



## **CMS: Region V Meeting: Top Ten Deficiencies, New Regulations of Participation, Focused Survey**

**Attention: LeadingAge Wisconsin Member and Subscriber Nursing Homes**

### **CMS Region V Meeting: Top Ten Deficiencies, New Regulations of Participation, Focused Surveys**

The Centers for Medicare and Medicaid Services (CMS) held its annual Region V (Wisconsin, Illinois, Indiana, Michigan, Minnesota and Ohio) Long Term Care Provider Association and survey agencies meeting December 13 and 14 in Chicago. LeadingAge Wisconsin was represented by John Sauer and Brian Schoeneck. Here is a summary of the key topics shared.

#### **Survey and Certification Citations**

- As always, CMS provided the SNF Citing Data for Federal Year ending 9/30/16. <http://www.leadingagewi.org/media/42379/CMS-SNF-Citing-Data-Sept-30-16.pdf> Similar to FY 2015, F441 (Infection control) made the list in all five regions and nationally for FY2016. In Illinois and Michigan, F441 was cited more than 50 percent. F323 (Accident Hazards) and F309 (Provide Care/Services for Highest Well

Being) also made the list in all five states and nationally.

- In Wisconsin, the top three (3) citations were F371, (Food Storage and Preparation) (49.4%), F441 (49.1%) and F314, (Treatment/Services to Prevent Pressure Ulcers) (39.3%) on standard surveys.
- In Region V, Michigan averaged 7.3 deficiencies per annual survey and Wisconsin was tied with Minnesota with 6.6 deficiencies cited per annual survey compared to the national average of 5.9 deficiencies. Wisconsin led the Region V states with 1.1 deficiencies per complaint survey compared to national average of 0.6 complaint deficiencies cited. Wisconsin cited F225, (Investigate/Report Allegations of Abuse) in over 11% of complaint surveys.
- Wisconsin ranked first (37 in total) in the region for the number of level 4 tags cited on standard surveys for FY2016. This is an increase compared to FY 2015 that had 24.

### **Life Safety Code (LSC) Citations**

- Bruce Wexelberg provided the top ten LSC deficiencies. CMS did not provide the helpful tips as they did last year, but are reconsidering it based on requests from the provider associations.
- K62 (Sprinkler System Inspection, Testing, and Maintenance) was the highest LSC cited deficiency in Region V and nationally again in FY 2016. Facilities need to ensure that the company hired to do the facility's annual inspection reviews the key components of this citation to confirm compliance. K144 (Electrical Systems – Maintenance and Testing) and K50 (Fire Drills) were the other two top cited areas.
- In Wisconsin the top three (3) LSC violations were K62 (Sprinkler System Inspection, Testing and Maintenance), K147 (Utilities – Gas and Electric) and K50 (Fire Drills).

## Life Safety Code 2012 Highlights

- Bruce Wexelberg shared that the **surveyor training** on the 2012 LSC is also available to providers under the **provider option tab**. [The name of the class is Life Safety Transitions Class](#)
- The K tags have changed and are now based on code section. You can see some of the 2012 LSC tags in the top ten LSC deficiencies list.
- The form the surveyors will use for survey is the **CMS 2786R**
- Door Inspections: CMS clarified that the person doing the door inspection does not have to have a specific certification. However, the person needs to be “knowledgeable” on the code as demonstrated through training, level of door violations and through interviews. Also, CMS recommended that facilities do their annual door and electrical inspections by 7/5/17, the date 2012 LSC was in effect.
- Facilities need their HVAC connected to a generator (emergency preparedness regulations)
- To determine compliance with the FSES, the information is plugged into a calculation and given a “pass” or “fail” score.
  - However, there are ways in which a facility can demonstrate compliance through the explanation of how they have items that are “equivalent to code” even without the prescriptive requirements in place.
- If a facility feels that they can’t meet the prescriptive requirements of the code the facility can apply for a waiver.
  - A waiver determines if the facility can’t meet the pass or fail criteria. It then considers:
    - Does it impact the life safety of residents?
    - How is it a hardship? (i.e. Financial hardship is an appropriate hardship to be considered by CMS)

**Requirements of Participation:** Evan Shulman, Deputy Director, CMS Central Office discussed several areas of the Requirements of Participation Rule

- There were several areas (transfers/discharges, physical plant requirements of a toilet in each resident pertaining to renovations, pre-admission education requirements) that CMS stated that they were unable to provide further guidance prior to the release of Interpretive Guidance anticipated in the summer of 2017. CMS recommends using the revised version of Appendix PP of the State Operations Manual. The rules are aligned with current guidance.
- In regards to further clarification on willful and deliberate definitions for Abuse, CMS commented that they suggest facilities look at preambles in the federal register and Section 483.12 (c) of Appendix PP. Phase II will address reasonable suspicion of crime.
- CMS responded to the following language: 21c1VIII - §483.21(c)(1)(viii) to require that the facility assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data are available.

Question: What data beyond the 5 star rating are providers expected to be aware of if discharging to another post-acute care provider?

CMS Response: Facilities should provide data on nursing home compare (such as the quality measures). The facility should know what special needs a resident has and then check to see if the other facility provides those services (vent example).

- Guidance for Sufficient Staffing; Facilities need to do self assessment of competencies of staff. Surveyors look at “reasonable method for determining compliance”. There will be more guidance on sufficient staffing.
- SNF Payroll Based Journal (PBJ)
  - Reports will be given to providers prior to publishing on the Five-star

- reports.
- 90% of nursing homes have submitted data
- NH Compare will reflect PBJ data at the earliest by the second half of 2017
- The PBJ reporting will eventually replace the Report-671.
- Quality Assurance Performance Improvement (QAPI)
  - Phase I requirements include the QAA committee – participants, frequency of meeting, and used to correct deficiencies
  - QAPI plan is not required at this time
- Behavioral Health
  - Phase I includes Non-pharmacological interventions
  - Continue to rely on current interpretive guidance until more guidance is available.
- Pharmacy Services
  - Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
  - Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
  - PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
  - PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
  - ***CMS' comments:*** PRN - 14 day (483.45 new)
  - DQA November/December Pharmacy News Capsule – Drug Regimen Review: <https://www.dhs.wisconsin.gov/newsletters/dqa-pharm-20160-nov-dec.pdf>

- Infection Control:
  - Phase 1 and 2 Policies and procedures should include the following:
    - Identification of infections
    - Transmission based isolation
    - Least restrictive isolation methods should be used
    - Infection control plan should consider all those entering the facility (staff, visitors, contractors, etc)
    - Plan is to be updated annually
  - Expectations and goals include Antibiotic Stewardship that includes policies and procedures that address infection control under current guidance. CMS suggested that providers start working on Antibiotic Stewardship using CDC – 7 core elements of antibiotic stewardship (Agency for Research and Quality - and nursing stewardship program)
  - Infection Preventionist is a Phase III requirement for 2019.
- **Infection Control** (S&C Memo 17-09) Infection Control Pilot and Worksheet

### **New Survey Process**

- The new survey process will be rolled out in 2017 in conjunction with the Phase 2 implementation.
- CMS will be combining the QIS and Traditional survey process and taking elements from both.

Refer to: **S&C 15-40NH** Summary of Traditional and Quality Indicator Survey (QIS)

Findings and Issues

**Exit Conferences:** Providers should expect the exit conference to include:

- Areas of concern described.
- Will not provide scope and severity. Will tell provider how many residents were involved in the citation.

- Will share their concerns but will not share F tags.
- Providers will be informed of IJ and harm level citations
- Survey team should accept information from providers until they leave the facility.

**S&C 16-11-ALL Exit Conferences – Sharing Specific Regulatory References or Tags**

Social Media: Protecting Resident Privacy and Prohibiting Abuse Related to Photographs and Audio/Visual Recordings By Nursing Home Staff

- Providers need to have Policy and Procedures addressing social media.
- Providers need to provide training, oversight and supervision of staff and if needed, report violations
- Compliance began in September, 2016. Surveyors are required to review Policy and Procedures related to social media to make sure is included as a potential issue. Violations can cause psychosocial harm and compliance can use the reasonable person concept. Can be cited at F164 and at the abuse related tags.

S&C: 16-33-NH **Social media**

**Quality Payment Program**

- The Quality Payment Program policy will reform Medicare Part B payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system.
- The Merit-based Incentive Payment System moves Medicare Part B Clinicians to a performance based payment system. Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location, or patient population.
- CMS commented:
  - 1 - This meets the initiative of paying for Value or Volume of care.

- 2 - Reduces burden for those seeing patients in different settings
- 3 – Improvement Activities for Clinicians
  - Better access to data
  - Money follows the clinician (+ or -)
  - Group reporting for clinicians
  - Improvement activities
- [Website](#)
- [Press Release](#)
- [Basic overview of the program](#)

### **Mandatory Model Update**

- Under the proposed [episode payment models](#), the hospital in which a patient is admitted for care for a heart attack, bypass surgery, or surgical hip/femur fracture treatment would be accountable for the cost and quality of care provided to Medicare fee-for-service beneficiaries during the inpatient stay and for 90 days after discharge. The first performance period would run from July 1, 2017 to December 31, 2017.
- Impact on SNF's
- Higher acuity admissions post-surgery
- Adequate cardiac care rehabilitation
- Quality Measures for each of the above is what hospitals are going to be focused on. This includes Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate

### **Dementia Focused Survey**

- CMS provided an update on the S&C letter 16-28NH. This report provides a brief overview of the National Partnership summarizes activities following the release of Survey & Certification policy memorandum 14-19-NH2 and outlines next steps. Additionally, this report describes the results of the Focused Dementia Care

Surveys conducted in FY2015 and the conclusions gathered based upon post-survey data analysis. The report covers the period of Calendar Year (CY) 2014 Quarter 2 through CY2015 Quarter 3.

- Continuing to be conducted, identifying providers with trends/meds/other indicators
- Opportunities for increased staffing, dementia training and non- pharmacological interventions
- Patterns also include the lack of changing of diagnoses that do not meet clinical/professional standards (e.g. indicated with schizophrenia but resident does not have it)

**S&C 16-28 NH** Update Report on National Partnership to Improve Dementia Care in Nursing Homes

#### **MDS Focus Survey**

- CMS provided a detailed update on trends from the surveys. A separate guidance will be provided on this in 2017.
- Refer to S&C letter that includes a summary of the MDS Focus Surveys: **17-06 NH**

#### **Infection Control Pilot Project**

- 3 year pilot program to improve infection control in Requirements of Participation
- Improve ability to assess programs for compliance
- Develop new surveyor tools
- Educational in nature, no citations

- Contractors and unannounced
- Hospital CoP changes
- Draft worksheet – surveyor tool includes tracers – go to bedside to observe care
- Developed list of facilities that will be surveyed
- This year 40 hospitals and 40 LTC facilities
- Focus on transitions of care

### **Infection Control Pilot Project Announcement** (December 2015)

### **Infection Control Pilot Project 2017 Update**

#### **Emergency Preparedness**

On September 8, 2016 the Federal Register posted the final rule **Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers**. The regulation goes into effect on November 16, 2016. Interpretative guidelines are not finished yet. CMS hopes the guidelines will be done by spring, 2017 since health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

- If a facility has a fire rated door without closures, are those non-required fire rated doors required to be tested?
  - CMS Response - Maintain what is installed – don't take label off.
  - Inspect door based on how it is supposed to function. Inspect based on its intended use.
- Risk assessment NFPA 99
  - The facility is responsible and surveyor will not do their own independent risk assessment but will check to see if it is accurate.
- **Four (4) provisions Four Core Elements of Emergency Preparedness**
  - Risk assessment and planning
  - Policies and procedures

- Communication plan
- Training and testing

## **Emergency Preparedness Regulation Guidance**

### **Civil Monetary Penalties (CMPs)**

- The total amount in effect of per day CMPs for Wisconsin in FY 2016 was \$2,435,265.
- The average amount in effect was \$45,098.
- The average days were 44 and there were 54 cases.
- The total amount in effect for per instance CMPs was \$82,565 for 20 cases.

CMS also discussed the Survey and Certification memo 16-40-NH/HHA/CLIA that explains the inflation “catch-up” adjustments for CMPs and the annual inflation adjustment. The new CMP amounts apply to any CMP imposed on or after September 6, 2016 for noncompliant conduct that occurred on or after November 2, 2015. CMS Region V discussed how they calculate Immediate Jeopardy (IJ) amounts based on the number of days an IJ will be calculated for. They also explained how they determine the per-day amount of an IJ CMP using the new CMP base amounts (page 4 of handout) that are included in S&C: 16-40.

Calculating IJ CMP Amounts: <http://www.leadingagewi.org/media/42848/cmpamts.pdf>

S&C: 16-40 –NH/HHA/CLIA: (CMPs) <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-40.pdf>

### **Involuntary Discharge Project**

CMS provided an update on a project that looks at Involuntary Discharge/

improper/wrongful discharge. The one reason for involuntary discharge is the safety of the individual is endangered due to the clinical or behavior status of the resident.

- Nursing facilities need to document in the residents medical record and make sure the appropriate information is communicated to the transfer facility. (Under F201 and F202)
- The notification requirements including notification to the Ombudsman. (F203)
- The power of attorney email must be included with the facility/resident contacts and orientation for the resident must be provided in an understandable manner (F204)
- Facility Policy and procedure must include a policy for permitting residents to return to the facility. (F206)

CMS reported that new guidance for the requirements of participation are not yet available. CMS indicated that providers should use the guidance included in the Revisions to State Operations Manual, Appendix PP-Revised Regulations and Tags included in S&C: 17-07-NH. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>

### **Medicare Advantage Update**

- Medicare Advantage enrollment continues to increase and in 2016 there were 31% (38% in Wisconsin) of Medicare Beneficiaries enrolled in the Medicare Advantage plans.
- Medicare enrollment in the three largest companies include: United Healthcare (21%), Humana (18%) and Blue Cross Blue Shield excluding Anthem (13%) In Wisconsin, these three companies have 68% of the market share.
- In 2016, 68% of the enrollees are in plans with a 4-5 star rating.
- The average out of pocket limit for enrollees in Medicare Advantage plans for 2016 was \$5,223.

Please contact Brian Schoeneck, [bschoeneck@leadingagewi.org](mailto:bschoeneck@leadingagewi.org) or John Sauer, [jsauer@leadingagewi.org](mailto:jsauer@leadingagewi.org) if you have questions regarding the CMS Region V meeting.

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