.
Psychosocial Outcome Severity Guide	• Clarifies the application of the "reasonable person concept" and severity levels for deficiencies.
State Operations Manual Chapter 5	• Clarifies timeliness of state investigations, and communication to complainants to improve consistency across states.

CMS F-Tag Crosswalk

F699	X	Trauma Informed Care	483.25(m)	483.25 Quality of Care	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F866		QAPI/QAA Data Collection and Monitoring	483.75(c)(1)-(4)	483.75 Quality Assurance and Performance Improvement	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F882		Infection Preventionist Qualifications/Role	483.80(b)(1)-(4)(c)	483.80 Infection Control	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F895		Compliance andEthics Program	483.85(a)-(e)	483.85 Compliance and Ethics Program	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F940		Training Requirements - General	483.95	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F941		Communication Training	483.95(a)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F942		Resident's Rights Training	483.95(b)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F944		QAPI Training	483.95(d)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F945		Infection Control Training	483.95(e)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F946		Compliance and Ethics Training	483.95(f)(1)(2)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3
F949		Behavioral Health Training	483.95(i)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/F-Tag-Crosswalk.xlsx

CMS F-Tag Crosswalk

F607	X	Develop/Implement Abuse/Neglect, etc. Policies	483.12(b)(1)-(4)	483.12 Freedom from Abuse, Neglect, and Exploitation	(b)(4) - Phase 3 Will not be in ASPEN until Phase 3
F659		Qualified Persons	483.21(b)(3)(ii)(iii)	483.21 Comprehensive Resident Centered Care Plans	(b)(iii) - Phase 3 Will not be in ASPEN until Phase 3
F837		Governing Body	483.70(d)(1)-(3)	483.70 Administration	(d)(3) - Phase 3 Will not be in ASPEN until Phase 3
F865		QAPI Program/Plan, Disclosure/Good Faith Attmpt	483.75(a)(b)(f)(h)(i)	483.75 Quality Assurance and Performance Improvement	(a)(1)(3)(4)(b)(f) - Phase 3 Will not be in ASPEN until Phase 3
F867		QAPI/QAA Improvement Activities	483.75(d)(1)(2)(e)(1)-(3)(g)(2)	483.75 Quality Assurance and Performance Improvement	(d)(1)(2)(i)-(iii)(e)(1)-(3)(g)(2)(iii) will not be in ASPEN until
F868		QAA Committee	483.75(g)(1)(i)-(iv)(2)(i)	483.75 Quality Assurance and Performance Improvement	(g)(1)(iv) - Phase 3 Will not be in ASPEN until Phase 3
F919		Resident Call System	483.90(g)(1)(2)	483.90 Physical Environment	(g)(1)- Phase 3 Will not be in ASPEN until Phase 3

Resources

- LeadingAge Resources/Nursing Home RoP Tools and Resources
  - PHASE 2 INTERPRETIVE GUIDANCE
    - **Resident Rights**
    - **Training Requirements**
  - QuickCast - New Nursing Home RoPs Guidance 2022: Abuse and Neglect
    - Webinar and checklist
    - https://learninghub.leadingage.org/learn/video/new-nursing-home-rops-guidance-2022-abuse-and-neglect

Resources

- Weekly newsletter updates in the Source
- Monthly STAT Call
- Survey forms will be updated
  - Surveyor resources zip file
  - Revision history
  - https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes
- Submitting clarification questions to ODH
- LeadingAge Ohio All Member Call slides and recording on: *Communications HUB/Recent All Member Calls*

  https://www.leadingageohio.org/aws/LAO/pt/sp/news