October 6, 2022

# LTC COVID-19 Update

Presented by:

**Lori Davenport, Director of Regulatory & Clinical Affairs**

**Indiana Department of Health Team**

Indiana Department of Health

IHCA INCAL

INDIANA HEALTH CARE ASSOCIATION

INDIANA CENTER FOR ASSISTED LIVING

# Today's Topics

- Updated LTC regulations – Brenda Buroker & Tammy Alley
- Q&A

- **REMINDER: No call on October 13. We'll see you back on October 20.**

***Expert Outbreak Management for the Infection Preventionist**, a webinar on Oct. 18, details HERE*

***Assisted Living Symposium**, an in-person event on Nov. 18, details HERE*

IHCA INCAL
INDIANA HEALTH CARE ASSOCIATION
INDIANA CENTER FOR ASSISTED LIVING

Indiana Department of Health

# UPDATED LTC REGULATIONS

## EFFECTIVE OCT. 24, 2022

**TAMMY ALLEY**
DEPUTY DIRECTOR SURVEY MANAGEMENT

**BRENDA BUROKER**
DIRECTOR, DIVISION OF LONG-TERM CARE

10/06/2022

## OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

## OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.

# Resident Rights

F 556: Respect and Dignity

Noncompliance can now include:

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. 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. 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.

# Resident Rights

F 561 Self-determination

Smoking:

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.

# Resident Rights

**F 563 Visitors**

Added guidance related to visitation during communicable disease outbreak to include:

Facilities may need to modify their visitation practices when there are infectious outbreaks or pandemics to align with current CMS guidance and CDC guidelines that enables maximum visitation, such as by: • Offering options for outdoor or virtual visitation, or indoor designated visitation areas • Providing adequate signage with instructions for infection prevention, i.e. hand hygiene, cough etiquette, etc. • Ensuring access to hand hygiene supplies • Taking other actions that would allow visitation to continue to occur safely in spite of the presence of a contagious infection • Contacting their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of communicable disease transmission during an outbreak. During an infectious disease outbreak, while not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors. In these cases, before visiting residents who are on TBP, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to principles of infection prevention.

# F 563 Visits

Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, consistent with §483.10(f)(4)(v), placed by the facility based on recommendations of CMS, CDC, or the local health department.

With the consent of the resident, facilities must provide 24-hour access to other non-relative visitors, subject to reasonable clinical and safety restrictions.

Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

# F 563 Visits

**Visitation and Illegal Substance Use**

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, particularly after interaction with visitors or leaves of absence, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. Following such occurrences, this may include asking residents, who appear to have used an illegal substance (e.g., cocaine, hallucinogens, heroin), whether they possess or have used an illegal substance.

If the facility determines illegal substances have been brought into the facility by a visitor, 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. Additionally, 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.

# Resident Rights

**F578 Right to accept or refuse**

Added language:

The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, **including the right to accept or refuse medical** or surgical treatment. In addition, the facility management is responsible for ensuring that staff follow those policies and procedures.

# Resident Rights

**F582 Medicare and Medicaid Eligibility information**

Added explanatory language for:

Beneficiary Notices

1. **Notice of Medicare Non-Coverage (NOMNC)** The NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization. See also 42 CFR 405.1200 and 422.624.

   The NOMNC is not given if:

   - The beneficiary exhausts the SNF benefits coverage (100 days), thus exhausting their Medicare Part A SNF benefit.
   - The beneficiary initiates the discharge from the SNF.
   - The beneficiary elects the hospice benefit or decides to revoke the hospice benefit and return to standard Medicare coverage.

# F 582

**Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN)** It is important to note that the SNF ABN, CMS-10055, is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential noncoverage and the option to continue services with the beneficiary accepting financial liability for those services.

Per Ch. 30, section 70.2 of the Medicare Claims Processing Manual (IOM Pub. 100-04), a SNFABN must be given to a beneficiary for the following triggering events:

- **Initiation** - In the situation in which a SNF believes Medicare will not pay for extended care items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it furnishes those non-covered extended care items or services to the beneficiary.

- **Reduction** - In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary.

# F 582

• **Termination** - In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF must provide a SNF ABN to the beneficiary before it terminates such extended care items or services.

The SNF: • Files a claim when requested by the beneficiary (this claim is called a "demand bill"); and • May not charge the beneficiary for Medicare covered Part A services during demand bill process.

NOTE: A facility's requirement to notify and explain via the SNFABN that the individual is no longer receiving Medicare Part A services based on the SNF's belief that Medicare Part A will not pay for the resident's stay is separate and unrelated to the admission and discharge requirements under 42 CFR §483.15, which outline the notification and requirements under which an individual may be discharged from the facility or when the transfer or discharge is not initiated by the resident.

Website information added to the tag for more information.

# Resident Rights

**F 584 Environment:**

Added under potential tags for citation:

For issues of fire danger, see guidance provided for §483.90(a) which states, "For additional guidance on life safety from fire and the survey procedures for these regulatory requirements, reference Appendix I in the SOM. Concerns regarding the above regulatory provisions would be addressed through the Life Safety Code survey (KTags)."

# Freedom from Abuse, Neglect and Exploitation

**F600 Freedom from Abuse, Neglect and Exploitation**

Changes and Clarification in Guidance for 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.

**Comment:**

- When investigating potential resident-to-resident abuse, look for patterns and outcomes.
- The Deficient Practice Statement (DPS) is standardized for abuse and neglect with required wording.

# F 600

**Sexual Abuse**

Language added:

Capacity and Consent Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, **the facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity.**

When investigating an allegation of sexual abuse, the facility must conduct a thorough investigation to determine the facts specific to the case investigated, including whether the resident had the capacity to consent and whether the resident actually consented to the sexual activity. A resident's voluntary engagement in sexual activity may appear to mean consent to the activity; in these instances, if the facility has reason to suspect that the resident may not have the capacity to consent, the facility must protect the resident from potential sexual abuse while the investigation is in progress.

# F 600

Determinations of capacity in this context are complex and cannot necessarily be based on a resident's diagnosis alone.

Capacity on its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation.

Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with state law, if applicable.

The facility's policies, procedures and protocols should identify when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded.

CMS is not requiring facilities to adopt a specific approach in determining a resident's capacity to consent. However, the facility administration, nursing and medical director may wish to consider establishing an ethics committee that includes legal consultation to assist in the development and implementation of policy related to aspects of quality of life and/or care, advance directives, intimacy and relationships.

# F 600

Added additional information for when abuse is identified.

NOTE: 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 actions including, but not limited to, the following:

- Taking steps to prevent further potential abuse.
- Reporting the alleged violation and investigation within required timeframes.
- Conducting a thorough investigation of the alleged violation.
- 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.

# F 600

Neglect

Definition changes:

Identifying Neglect "**Neglect," is defined at §483.5 as "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Neglect occurs when** the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), **that has resulted in or may result in physical harm, pain, mental anguish or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety resulted in or could have resulted in physical harm, pain, mental anguish or emotional distress.** Neglect may be the result of a pattern of failures or the result of one or more failures involving one resident and one staff person.

# F 600

The cumulative effect of different individual failures in the provision of care and services by staff leads to an environment that promotes neglect. **Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in or possibly resulting in physical harm, pain, mental anguish or emotional distress**.

Added the example:

Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff. practitioners, and resident representatives

Neglect is not necessarily cited when Quality of Care or Quality of Life tags are cited.

# F 600

Deficiency Categories:

Added information related to Psychosocial Outcome Severity Guide and describes how 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 are 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

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), recall what has occurred or express outward signs 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).

Examples have been added: sexual assault, unwanted sexual touching, sexual harassment, any staff-to-resident physical, sexual or mental/verbal abuse. Staff posting of demeaning photographs/video of residents and instances when the facility threatens to take away some of the resident's rights or privileges or preferred activities or withhold care from the resident.

A reasonable person would not expect that they would be harmed in his/her own "home" or a healthcare facility and would experience a negative psychosocial outcome (e.g., fear, anxiety, anger, humiliation, a decline from former social patterns).

# F 600

Severity Outcome examples have been added for Level 4, 3 and 2.

**Level 4** has examples of sexual, physical, mental/verbal, neglect, psychosocial harm and reasonable person.

The facility deprived residents of care related to the failure of staff to respond timely to residents' requests and treat residents with dignity and respect, which resulted in ongoing embarrassment, humiliation and the failure to provide incontinence care as needed to meet the needs of several residents. Based on family and resident group interviews, other residents and their family members complained that residents often waited a long time (up to an hour) before staff took them to the bathroom, resulting in residents urinating in their beds and laying in urine for long periods of time. Residents indicated that this is a problem, especially on the night shift. Residents were told by nurse aides to just urinate on their beds and staff would change the sheets in the morning. Two night-shift staff members confirmed that they had seen other staff disconnect call lights in residents' rooms so that they were not functioning. After investigation, it was determined that the nursing home failed to provide the necessary care. [NOTE: In this example, the surveyor had already identified noncompliance at dignity (F550) and urinary incontinence (F690)]. It can be determined that the reasonable person in the residents' position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation) as a result of the abuse.

# F 600

**Level 3** has example added for resident-to-resident abuse: The facility failed to protect a resident from physical abuse when Resident 1 slapped Resident 2 in the face. Based on resident and staff interviews, Resident 1 had previously exhibited an aggressive tone toward other residents. Based on the interview with the nurse aide, Resident 2 was talking loudly to Resident 1 in the hallway. Resident 1 shouted profanity to Resident 2, followed by: "If you say one more word, you're going to be sorry." The nurse aide was the only staff present in the area and was transferring another resident; the nurse aide could not intervene and did not call for assistance from other staff. Resident 2 continued to talk loudly. Resident 1 then reached out, slapped Resident 2 on the left side of his face and backed his wheelchair away from Resident 2. Based on the assessment of Resident 2, his left cheek exhibited some redness in the area that was slapped, but there were no other physical injuries. Based on the survey team's interview with Resident 1, Resident 1 was also able to recall the incident and said, "He [Resident 2] just won't stop talking….I don't know what came over me." Resident 2 was moderately cognitively impaired and when interviewed could not recall the incident. The survey team interviewed Resident 2's son, who said that his father would have been mad after an incident like this. Therefore, by using the reasonable person concept, the survey team would conclude that Resident 2 would have experienced psychosocial harm (e.g., anger directed at the action or at a person) as a result of the physical abuse since there is an expectation that the resident would not be slapped in the face in the facility.

# F 600

**Level 2:**

The facility failed to protect Resident 2 from verbal abuse. During the interview with Resident 2, she mentioned that she does not get along with Resident 1. During interviews with staff, Resident 1 previously demanded Resident 2 to sit up at the table and that there was something wrong with her. However, staff would redirect the residents to separate tables to prevent any situation from escalating. According to interviews with other residents, one weekend, residents recall that temporary staff had placed Resident 1 and Resident 2 at the same table for a group activity. Resident 1 yelled to Resident 2 to sit up straight a few times. However, staff in the room would not intervene. Resident 1 called Resident 2 a derogatory name. Upon review of Resident 1's and Resident 2's records, there was no documentation related to altercations. Even though Resident 2 did not have a reaction, it can be determined that the reasonable person would experience no actual harm with the potential for more than minimal psychosocial harm as a result of the verbal abuse.

# Freedom from Abuse, Neglect and Exploitation

**F 604 Respect and Dignity**

Guidance added for use of bed rail.

As described under Definitions, a physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. The resident's physical condition and his/her cognitive status may be contributing factors in determining whether the resident has the ability to remove it.

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.** Similarly, a lap belt is considered to be a restraint if the resident cannot intentionally release the belt buckle.

# Freedom from Abuse, Neglect and Exploitation

F 607 Abuse, Neglect and Exploitation Policy and Procedures:

Added definitions:

For purposes of this guidance, “staff” includes employees, the medical director, consultants, contractors and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility; students in the facility’s nurse aide training program; and students from affiliated academic institutions, including therapy, social and activity programs.

DEFINITIONS: “Covered individual” is anyone who is an owner, operator, employee, manager, agent or contractor of the facility (see section 1150B(a)(3) of the Act).

“Crime”: Section 1150B(b)(1) of the Act provides that a “crime” is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to state law. “Law enforcement,” as defined in section 2011(13) of the Act, is the full range of potential responders to elder abuse, neglect and exploitation, including: police, sheriffs, detectives, public safety officers, corrections personnel, prosecutors, medical examiners, investigators and coroners.

# F 607

“Serious bodily injury” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ or mental faculty; requiring medical intervention such as surgery, hospitalization or physical rehabilitation; or an injury resulting from criminal sexual abuse (see sections 2011(19)(A) and (B) of the Act).

“Criminal sexual abuse”: In the case of “criminal sexual abuse”, which is defined in section 2011(19)(B) of the Act, serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under state law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

# F 607

Added language to Screening:

If a facility has not developed and/or implemented policies and procedures related to screening procedures prior to employment, a finding of noncompliance should be considered at F607, not F606.

If it is determined that the facility employed or engaged an individual, either directly or under contract, who was found guilty by a court of law of abuse, neglect, misappropriation of property, exploitation or mistreatment or had a finding entered into the state nurse aide registry or has a disciplinary action in effect against his/her professional license concerning abuse, neglect, mistreatment of residents or misappropriation of resident property, a finding of noncompliance must be cited at F606.

# F 607

Changes to Reporting and Response:

Added to required written procedures: Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint.

Added facilities to develop and implement policies and procedures that promote a culture of safety and open communication and prohibit any form of retaliation against an employee who reports a suspicion of a crime (staff member harassment, reporting the employee to licensing board).

# F607

Add section VIII. Coordination with QAPI with Investigative Protocol.

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: o Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/ exploitation, o Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, o Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, o Measures to verify the implementation of corrective actions and timeframes, and o Tracking patterns of similar occurrences.

# Freedom from Abuse, Neglect and Exploitation

F608 removed, language moved to F607 and F609

F 609 **develop and implement policies and procedures that:**

**§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act.**

**The policies and procedures must include but are not limited to the following elements:**

**(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.**

**(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.** (good reference chart in SOM)

# F 609

Additional guidance added for reporting:

**The facility must submit reports that are accurate, to the best of its knowledge at the time of submission of the report. It is important that facilities not make reports that are misleading, such as reports that deliberately omit facts, or reports that are designed to make the incident appear less serious than it was, or reports that misrepresent the facility's response. Deliberate misrepresentations or omissions could result in a deficiency at F609 or may give rise to other deficiencies.**

Initial/follow-up guidance added

**The facility must provide in its report sufficient information to describe the alleged violation and indicate how residents are being protected [see §483.12(c)(3)]. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report, so that State agencies can initiate action necessary to oversee the protection of nursing home residents. Please see Exhibit 358 for a sample form for initial reporting, with examples of information.**

# F 609

**The following addresses facility responsibilities for reporting allegations/occurrences involving staff-to-resident abuse; resident-to-resident altercations; injuries of unknown source; misappropriation of resident property/exploitation; and mistreatment.**

**Staff to Resident Abuse All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes.**

**Resident to Resident Altercations Resident-to-resident altercations that must be reported in accordance with the regulations include any willful action that results in physical injury, mental anguish, or pain**. (SOM has charts on required and not required to report, though it's not exhaustive.)

# F 609

**Reporting Suspicious Injuries of Unknown Source "Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when ALL of the following criteria are met:**

- **The source of the injury was not observed by any person; and**
- **The source of the injury could not be explained by the resident; and**
- **The injury is suspicious because of: a. The extent of the injury, or b. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or c. The number of injuries observed at one particular point in time, or d. The incidence of injuries over time.** (SOM has charts on required and not required to report, though it's not exhaustive.)

**Reportable Events Related to Potential Neglect "Neglect," means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."** (good examples in SOM)

# F 609

**Reportable Allegations of Misappropriation of Resident Property and Exploitation** Examples in SOM of what must be reported, i.e., theft of personal property, including but not limited to jewelry, computer, phone, eyeglasses and hearing aids, money from bank accounts, unauthorized use of property, unauthorized/coerced purchases on credit cared or resident funds, staff who accept money from resident when resident believes in financial crisis, gifts to staff for ongoing care and missing prescription medications or diversion of medications for staff personal gain. What would not be reported includes but is not limited to theft of nominal items with little or no monetary or sentimental value and lost items not listed must be reported.

**Reportable Allegations of Mistreatment "Mistreatment," as defined at §483.5, is "inappropriate treatment or exploitation of a resident." Allegations of mistreatment should be reported only if they meet the criteria for reporting alleged violations of abuse and/or exploitation, which are described under the Sections above.**

SOM has an investigative protocol.

# Admission, Transfer, Discharge

**F622 Transfer and Discharge**

Language added to clarify resident- versus facility-initiated discharge. Ensure coercion has not occurred when a resident chooses to go AMA or when they want to stay in facility after MCR discharge.

Prior to admission of a resident, the facility should have determined its capability to care for the resident based on the Facility Assessment. **This means that once admitted, residents have a right to remain in the facility unless the discharge or transfer meets one of the specified exceptions in §§483.15(c)(1)(i)(A)-(F).** 1. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs; 2. The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility; 3. The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility; 4. The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility; 5. The resident has failed, after reasonable and appropriate notice, to pay or has paid under Medicare or Medicaid for his or her stay at the facility; 6. The facility ceases to operate.

# F 622

**Nonpayment as Basis for Discharge:**

In situations where a resident's Medicare coverage may be ending, the facility must comply with the requirements at §483.10(g)(17) and (18), F582. If the resident continues to need long-term care services, the facility, under the requirements above, should offer the resident the ability to remain, which may include: : • Offering the resident the option to remain in the facility by paying privately for a bed; • Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:

- if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and
- if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.

# F 622

Emergency Transfer to Acute Care

Residents who are sent **emergently to an acute care setting**, such as a hospital, must be permitted to return to the facility (§483.15(e)(1), F626). In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, **the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria at §483.15(c)(1)(i)(A) through (D). Additionally, the resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that the failure to transfer or discharge would pose (§483.15(c)(1)(ii)).**

**NOTE: Residents who are sent to the acute care setting for routine treatment/planned procedures must also be allowed to return to the facility (see F626, Permitting Residents to Return to Facility).**

# F 622

**Deficiency Categorization** (examples added)

Level 4:  Facility initiated a discharge on the basis that the resident's health had improved; however, the resident and her family disagreed and filed an appeal. The facility did not allow the resident to remain in the facility while the appeal was pending and dropped her off at her daughter's home. The resident's daughter previously stated she could not care for her mother at her home where necessary medical equipment and wound care were not available. The resident developed sepsis from inadequate wound management and remains hospitalized post-amputation of the infected limb.

Level 3: The facility failed to allow a resident to remain in the facility after his skilled rehabilitation ended and while his application for Medical Assistance was pending. The resident consequently was discharged to another facility that was located further from the resident's family, resulting in the resident expressing persistent sadness and withdrawal from social activities.

Level 2: A facility transferred a resident to the hospital emergently due to a change in condition. The facility failed to provide the hospital with contact information for the practitioner responsible for the resident's care, leading to a delay in admitting the resident.

# Admission, Transfer, Discharge

**F 623 Notice before Transfer**

Added language related to leaving AMA and if there was coercion, this would be a facility-initiated discharge.

Notice of Transfer or Discharge and Ombudsman Notification/Facility-initiated discharges: added language

- **transferred** or discharged
- **prior to the transfer or discharge**
- **The facility must maintain evidence that the notice was sent to the Ombudsman**

Emergency Transfers:

- When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident's representative as soon as practicable **before the transfer.**

# F 623

Content of Notice changes:

The facility's notice must include **all of** the following **at the time notice is provided**: • The specific reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F); • The effective date of the transfer or discharge; • The **specific** location (**such as the name of the new provider or description and/or address if the location is a residence**) to which the resident is to be transferred or discharged; • An explanation of the right to appeal the **transfer or discharge** to the state; • The name, address (mail and email), and telephone number of the state entity that receives **such** appeal hearing requests; • Information on how to obtain an appeal form; • Information on obtaining assistance in completing and submitting the appeal hearing request; and • The name, address **(mailing and email)** and phone number of the representative of the Office of the State Long-Term Care Ombudsman.

# F 623

Timing of Notice: added exceptions to the 30 days prior to transfer or discharge:

- **The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;**
- **The resident's health improves sufficiently to allow a more immediate transfer or discharge;**
- **An immediate transfer or discharge is required by the resident's urgent medical needs; or**
- **A resident has not resided in the facility for 30 days.**

# Admission, Transfer, Discharge

**F626 Permitting Residents to Return:**

Facilities develop and implement policies that address permitting residents to return to the facility after hospitalization or therapeutic leave. If the facility does not allow the return, this would be a facility-initiated discharge.

Facilities must develop and implement policies for bed-hold and permitting residents to return following hospitalization or therapeutic leave. **These policies apply to all residents, regardless of their payment source.** The **facility** policies must **provide that residents who seek to return to the facility within the bed-hold period defined in the state plan are allowed to return to their previous room, if available. Additionally, residents who seek to return to the facility after the expiration of the bed-hold period or when state law does not provide for bed-holds are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident: • Still requires the services provided by the facility; and • Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.**

# Admission, Transfer, Discharge

Changes to not permitting a resident to return due to payment added:

The resident **has failed, after reasonable and appropriate notice, to pay for** (or to have paid under Medicare or Medicaid) his or her stay at the facility, **which applies if:**

- **The resident does not submit the necessary paperwork for third-party payment; or**
- **The third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.**

Deficiency Categorization

Level 3 example added: **After transfer to a behavioral health hospital, a facility failed to allow a resident to return to the facility where the resident had lived for several months, resulting in the resident being transferred from the hospital to a different nursing home 40 minutes away, where he did not know anyone and where he developed increased anxiety and depression.**

# Resident Assessments

**F 641 and 658 Accuracy of Assessment:**

Added information:

CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if noncompliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to state medical boards or boards of nursing.

# Resident Assessments

## F 656 Comprehensive Care Plans

Added:

§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—(iii) Be 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.

"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.

"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.

# F 656, continued

**Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?**

For residents with a history of trauma, does the care plan describe corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident?

Added Level 4 Deficiency Categorization:

The facility failed to identify a resident's cultural dietary restrictions related to eating pork. After eating her dinner, upon realization that she had eaten pork, the resident began crying inconsolably and screaming that this was explicitly forbidden in her culture and faith of Islam. The resident remained tearful and inconsolable for several days and would not eat the food provided by the facility, which resulted in weight loss and serious psychosocial harm.

# Quality of Life

**F 679 Activities**

Guidance Added

Opportunities for each resident to have a meaningful life may be created by supporting his/her domains of well-being (e.g., security, autonomy, growth, connectedness, identity, joy and meaning) as identified by the Eden Alternative philosophy of care. More information may be found at http://www.edenalt.org/about-the-eden-alternative/theeden-alternative-domains-of-well-being/.

# Quality of Care

**F 687 Foot Care**

Language added:

**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 files and surgical instruments) that are used on one resident must be cleaned and reprocessed (disinfection or sterilization) for use according to the manufacturer's instructions prior to use on another resident. If the manufacturer does not provide such instructions, the device may not be suitable for multipatient use. Recommendations for the cleaning, disinfection and sterilization of medical devices are available in CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities.**

Staff would include the podiatrist.

# Quality of Care

**F 689 Accidents**

Added Language;

Assistive and assistance devices are the same thing and may be used interchangeably.

Resident Smoking: added electronic cigarettes

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. 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.

Residents who wish to use e-cigarettes should be assessed for their ability to safely handle the device. Concerns related to resident safety with use of e-cigarettes should be investigated using the guidance at 42 CFR 483.25(d), F689, Accidents and Supervision. Surveyors should also consider how facilities balance resident safety with a resident's right to use these devices while also considering the rights of residents who do not want to be exposed to second-hand aerosol.

# F 689

Falls: Added language to fall risk to include loose or improperly worn clothing.

Elopement: Added language

A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning or being struck by a motor vehicle.

Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address this risk. 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. A resident who leaves the facility prior to his or her planned discharge, but with facility's knowledge of the departure and despite facility efforts to explain the risks of leaving, would be leaving against medical advice (AMA). Documentation in the medical record should show that facility staff attempted to provide other options to the resident and informed the resident of the potential risks of leaving AMA. Documentation should also identify the time the facility became aware of the resident leaving the facility.

# F 689, continued

Added Guidance for SUD:

**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.**

**For example, residents with substance use disorder may leave the facility to satisfy an addiction to alcohol, prescription drugs or illegal substances. 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 that 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.**

# F 689, continued

SUD:

**Facility staff should assess the resident for the risk for substance use in the facility and 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 change, particularly after interaction with visitors or absences from the facility. Efforts to prevent substance use may include providing substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), alcoholic/narcotics anonymous meetings, working with the resident and the family (if appropriate) to address goals related to their stay in the nursing home and increased monitoring and supervision.**

**Overdose can occur in a facility, so care plan interventions should address risk, prevention and interventions. Facilities 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.**

# F 689, continued

Physical Plant Hazards: Added language

**Supervision and/or containment of hazards are needed to protect residents from harm caused by environmental hazards. Examples of such hazards can range from common chemical cleaning materials to those caused by adverse water temperatures or improper use of electrical devices.**

**Chemicals and Toxins — Various materials in the resident environment can pose a potential hazard to residents. Hazardous materials can be found in the form of solids, liquids, gases, mists, dusts, fumes and vapors. The routes of exposure for toxic materials may include inhalation, absorption or ingestion.**

**For a material to pose a safety hazard to a resident, it must be toxic, caustic or allergenic and accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access or are exposed to them.**

# F 689, continued

Assistive Device /Equipment Hazard:  Added language and reference materials

Evidence shows that physical restraints cause more harm than good and seriously infringe upon a person's autonomy as explained in this article in the *Journal of Medical Ethics*, "Use of physical restraint in nursing homes: clinical-ethical considerations." The Food and Drug Administration (FDA) also provides guidance on bed rail safety and reducing entrapment:

Installation and maintenance of siderails are reviewed in F700.

Deficiency categorization added at Levels 4 and 2.

Level 4: **The facility failed to keep a resident free from hazards and provide the necessary monitoring and supervision for a resident with known substance use disorder and history of using illicit substances when outside of the facility. Through an interview with a certified nurse aide (CNA), the surveyor discovered the resident left the facility for approximately five hours with facility knowledge of the absence. Upon return to the facility, the resident went to his room. Facility staff did not assess the resident's condition for several hours and then found the resident unresponsive. Medical records showed that the resident had sustained an overdose.**

# Quality of Care

F 690 Incontinence

Clarified: **F690 includes the appropriate treatment and services to restore bowel function for a resident with fecal incontinence, however, for concerns related to bowel management (such as constipation, fecal impaction), refer to F684.**

F694 Parenteral Fluids:

Added definitions for parenteral fluids and IV therapy. For IV therapy, the facility must have policies based on current professional standards and include the use of aseptic technique for IV care, frequency of assessment and what to look for.

# Quality of Care

F697 Pain Management

Added new definitions:

**"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.**

**"Opioid Use Disorder" (OUD) is a problematic pattern of opioid use leading to clinically significant impairment or distress.**

Added new section:

**Use of Opioids for Pain Management,** which includes information on prescribing, assessments, risks, hospice use, chronic pain and SUD. Added a review of the history of SUD and treatments, a section on the side effects of opioid use and one on the use of Naloxone. Facilities should have written policies addressing overdoses.

# Quality of Care

F 699 Trauma-Informed Care:

**The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.**

Definitions:

**"Trauma" results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being**

**"Trauma-informed care" is an approach to delivering care that involves understanding and 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. Referred to variably as "trauma-informed care" or "trauma-informed approach."**

# F 699, continued

F 699 has new guidance for assessments with additional website information added. It needs to be multipronged and identify the history of trauma and cultural preference. Trauma can be experienced by military veterans, survivors of disasters, survivors of abuse, those with a history of homelessness or imprisonment and those who have lost a loved one, to name a few.

The facility needs to identify triggers (even by asking the resident). What prompts the resident to recall a previous traumatic event, even if the stimulus is not **traumatic or frightening**.

Address culture and cultural competency to ensure the resident is in the best setting possible that meets his/her needs and provides the ability to communicate with those around in a meaningful manner.

Care planning should be collaborative with the resident, as appropriate, the resident's representatives and healthcare professionals, and it should be individualized. **Trigger-specific interventions should identify ways to decrease the resident's exposure to triggers that re-traumatize the resident, as well as identify ways to mitigate or decrease the effects of the trigger on the resident**.

# F699, continued

Deficiency Categorization:

Level 4 example: resident admitted with PTSD from a sexual assault and requests only female caregivers. A male staff member answered a call light for requests for toileting. Resident was upset and refused his assistance and asked for a female caregiver.  The male caregiver insisted on providing perineal care after toileting despite the resident's past trauma. The resident became distraught and was afraid to request care. She cried all night, with profuse sweating; was fearful; and had dreams that awakened her screaming and kicking. She was fearful, felt dirty and demeaned and did not want to go on living.

Level 3 example: Resident with known history of surviving a mass shooting was placed in a room to watch fireworks. He became tearful and frightened as the fireworks went off. The staff noticed his discomfort and told him the show only lasted 30 minutes, and he remained there and continued to be tearful. In the following weeks he had decreased participation in activities.

# Quality of Care

F 700 Bed Rails

Added language to ensure other approaches are attempted prior to use and risks are identified **prior to installation or use.**

Information add for appropriate alternatives that could include, but are not limited to, roll guards, foam bumpers, lowering the bed and using concave mattresses. Website information included.

Added information for facilities to have a process to assess if bed rails and mattresses are appropriate and safe for the resident. Also, should follow the manufacturer's instructions and guidelines on use.

# Physician Visits

F712 FREQUENCY OF PHYSICIAN VISITS

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required.

Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

Must be seen means: face-to-face contact

at the same physical location

not via telehealth

# Authority for PA, NP and CNS

| | Initial Comprehensive Visit | Admission Orders | Other Required Visits and Orders | Other Medically Necessary Visits and Orders | Certification Recert |
|---|---|---|---|---|---|
| SNFs | | | | | |
| PA, NP and CNS facility employed | May not perform | May not provide | May perform alternate visits and sign | May perform and sign | May not sign |
| PA, NP and CNS not employed | May not perform | May not provide | May perform alternate visits and sign | May perform and sign | May sign as permitted under state law |
| NFs | | | | | |
| PA, NP and CNS facility employed | May not perform | May not provide | May not perform or sign | May perform and sign | Not applicable |
| PA, NP and CNS not employed | May perform | May provide | May perform and sign | May perform and sign | Not applicable |

# Nursing Services/Sufficient Staff

F725 The facility submits staffing data through the Certification and Survey Provider Enhanced Reports (Casper) reporting system.

Surveyors will use this report to identify concerns with staffing.

Possible IJ: The survey team was made aware the facility had 4 days in the previous quarter of PBJ submission when there were no licensed nurses in the facility for all 24 hours each day. After a thorough investigation, the team determined the absences of a licensed nurse in the facility created the likelihood for serious injury, harm, impairment or death for all residents.

# Registered Nurse

F727 still requires the full-time services of an RN for 8 consecutive hours, 7 days a week.

12-hour shifts are allowed, but still require 8 consecutive hours by an RN within each 24 hours.

The facility may permit the DON to serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Charge nurse is defined as a nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physical liaison as well as direct resident care.

FACILITY ASSESSMENT – If the acuity of the residents is high, there may be a need for more than the requirement for 8 hours each day.

This will also be available through Casper to review for survey.

# F729

If concerns are identified with Nurse Aide Services at F725 and F726

SUFFICIENT STAFF AND COMPETENCIES

Review a minimum of five NA personnel files, including any specific staff member with whom concerns were identified:

- Review to ensure registry confirmation.
- Did the facility verify with every state?
- Has the nurse aide provided nursing-related services for monetary compensation ever in the 24-month period and, if not, did he/she complete a new training and competency program?

Nurse Aide

# F732 Nurse Staffing Information

PROCEDURES AND PROBES §483.35(g) Surveyors must determine through information obtained by observations and verified by record reviews the following:

• The facility posts the following information daily:

1. Facility name 2. The current date

3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides.

4. Resident census

The facility must post the nurse staffing data mentioned above DAILY at the beginning of each shift. • The data must be posted in a **clear and readable format** and in a prominent place readily accessible to residents and visitors. • 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. • The facility must maintain the posted daily nurse staffing **data for a minimum of 18 months**, or as required by state law.

# F740 Behavioral Health Services

Definitions added

**MENTAL DISORDER** IS A SYNDROME CHARACTERIZED BY A CLINICALLY SIGNIFICANT DISTURBANCE IN AN INDIVIDUAL'S COGNITION, EMOTION REGULATION OR BEHAVIOR THAT REFLECTS A DYSFUNCTION IN THE PSYCOLOGICAL, BIOLOGICAL OR DEVELOPMENTAL PROCESSES UNDERLYING MENTAL FUNCTIONING. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities.

American Psychiatric Association. "Diagnostic and Statistical Manual of Mental Disorders – Fifth edition" 2013.

**SUBSTANCE USE DISORDER (SUD)** IS DEFINED AS RECURRENT USE OF ALCOHOL AND/OR DRUGS THAT CAUSES CLINICALLY AND FUNCTIONALLY SIGNIFICANT IMPAIRMENT, SUCH AS HEALTH PROBLEMS, DISABLITY AND FAILURE TO MEET MAJOR RESPONSIBILITEIS AT WORK, SCHOOL OR HOME.

Adapted from Substance Abuse and Mental Health Services Administration (SAMHSA). "Mental Health and Substance Use Disorders." Accessed March 2, 2021. hhtps://www.samhsa.gov/find-help/disorders.

# Behavioral Health, Continued

The behavior health needs of those with SUD or serious mental disorders should be part of the facility assessment (F838), and services and training should be provided accordingly.

**DO YOU HAVE THE CAPACITY, SERVICES AND STAFF SKILL SETS TO MEET THE REQUIREMENTS?**

SCREENING: The resident will be screened for specialized services through the PASARR requirements. If the resident does not qualify for specialized services but requires more intensive behaviors health services, the facility must demonstrate reasonable attempts to provide and/or arrange for these services.

These could include:

Residents living with mental health and SUDs may require different activities than other nursing home residents. Facilities must ensure that activities are provided to meet the needs of their residents.

# Behavioral Contracts

May be a method for encouraging residents to follow their plan of care.

Be ALERT. You cannot use behavioral contracts to impose a system of rewards and/or punishments as they could be construed as abuse, which includes the willful infliction of punishment and/or the deprivation of goods and services.

These contracts are only intended to be used for residents who have the capacity to understand them.

CONTRACTS MAY ADDRESS ISSUES SUCH AS: leaving AMA, leave of absence, facility efforts to help residents attend counseling sessions, medication-assisted treatment programs, increased monitoring and supervision if there is suspected substance use, restricted or supervised visits if a visitor has been deemed a threat, voluntary drug testing and voluntary room searches.

Refusal or nonadherence to a behavioral contract cannot be the sole basis for a transfer or discharge.

Nonadherence should be treated like any other care plan intervention that needs altered.

# Depression

**Not a natural part of aging, but older adults in nursing homes are more at risk than older adults in the community.**

The facility is responsible to ensure an accurate diagnosis.

Symptoms may include:

- Fatigue
- Sleep and appetite disturbances
- Agitation
- Expressions of guilt
- Difficulty concentrating
- Apathy and withdrawal
- Suicide ideation

# Schizophrenia

It is uncommon for schizophrenia to be diagnosed in a person younger than 12 years or older than 40.

A serious mental disorder that is presented with delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and diminished expression. Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts. Hallucinations include a person hearing voices, seeing things or smelling thing others can't perceive.

*National Alliance on Mental Illness (NAMI). "Schizophrenia." Accessed March 2, 2021. https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia.*

*American Psychiatric Association. "Diagnostic and Statistical manual of Mental Disorders – Fifth edition." 2013.*

# Example of IJ for F740

- Resident admitted one month ago with diagnoses of major depression, SUD and a history of a suicide attempt.
- Resident expressed continuously wanting to die and often yelled and cursed at staff.
- Physician ordered a psychological evaluation, an antidepressant and 30-minute checks. All were implemented by the facility.
- The psychological evaluation recommended several non-pharmacological interventions that were NOT implemented. The resident was found hanging in his closet with a sheet tied around his neck and no pulse. CPR was started, and the resident was resuscitated.

# F741 Sufficient Staff with Skill Sets

Skill Sets for Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or PTSD and implementing non-pharmacological interventions.

Additional definitions:

**Trauma** results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual.

**Post-traumatic stress disorder** occurs in some individuals who have encountered a dangerous, shocking situation. Symptoms usually begin within three months, but sometimes years, following the event. Symptoms must last for more than a month and interfere with relationships or work.

*SAMHSA. "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach." July 2014. Accessed Feb. 25, 2021. https:ncsacw.samhsa.gov/userfiles/files/SAMSA_Trauma.pdf.*

# F755 Pharmacy Services

Fentanyl patches:

Due to life-threatening risks associated with exposure to or ingestion of the patch, the FDA and manufacturer's instructions recommend consumers dispose of used fentanyl patches by folding the patch in half with sticky sides together and flushing the patch down the sink or toilet.

EPA bans the flushing of drugs they consider hazardous waste, but these patches are not in this category.

If the facility prohibits flushing, the nursing home may use drug disposal products or systems for destruction if they can show the system minimizes accidental exposure of diversion.

**They cannot be placed in a sharps container.**

# F758 Psychotropic Drugs

Psychotropic drugs: Any drug that affects brain activities associated with mental processes and behavior:

- **Antipsychotic**
- **Antidepressant**
- **Anti-anxiety**
- **Hypnotic**

# F758 Psychotropic Drugs, continued

New guidance added:

Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented.

Risks associated with psychotropic medications exist regardless of the indication for their use (nausea, insomnia, itching); therefore, the requirements pertaining to psychotropic medications apply to the four categories of drugs without exception.

Other medications not classified as antipsychotic, antidepressant, anti-anxiety and hypnotic can also affect brain activity and should not be used as a substitution for another psychotropic medication.

Antihistamines-Anticholinergic-CNS agents used to treat seizures, mood disorders, muscle spasms.

CONCERNS RELATED TO INAPPROPRIATE PRESCRIBING OF PSYCHOTROIC MEDICATIONS MAY REQUIRE REFERRALS BY THE FACILITY AND/OR SURVEY TEAM TO STATE MEDICAL BOARDS OR NURSING BOARD.

# F801 Sufficient Dietary Staff

Reminder: 10/1/22 sent in 9/1/22 LTC Newsletter

DIRECTOR REVISED REQUIREMENTS

An individual who has served several years in this role as dietary manager may continue to do so if they have two or more years of experience in the manager role and have completed a minimum course of study in food safety.

# F812 Food Safety

**Food service:** The processes involved in ACTIVELY serving food to the residents. When actively serving residents in a dining room or outside a resident's room where staff are serving from a cart or steam table, There is no need for food to be covered. However, food should be covered when traveling a distance, down a hallway, to a different unit or floor.

**Hair restraints/jewelry/nail polish:** Food service must wear hairnets when cooking, preparing or assembling food, such as stirring pots, or assembling ingredients. However, staff do not need to wear hairnets when distributing foods to residents or when assisting residents to dine.

**Gloves:** Necessary when touching ready-to-eat food and when serving food to residents in TBP. Staff do not have to wear gloves to distribute food to residents or when assisting residents to eat unless touching ready-to-eat food.

**Eggs:** Don't forget that eggs are required to be pasteurized if foods are not fully cooked.

# F847 and F848 Binding Arbitration

New Regulation, New Guidance

If the facility chooses to ask a resident or representative to enter into an agreement for binding arbitration, the facility must:

- Not require to sign as a condition of admission
- Ensure the agreement is explained to the resident with acknowledgment of understanding
- Explicitly grant the right to rescind the agreement within 30 days of signing
- Must explicitly state the resident is not required to sign as a condition of admission
- Must not contain any language that prohibits or discourages the resident from communicating with federal, state or local officials.

**THE PROCESS MUST BE TRANSPARENT.**

# F848 The Arbitrator/Venue and Retention

If the facility chooses to ask a resident to enter into an agreement for binding arbitration, the facility must:

- Ensure the agreement provides for the selection of a neutral arbitrator agreed upon by both parties
- Ensure the agreement provides for the selection of a venue that is convenient to both parties

When the facility and resident resolve a dispute through arbitration, a copy of the signed agreement and the arbitrator's final decision must be retained by the facility for 5 years.

**Survey procedures:** Verify with the facility whether arbitration agreements are used to resolve disputes.

If so, interview a sample of residents, resident representatives, resident council and LTC ombudsman.

Review the binding arbitration agreement and, if applicable, the final decision of a dispute.

# F851 Mandatory Submission of PBJ

The surveyors can obtain PBJ data from the Certification and Survey Provider Enhanced Reports (CASPER) to determine if the facility submitted the required staffing information based on payroll data in a uniform format.

**The facility's failure to submit PBJ data as required will be reflected on the CASPER and will result in a deficiency at F851.**

# F 865 QAPI

INTENT: to ensure the LTC facilities (including multiunit chains) implement a comprehensive QAPI program that addresses all the care and unique services a facility provides.

Demonstration of compliance includes:

- Evidence of systems and reports demonstrating identification, reporting, investigation, analysis and prevention of adverse events
- Data collection and analysis at regular intervals
- Documentation demonstrating development, implementation and evaluation of corrective actions or performance improvement activities

UPON REQUEST OF THE STATE AGENCY OR CMS, THE FACILITY MUST PRESENT EVIDENCE, INCLUDING DOCUMENTATION, OF ITS ONGOING QAPI PROGRAM'S IMPLEMENTAITON AND FACILITY'S COMPLIANCE WITH REQUIREMENTS.

# Disclosure of Information

Protection from disclosure is afforded documents generated by the QAA committee, such as minutes, internal papers or conclusions. However, if those documents contain the evidence necessary to determine compliance with the QAPI/QAA regulations, the facility must allow the surveyors to review and copy them.

**Key:** The facility must provide satisfactory evidence it has identified its own high-risk, high-volume and problem-prone quality deficiencies and is making a good faith attempt to correct them.

**Reports and logs:** Incident and accident reports, wound logs and infection control logs used to track adverse events are not protected from disclosure. Surveyors may request these documents as part of their normal investigation of other areas of concern throughout the survey to support their findings.

# F867 QAPI Program

Program feedback, data systems and monitoring

Facility maintenance of effective systems and input from direct care staff, other staff, residents and resident representatives.

**Facility adverse event reporting:** In addition to self-identified improvement activities, the facility must track medical errors and adverse resident events. When medical errors or adverse resident events are identified, the facility must analyze the cause of the event, implement corrective action, prevent future events and conduct monitoring to ensure desired outcomes are achieved and sustained.

Feedback and learning of adverse events must be provided throughout the facility. Educating staff, residents, resident reps and family members is important in reducing and preventing medical errors and adverse resident events.

# Performance Improvement Projects PIPs

**A part of the requirement for the QAPI program is to identify projects based on the needs of the facility assessment. Each facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified through data collection and analysis.**

To evaluate the program, did the facility:

- Include in P/P how it will obtain and use feedback from residents, staff and families
- Develop P/P to include all departments
- Develop P/P on how it develops, monitors and evaluates performance indicators and frequency
- Develop P/P for how it will identify, report and track adverse events
- Establish priorities for improvement activities
- Conduct at least one PIP
- Ensure the QAA committee regularly reviews and analyses data from drug regimen reviews

# F868 Quality Assessment and Assurance

Addition of the Infection Preventionist to the QAA Committee

The IP must report to the committee on the IPCP on a regular basis (each meeting):

- Facility process and outcome surveillance
- Outbreaks and control measures
- Antibiotic stewardship program

Governing Body

The committee must report its activities of the governing body. If there is no governing body, as in small facilities, the administrator would already be apprised of the QAPI activities.

# F880 Infection Control

**Intent: added:** For purposes of this guidance staff includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions.

New definitions for **Legionellosis** and **Multi-drug organisms**

**Environmental Cleaning:**

- Routine cleaning and disinfection of frequently touched or visibly soiled surfaces in common areas, resident rooms and at the time of discharge; and
- Privacy curtains should be changed when visibly soiled
- Routine cleaning and disinfection of resident care equipment including equipment shared between residents

# F880 continued

New Section WATER MANAGEMENT

Facilities must:

- Demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as having a documented water management program.
- Water management must be based on nationally accepted standards (ASHRAE, CDC, EPA)

Water cultures are not required at this time.

# F880

**MDRO** Contact Precautions used for residents infected or colonized with MDROs.

- When a resident has wounds, secretions, or excretions that cannot be contained
- On units or in facilities where, despite attempts to control the spread of MDROs, ongoing transmission is occurring.

These strategies may differ depending on the prevalence or incidence of MDRO in the facility or region.

Staff can use gloves and gowns in order to prevent contamination of hands and clothing while performing high contact resident care activities

Dressing*Bathing*Providing hygiene*Transferring*Toileting*Changing linens*Wound or Catheter care

Use of additional PPE should not restrict a resident's ambulation and socialization and use of common areas and participation in group activities.

# F880 continued

**Glucometers**

If the facility failed to clean and disinfect blood glucose meters per manufacturer's instructions, and they are used for more than one resident, and there is a resident with a known bloodborne pathogen in the facility, surveyors must cite noncompliance under this tag and utilize the guidelines in Appendix Q for determining immediate jeopardy.

The state must also notify the local/ state public health authority of this practice.

# F881 Antibiotic Stewardship Program ASP

- The program should incorporate monitoring of antibiotic use, including the frequency of monitoring/reviewing.
- Monitor/review response to antibiotics and lab results when available to determine if the antibiotic is still needed or if adjustments should be made.
- If there are concerns with the ASP, surveyors must include at least one resident on an antibiotic in the resident sample to assess whether the resident is being prescribed an antibiotic unnecessarily and whether there were any adverse events.
- The prescribing of antibiotics unnecessarily would be cited at F757 and possibly F881, too.

# F882 Infection Preventionist

Intent:  To ensure the facility designates a qualified individual onsite, who is responsible for implementing programs and activities to prevent and control infections.

One or more persons to:

- Assess
- Develop
- Implement
- Monitor
- Manage

… the infection prevention and control program

# Qualifications of IP

- The IP must be professionally trained in nursing, medical technology, microbiology, epidemiology, or other related fields.
- The IP must have specialized IPC training beyond initial professional training or education prior to assuming this role.
- **This does not mean the IP has to do all this all alone.  It takes all staff.**

# F895 Compliance and Ethics Program

To ensure that facilities have in operation an effective compliance and ethics program that uses internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements to deter criminal, civil and administrative violations under the Act and promote quality of care for nursing home residents.

1. Implement written policies, procedures and standards of conduct
2. Designate a compliance officer and committee
3. Conduct effective training and education
4. Develop effective communication
5. Enforce standards through well-publicized disciplinary standards
6. Conduct internal monitoring
7. Respond promptly to detected violations and corrective action

# F919 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 a centralized staff work area
- Added:  From each resident's bedside and toilet and bathing facilities
- The call system must be accessible to the resident at each toilet or shower facility.  The call system should be accessible to a resident lying on the floor.
- Within reason, a facility should ensure the call light can be reached by a resident on the floor next to the toilet, bedside or bathing facility.  There is no expectation the resident would be able to reach the call light from every location in the room.

# F940 Effective Training Program for all staff

Facilities should develop training needs based on its facility assessment

Training requirements should be met prior to staff and volunteers independently provide services to residents, annually and as necessary based on the facility assessment.

Training topics must include:

- F941 Communication
- F942 Resident's Rights and facility responsibilities to properly care for the residents
- F943 Abuse, neglect and exploitation
- F944 Quality Assurance and Performance Improvement
- F945 Infection Control
- F946 Compliance and Ethics

# F947 Required Inservices for Nurse Aides

- No fewer than 12 hours/year
- Includes dementia management training and resident abuse prevention training
- Addresses areas of weakness as determined by nurse aide performance and facility assessment
- Caring for cognitively impaired

Can be a variety of methods: in-person instruction, webinars (but should not be webinars alone), supervised practical training hours.

# F949 Behavioral Health Training

Facility must develop, implement and maintain and effective training program for all staff that includes at a minimum training on behavioral health care and services.

Changes to the facility's resident population, staff turnover, the facility's physical environment, and modifications to the facility assessment may require ongoing revisions to the training program.

All training discussed above should support current scope and standards of practice through curricula that detail:

- Learning objectives
- Performance standards
- Evaluation criteria

# Questions?

**Brenda Buroker**
Director LTC
bburoker@isdh.in.gov

**Tammy Alley**
Deputy Director LTC
talley@isdh.i.gov

# Contact Information

Lori Davenport – IHCA/INCAL Clinical/Regulatory
- ldavenport@ihca.org
- 765-516-0148

Amy Kent – Assistant Commissioner, IDH
- amkent1@isdh.in.gov
- 317-233-7289

Jennifer Spivey – Infection Control, IDH
- JSpivey1@isdh.IN.gov
- 317-232-0639
- 317-471-7844 cell

Paul Krievins
- pkrievins@isdh.in.gov

Kelly White – Reporting, IDH
- kewhite@isdh.in.gov

Tammy Alley – Vaccine Questions, IDH
- talley@isdh.in.gov
- 317-223-7441

Randy Synder – Vaccine Questions, IDH
- rsnyder1@isdh.in.gov

Russell Evans
- russ@probarisystems.com
- outreach@probarisystems.com
- 317-804-4102

Paul Peaper – IHCA/INCAL President
- ppeaper@ihca.org

Dr. Shireesha Vuppalanchi – Clinical, IDH
- svuppalanchi@health.in.gov

Brenda Buroker – Survey, IDH
- bburoker@isdh.in.gov
- 317-234-7340

Jan Kulik
- jkulik@isdh.in.gov
- 317-233-7480

Peter Krombach
- pkrombach2@isdh.in.gov

Michelle Donner
- midonner@isdh.in.gov

Pam Pontones – CDC Guidance, IDH
- ppontones@isdh.IN.gov
- 317-233-8400

Kara Dawson – NHSN
- kdawson@qsource.org
- 317-628-1145 OR contact:
- Angeleta Hendrickson - ahendrickson@qsource.org
- Teresa Hostettler - thostettler@qsource.org

- Deeksha Kapoor – IHCA/INCAL Communications/PR
  - dkapoor@ihca.org
- Rob Jones – IDH Gateway Assistance
  - rjones@isdh.in.gov
- David McCormick
  - DMcCormick@isdh.IN.gov
- Dr. Lindsey Weaver
  - lweaver@isdh.in.gov
- **Langham Customer Service**
  - 866-926-3420
  - Covidsupport@elangham.com
- Deanna Paddack – Infection Prevention, IDH
  - dpaddack@isdh.in.gov
  - 317-464-7710
- Dave McCormick – Immunization Division, IDH
  - DMcCormick@isdh.IN.gov

# THANK YOU!