Issue: Summer 2018

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MONTANA DPHHS

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Certification Bureau Highlights

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* Click on policy number to access QSO Memo

LTC – Pureed: Food for Thought

By: Lore Latham, RDN & Jamie Van Zee, MS, CCC-SLP

Have you ever thought about life in general, and what it would be like to lose your ability to swallow? Let's take a few moments and think about the following…

Have you ever thought about having pureed food every day for the rest of your life? And to your dismay, you could not tell what was in the pureed food mound placed in front of you? No more burgers, french fries, or fresh watermelon; oh my!

Who doesn't love potatoes, right? What if you were served mashed potatoes every day for a month, made from a powder rather than a real potato? And what about when you are eating the mashed potatoes, again, while others around you are eating french fries or potatoes au gratin? I am not sure that sounds appealing; does it to you?

What about those fresh eggs, served crumbly and dry, every day, because someone thinks you really like them? They don't notice you cough and choke, only to have the eggs go down the wrong pipe so you choke more, then you are unable to catch your breath. That sounds a bit scary, doesn't it? After that, would you enjoy the rest of your meal and would you really want eggs again?

But more importantly, what if you could not talk anymore? What if you could not communicate your preferences? What if you could not relay that you were choking? How dreadful could that feeling be, thinking your life may be passing you by in that moment in time. Have you personally considered the challenges and fears others face, when life throws them that curve ball, and now they are unable to swallow or communicate?

This may not sound pleasing, but unfortunately, these scenarios can be frequent occurrences in the lives of the residents served pureed diets, or those who cannot feed themselves, and cannot make their needs known. Often, these are residents who cannot complain, and who may receive meals that are similar day after day, and, at times, are not served or receive what is on the regular menu. The pureed texture of food can also be vastly different, from meal to meal, cook to cook, and facility to facility.

The swallowing process is a well-choreographed synchronization of breathing, sensory input, reflexes and muscle contraction. For our nursing residents, there can often be a medical disorder or dysfunction in this coordinated process. The result is an inability to protect the airway, and can lead to aspiration or penetration of the airway while eating or drinking, commonly referred to as food and/or liquid "going down the wrong pipe." Residents who demonstrate poor airway protection, tend to have significant difficulty with dry or particulate foods, i.e., "crackers, dry scrambled eggs, raw carrots, or rice." These foods do not form a cohesive bolus during the chewing process, and can result in early spillage before the swallow reflex is triggered. Foods remaining in the oral cavity following the initiated swallow, or an interruption in the pattern of breathing and swallowing may cause particles of food to enter the airway during inhalation.

The ideal pureed meal should hold some shape, like pudding; be smooth and creamy; free of lumps and particles, and look and smell appealing. So please, if you are an Administrator, Director of Nursing, Dietary Manager or staff member working in a healthcare facility, to include long term care, watch what food is served and how the pureed meals are provided. How do the pureed foods taste? How does the food look, and is the food appealing? Do the pureed meals provided follow the menu plan for the resident or facility? One day, it may be us receiving the pureed food, sitting at the dining table, wondering what curve ball is going to be thrown our way next. Our bodies require fuel just like a motor does. Our fuel is our food. So, let's make it the best food we can for those we care for, because one day, it may be served to us all.

LTC – CMS-671

By: Becky Yancy & Brittney Nelson

QSO Update – Long Term Care Application for Medicare and Medicaid

For years facilities have been completing the Long-Term Care Application for Medicare and Medicaid, but there has been a change to the form which went into effect June 1, 2018. See CMS memo QSO-18-17-NH, dated 4/6/18. As of June 1st, the staffing information and hours that were previously included on page two of the form, will no longer be necessary. This information is now captured electronically, by use of the Payroll Based Journals (PBJs).

Surveyors will now provide each facility with the new CMS-671 Form for completion during recertification surveys. To ensure the facility is completing the correct form, you may refer to the bottom left side, which will reflect the date of (06/2018). The form may also be accessed and printed at the following website: www.cms.gov

NLTC – CLIA Requirements for Waived Testing

By: Joyce Shepard, Ph.D., MLS (ASCP)CM

A Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver covers all tests classified as waived by the FDA (www.cms.gov/CLIA). A test is classified as waived when the test is determined to be so simple that there is little risk of error (use the following to determine test complexity https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/search.cfm).

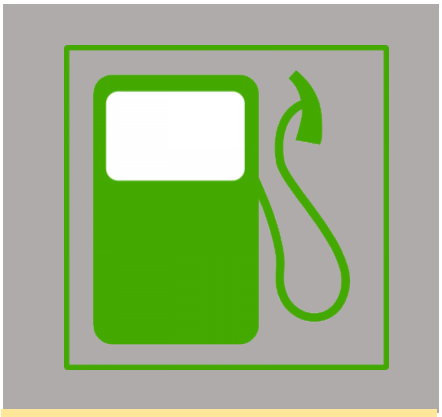
The federal regulations for waived testing require testing to be **performed per manufacturer directions**, have a CLIA certificate, keep the CLIA certificate up to date, and work with the surveyor.

A CDC booklet ("Ready, Set, Test") is an available resource to help entities ensure accurate patient test results (download from https://wwwn.cdc.gov/CLIA/Resources/WaivedTests/default.aspx). The booklet contains information and templates to aid facility documentation and understanding.

To update your CLIA certificate or for more information about the CLIA program, contact Joyce Shepard at jshepard@mt.gov, or 406-438-1793.

LSC – Emergency Generator Fuel Testing

By: DJ Rankosky



Now that we are in the middle of the third quarter of 2018, we have been able get out to many of you and survey your building under the 2012 Life Safety Code. Many facilities have been ahead of the curve and have responded well to the changes of the adoption of the 2012 Code. There has, of course, been some requirements which have been over-looked or just slipped through the cracks, that some facilities were not aware of and thus came as a surprise to them as being a necessary part of the life safety process in their building. There are three requirements I would like to discuss that seem to be the most over-looked.

The first requirement we will be asking for is documentation of an annual fuel quality test for diesel powered generators. You will need to contact your fuel supplier to find out where you can have this test performed. Western States Caterpillar is one place to contact to find out more about this test. This will be an "FYI" on surveys this federal fiscal year, but next federal fiscal year, we will enforce the code for this.

The second requirement that seems to be missed on our surveys is monthly documentation of proper gauge readings at the standpipe of your sprinkler system in accordance with NFPA 25, 2011 Edition, Section 13.2.7.1. It states, "Gauges shall be inspected monthly to verify that they are in good condition and that normal pressure is being maintained." Additionally, the gauges at the standpipe need to be replaced every five years, or tested every five years with a calibrated gauge.

One of the problems we also tend to find at facilities is that of incomplete quarterly sprinkler documentation. Please ensure your sprinkler contractor completes all parts of the forms they use. They need to carry information forward. Information such as the last time the gauges were replaced, the last five year internal inspection was carried out, trip tests, partial and full three year tests, etc. Do not accept incomplete paperwork. We are going ask for this information and it must be provided at the time of the survey. Some vendors are now emailing the report to the facility, please print it off and have it available for review.

The third requirement we are now enforcing is that of the annual fire door inspections. Please reference S&C 17-38-LSC for this requirement adopted for the 2012 Code. The reference source your maintenance person will need for this is NFPA 80, 2010 Edition. Chapter 5 is where to find the details of this annual test.

What we tend to see on survey is just a "check-off" list of doors that closed during a fire drill, however, the requirements for this annual inspection are a bit more stringent and detailed. Specifically, NFPA 80, 2011 Edition Sections 5.2.4 and 5.2.5 has a detailed list of what you need to document, depending on the type of rated door you have. While the non-rated smoke doors and corridor doors to patient rooms are not subject to this annual inspection, they should still be part of a regular preventative maintenance program at your facility.

There is a website your maintenance personnel should bookmark, and subscribe to the email list, it is called **keyeslifesafety.com**. Each day they will receive a question and an answer to a healthcare life safety code question. Most of which will be pertinent to their building. The website has a tab at the top called "tools," where they will find items of documentation they can use in your building. Specifically, one of the tools is titled "Fire door inspection." The items on the tool come right from the above reference in NFPA 80. Quite handy in the development of your life safety code binder you will bring to me when I show up at your facility.

Note: While facilities should already be in compliance with the requirements, the Bureau will begin citing for a failure to meet the annual fuel quality test for diesel powered generators starting with the new federal fiscal year – October 1st, 2018.

ask the bureau >>>

Q: What is the scope of practice for a CNA in Montana?

A: The CNA Registry only recognizes those skills that are located on the "Skills Checklist." Any additional skills cannot be endorsed by the Registry. Facilities must ensure that if they are training CNAs for additional tasks, that those tasks would not require another license to perform. CNAs should be able to thoroughly explain any advanced training or other certifications/ license they are working under if interviewed during a survey. These additional tasks should be addressed in the facility's policies and the facility must have evidence in the employee's personnel file of their competency.

LTC – Discharge Dilemma?

By: Tina (Frenick) Smith, NHA, LTC Supervisor

Do you know your facility's discharge process, and the Federal requirements for discharges? Discharges, in general, continue to be a focus area in FY2018. The new Federal Oversight Survey (FOSS) process happens to include the review of transfers and discharges. Both Federal and State surveyors use the investigative protocols and Critical Element Pathways for the review of transfers and discharges. This allows each facility the opportunity to know what surveyors are investigating for discharges.

The goal of all discharges in LTC is to ensure a resident's discharge needs are met for safety and well-being, and for the continuum of care. Specific steps must be taken by the facility and documented in the resident's medical record, for both the resident initiated and facility initiated discharge. A resident's discharge plans are to be initiated on admission and are ongoing until discharge. The comprehensive care plan must include the discharge plan and goals, and be updated throughout the resident's stay.

Currently, five Federal regulations, outlined in the State Operations Manual (SOM), address the transfer and discharge requirements. Below, you will find a brief explanation of these, to include the important components for the discharge process.

F622 - Transfer and Discharge Requirements

This deficiency specifies the conditions for which a facility may initiate a transfer or discharge of a resident, the necessary documentation for a discharge, who is responsible for the documentation, and information conveyed to receiving providers regarding discharges or transfers. *The regulation addresses both facility and resident initiated discharges*, to include the Immediate and 30-Day discharge requirements, Appeals, Emergent Transfer to Acute Care, Non-Payment of Services, Physician Documentation, Resident/Responsible Party Notification Requirements, Information Conveyed to Receiving Provider, and residents returning to the facility.

F623 Notice Requirements Before Transfer/Discharge

This regulation applies to the facility-initiated transfers and discharges, not resident-initiated transfers and discharges. This guidance addresses the requirement to send notices to specific individuals or entities in situations where the facility initiates the transfer or discharge, including discharges that occur while the resident remains in the hospital after an emergency transfer. Facility-initiated transfers and discharges generally occur when the facility determines it should not, or cannot provide needed care or services to a resident, as applicable in F622. Whether or not a resident agrees with the facility's decision, the requirements of §483.15(c)(3)-(6) apply ***whenever a facility initiates the transfer or discharge***. The content of the Notice to Discharge, Resident/Representative and Ombudsman Notifications, Emergency transfers, Notice Timing, and Facility Closure, is addressed in F623.

Facility initiated discharges should be relatively low in number, as all facilities are required to assess each residents' needs prior to admission. If changes do occur during a residents' stay, and the facility is no longer able to meet the care needs of the resident, the facility must show evidence of the efforts made, to include care plan modification, to meet the residents' needs, prior to the facility initiated discharge.

F624 Preparation for Safe/Orderly Transfer/Discharge

F624 addresses the immediate orientation and preparation necessary for a transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate discharge where a complete discharge planning process is not practicable.

F625 Notice of Bed Hold Policy Before/Upon Transfer

The Bed Hold notice is provided so residents and responsible parties are aware of a facility's bed-hold and reserve bed payment policy, *before and upon transfer* to a hospital, or when taking a therapeutic leave of absence from the facility. Medicaid law requires each state Medicaid plan address bed-hold policies. F626 requires facilities to

permit residents to return to the facility immediately to the first available bed in a semi-private room. The bed hold notice must be provided *prior to and upon transfer* and must include information on how long a facility will hold the bed, how reserve bed payments will be made (if applicable), and the conditions upon which the resident would return to the facility.

F626 Permitting Residents to Return to Facility

The regulation mandates facilities develop and implement policies that address the requirements for a bed-hold, and the ability of a resident to return to the facility, if transferred. Specifically, residents who are hospitalized or on therapeutic leave must be allowed to return for skilled nursing or nursing facility care or services. In situations where the facility intends to discharge the resident, the facility must comply with Transfer and Discharge Requirements at §483.15(c), and the resident must be permitted to return and resume residence in the facility while an appeal is pending. Medicaid-eligible residents must be permitted to return to the first available bed even if the resident has an outstanding Medicaid balance. Residents must be permitted to return to their previous room, if available, or to the next available bed in a semi-private room, providing the resident:

- Still requires the services provided by the facility; and
- Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.

Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in §483.15(c)(1)(ii).

If a facility transfers or discharges a resident for the resident's welfare or because the resident's needs cannot be met in the facility, the medical record must contain documentation to show the needs which are not met, and attempts to meet the needs, to include care planning revisions. Documentation must also include the services available at the receiving facility to meet the resident's needs. Resident decisions to refuse care *should not* be considered a basis for transfer or discharge unless the refusal poses a risk to the resident or other individuals' health or safety. In situations where risk is identified for the resident or others, the comprehensive care plan must identify and show the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate (See F656, §483.21(b)(1)(ii), Comprehensive Care Plans).

We encourage facilities to review the current discharge process, along with regulatory compliance, as outlined in the State Operations Manual. If you have questions, please contact Tina (Frenick) Smith at 444-4463.

NLTC – Summary of Changes to the OASIS-D

By: Didem Park, RDN, OEC

The OASIS D is scheduled for implementation on **January 1, 2019,** to comply with requirements for the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act).

Changes pursuant to the IMPACT Act include the following:
New standardized items (GG0100, GG0130, GG0170, J1800, J1900) to support measures mandated by the ACT; Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF # 0674); and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

A modification was made to OASIS items M1311 to support a new pressure ulcer measure and replace the current one. The new measure is titled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. New items have been added to the OASIS for standardization and to align with IRF-PAI and MDS. These include: M1900 Prior, Function and GG0110 Prior Device Use.

Item removals include: 75 data elements from the OASIS at the time point of Start of Care (SOC), 75 data elements at the time point of Resumption of Care (ROC), 20 data elements at the time point of Follow-up (FU), 42 data elements at the time point of Transfer to an Inpatient Facility (TOC), 1 data element at the time point of Death at Home (Death), and 34 data elements at the time point of Discharge from Agency (DIS).

Please check the CMS website frequently for upcoming changes and training at https://qtso.cms.gov/hhatrain.html.

OASIS Q&A July 2018 **(click to follow)**

Please check your email, as I will be sending the draft version of the OASIS D Guidance Manual AND the OASIS D all item set **(**see link**)**

All - Infection Control & Drug Diversion

By: Liz Adams, LPN

Drug diversion is universal among health care institutions. A proactive system of surveillance is key in the prevention of bloodborne pathogen exposure to resident/patients in the healthcare setting. **Personal observation is vital! It is the first step to investigation.**

Methods of diversion can include:
- Pulling the medication from the container and injecting part of a dose, and pulling normal saline or sterile water to make up difference, and injecting resident/patient with the same needle;
- Withdrawal from a resident/patient PCA, drip line, and I.V. line.

Impact on Residents/Patients:
- Potential to expose residents/patients to a bloodborne pathogen;
- Residents/Patients do not receive appropriate pain relief;
- Theft;
- Staff diverting may be impaired and place residents/patients at risk.

Quality assurance reviews of pharmaceutical services and the Infection Control program are essential in conducting ongoing surveillance and putting preventative action plans in place to address this universal concern for all health care providers.

See below for information provided on the topic by the Centers for Disease Control and Prevention.

Coming Soon >>>

Conducting an accurate medication reconciliation

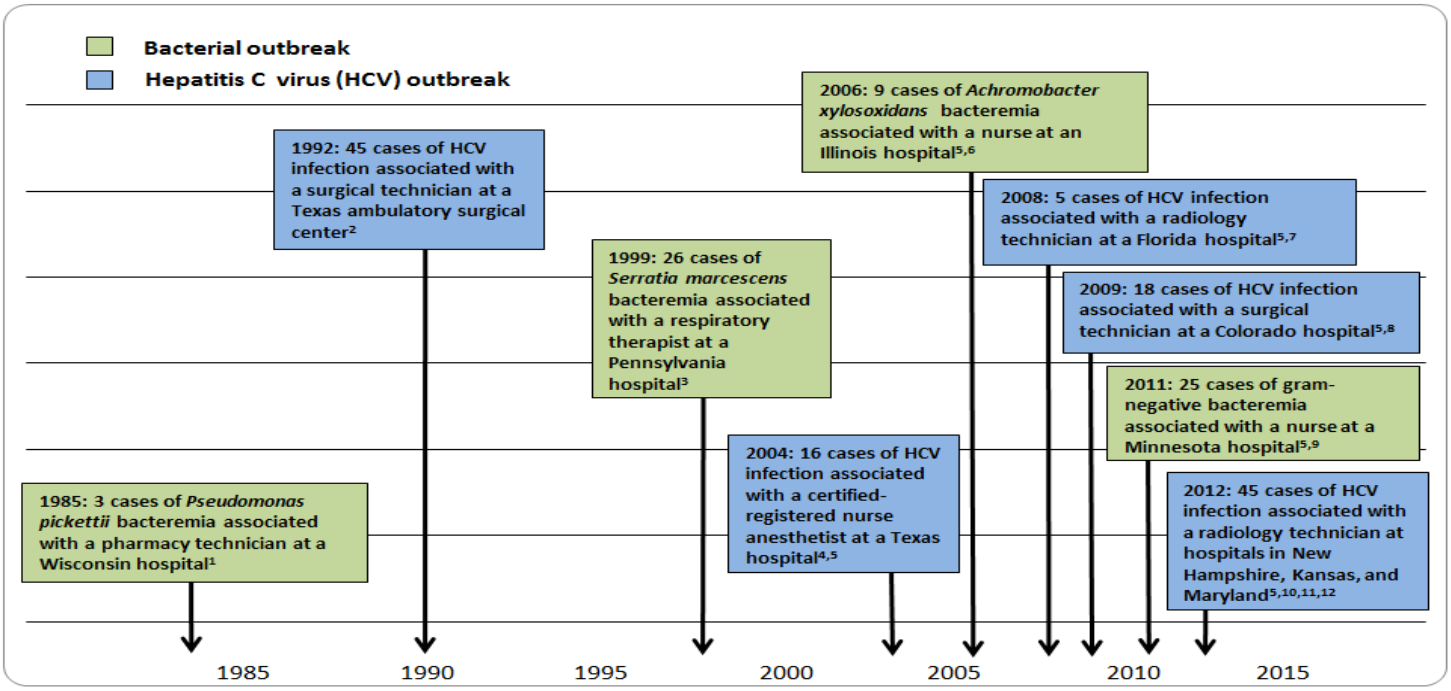
How the LTC regulations address residents found on the floor

Special thanks to:

Becky Yancy & Brittney Nelson, Certification Specialists

Liz Adams, Laura Carney, Joyce Shepard, DJ Rankosky, Lore Latham, Jamie Van Zee and Didem Park

U.S. Outbreaks Associated with Drug Diversion by Healthcare Providers, 1983-2013



https://www.cdc.gov/injectionsafety/drugdiversion/drug-diversion-2013.html

LTC – Abuse, Neglect & Exploitation

By: Todd Boucher, Bureau Chief

One issue that has been in the forefront with survey is the reporting of abuse, neglect, and exploitation of residents in long term care facilities. The computer based long term care survey process, which surveyors started using in December 2017 includes, some renumbering of deficiencies and some additional information for abuse, neglect, and exploitation. The deficiencies cited prior to November 28, 2017 related to these areas were written in tags F223 Free from Abuse; F224 Mistreatment, Neglect, Misappropriation; F225 Not Employ Abusers, Reporting & Investigation; and F226 Abuse Policies & Procedures.

The revised regulations issued for long term care of November 22, 2017 have included abuse, neglect, and exploitation in 10 deficiencies are as follows: F600 Free from Abuse and Neglect; F602 Free from Misappropriation/Exploitation; F603 Free Involuntary Seclusion; F604 Right to be free from Physical Restraints; F605 Right to be Free from Chemical Restraints; F606 Not Employ/Engage Staff with Adverse Actions; F607 Develop & Implement Abuse and Neglect Polices; F608 Reporting of Reasonable Suspicion of a Crime; F609 Reporting; F610 Investigate, Prevent, and Report Results. All of ten deficiencies can be written during survey with one exception - F607. There is a component involving ensuring the Quality Assurance Performance Indicator (QAPI) program should be involved which will be required by November 28, 2019.

The addition of these changes increases the number of pages related to abuse, neglect, and exploitation from 4 tags & approximately 10 pages to 10 tags & approximately 90 pages. Of the five long term care Immediate Jeopardy situations identified by the Certification Bureau since October 1, 2017, one was directly related to tags F606 Not Employ/Engage Staff with Adverse Actions and F607 Develop/Implement/Abuse/Neglect Policies. Total deficiencies written since related to these 10 tags and the new regulations can be summarized as follows:

F610 Investigate/Prevent/Correct Alleged Violation	44%
F609 Reporting of Alleged Violations	44%
F600 Free from Abuse and Neglect	31%
F607 Develop/Implement Abuse/Neglect Policies	13%
F606 Not Employ/Engage Staff w/Adverse Actions	13%

The percentages represent how many facilities were written of the 16 long term care surveys completed. Furthermore, the rewritten Federal Oversight Support Survey (FOSS) process has identified three focus areas that CMS surveyors will evaluate the State Survey Agency against. The three areas are:

Abuse and Neglect;
Admission, transfer, and discharge; and,
Dementia Care Services.

As a reminder, a CMS FOSS survey is conducted in conjunction with the state surveyors. The FOSS program is one of CMS' evaluation tools of the State survey process. An administrative memo was issued by CMS providing information about this new pilot program for FOSS. The memo can be seen at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Admin-Info-18-06.pdf.

In summary, CMS in their focus of person centered care has identified abuse and neglect as important considerations by all State Agencies. As a provider, you will need to consider all steps for review of abuse, neglect, exploitation by completing investigations of allegations/incidents, prevention of additional issues, and correction of any violations. All 10 tags of abuse can trigger substandard quality of care (SQC) and extended survey with a severity & scope of F, H, I, J, K or L. A substandard quality of care determination triggers additional survey tasks and an "extended survey."

LTC – PRN Antipsychotic Use (F758)

By: Laura Carney, RHIT

The definition of a psychotropic medication is; Any drug that affects the brain's activities associated with mental processes and behaviors. The drugs included, but not limited to, are antipsychotics, antidepressants, antianxiety, and hypnotic/sedatives.

Citation F758 addresses this concern.

Psychotropic PRN medications may be ordered for 14 days. The order may extend beyond 14 days if the physician or practitioner believes it appropriate to extend the order. If so,

* The physician or practitioner needs to document the reason for the extension of the psychotropic medication in the medical record, and;
* They must indicate a specific time frame this medication will be used.

Antipsychotic PRN medication may be ordered for 14 days. If it is determined to the be beneficial for the resident, the physician or practitioner may write a new order for the PRN antipsychotic. If the physician or practitioner believes it appropriate to write a new order, the physician or practitioner must:

* Directly exam and assess the resident.
* Document a clinical rationale for the new order which includes:
    - What is the benefit of the medication to the resident?
    - Has the use of the PRN medication resulted in improved mental health for the resident?

The facility staff **is not permitted** to evaluate the resident prior to a new PRN antipsychotic order being written by the physician or practitioner.

Behavior monitoring is a valuable tool, provided by the facility, to assist the physician or practitioner in assessing and evaluating the use of psychotropic and antipsychotic medications.

Contact the Bureau >>>

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