FY 2014 Michigan Top Cited F Tags

Top 5 citations for Standard Surveys in Michigan
- F441 Infection Control (45.6%)
- F323 Accident Prevention/Supervision (39%)
- F371 Store/Prepare/Distribute Food (35.4%)
- F329 Unnecessary Medications (26.8%)
- F309 Quality of Life (26.4%)

Infection Control – F441

Facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
**Infection Control Program**

- Investigates, controls & prevents infections
- Decides what procedures, such as isolation, should be applied to a particular resident
- Maintains record of incidents & corrective actions related to infections

**Components of an IC Program**

- Policies and procedures
- Infection preventionist (coordinator)
- Surveillance
- Ongoing training
- Medication (antibiotic review)
- Communicable Disease Reporting

**Resident Infection Tracking**

- Cluster mapping to monitor for infection incidence
- Culture results – colonization vs infection
- Antibiotic use
- Community vs. facility acquired
- McGeer’s vs. the MDS coding requirement
Linen Handling

Focus Areas: Isolation rooms; General soiled linen; Hand washing after handling linens

CDC/CMS Guidelines
- Leave washing machine open to air when not in use
- Any detergent is OK – does not need to be “anti-microbial”
- Ozone cleaners OK
- Chlorine Bleach not required – Hot water - 160° (for 25 min) or 71 - 77° with 125ppm bleach are effective
- Facilities are NOT required to maintain a record of water temps during laundry processing cycles

Employees

Prohibit employees with communicable diseases and infected skin lesions from food handling & direct resident contact.

Facilities are not required to track employee infections!

Employees

“Communicable Disease” aka “Contagious Disease” is an infection transmissible by direct contact with an affected person or the person’s body fluids or by indirect means (e.g. vector)
- Don’t confuse with “reportable” diseases
- Should have policy that prohibits employees from working with contagious diseases
- Annual Inservicing
Avoid Citations - Infection Control “Hot Spots”

**HAND WASHING!**
- Dirty to clean tasks
- After removing gloves
- After leaving a resident’s room

**Dressing Changes**

**Medication Pass**

**C-Diff**

Tips

- Periodically monitor housekeeping staff and nursing on hand washing and infection control techniques
- All staff should be knowledgeable about infection control policies
- Review and update all policies and procedures on isolation, universal precautions, and tracking procedures
- Make sure infection control coordinator is knowledgeable about program and can explain/defend tracking tool
Center for Disease Control

CMS Guidance incorporates CDC Recommendations into the Guidance
Consult CDC Guidance
• When developing policies and procedures on isolation
• For management and control of unusual illnesses and infections – e.g., MDRO

CMS Program Letters

SOM Appendix PP Changes
• 14-25-NH (5/16/14): F441 Infection Control (Single-Use Devices)
• 14-34-NH (5/20/14): F371 Sanitary Conditions (Pasteurized Eggs)

Infection as a Disaster?

Influenza outbreaks
• Vaccine use for residents
• Vaccine use for employees
Norovirus outbreaks
TB Infections
What We Learned From the Ebola “Scare”

Quality of Care and Pain (F309)

CFR 483.25
Quality of Care – F309

“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”

Among other conditions, F309 includes facility practices related to resident pain management.
Quality of Care

Consideration given to the following:

- An accurate and complete assessment (target area);
- The care plan is implemented consistently and based on information from the assessment (resident specific); and
- Evaluation of the results of the interventions and revising the interventions as necessary (outcomes).

Facility Responsibilities Related to Pain

- Identify potential for pain or current pain issues and when pain might be anticipated (assessment of risk)
- Identifies cause of pain (etiology/root cause analysis)
- Manage or eliminate pain based on resident specific interventions and goals for pain (care plan)

Pain Recognition

- How is pain assessed in your facility?
- Do you look for nonverbal indications for pain?
- Who monitors the resident/elder for pain?
- How often is the resident/elder assessed for pain?
- Staffing training for pain assessment?
MDS and the Pain Interview

- The MDS pain interview can set the facility up for unwanted consequences if staff are not frequently assessing and providing interventions for pain.
- The MDS pain interview can have a significant impact on the Short and Long Stay Quality Measures and Five Star Rating.

MDS Pain Assessment

- Consists of an interview with the resident.
  - Staff interview only if resident is unable to participate in the interview.
- Pain items assess:
  - Presence of pain
  - Frequency of pain
  - Effect on function
  - Intensity
  - Management
  - Control

  Challenge is to find the etiology of the pain.

  Warning – Do NOT try to talk a resident out of the pain response they provide.

Pain Assessment Interview

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Pain Frequency & Effect on Function – Are you Prepared for the Answer?

- **Pain Frequency**
  - How much of the time have you had pain/hurting in the last 5 days?

- **Pain Effect on Function**
  - Over the past 5 days:
    - has pain made it hard for you to sleep at night?
    - have you limited your day-to-day activities because of pain?

Based on the resident's interpretation of pain presence and frequency.

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Pain Management – Why the Focus?

- Pain can cause suffering and is associated with:
  - Inactivity
  - Social withdrawal
  - Depressed mood
  - Functional decline

- Pain can interfere with participation in rehabilitation
- Effective pain management interventions can help to avoid these adverse outcomes
- Even if the resident denies pain – assessment should be ongoing

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Pain Management

- What are the options for pain management at your facility? (hint – it’s not all about the medications)
- Departmental involvement – not just the nursing department.
Pain and Harm Level Citations

- Change In Guidance!
  - Removed specific examples for Level 2, 3 & 4 severity
  - Isolated instances of pain cited at G

- Documentation
  - Response to the intervention
  - If no relief – must have evidence of follow-up
  - Pre-medication for dressing changes, if indicated (STOP the dressing change if pain persists)

Hot Topics

- Antipsychotic Use (F329 & F309)
- Dementia Care (F309)
F329 Unnecessary Drugs

Still a big focus
• Antipsychotic use recently added to short-stay and long-stay QMs

What makes a drug unnecessary?
• No supportive reason (diagnosis) for med
• Incorrect dosage – too much
• Incorrect duration – too long
• Given in presence of adverse reaction(s)
• Failure to attempt a dose reduction or have documentation stating why you didn’t

CMS F329 Harm Examples

Example #1
• Admission meds: Reglan, Ativan (anti-anxiety), Amitriptyline (anti-depressant) and Ambien for facility defined behaviors of – stomach pain, SOB and sleep disturbance
• None of the issues are considered by CMS to be “behavioral”
• Resident began showing decline in functional status
• No comprehensive assessment completed by facility
• No consideration meds could be causing the decline
• No reduction in meds and an ↑ in Ativan and Amitriptyline

Example #2
• Resident on Seroquel for 18 months for paranoid/anxiety/suspicious behavior with only 1 GDR attempt
• From 7/24/13 – 9/17/14 documentation of only 3 instances of suspicion of others
• No other interventions or quantitative/qualitative goals to determine if the medication was necessary.

Resident #3
• Resident given nightly antianxiety for insomnia without any assessment as to quality or quantity of her sleep
• Facility did not attempt any non-pharmacological interventions or GDR
**Dementia Guidance Under F309**

- Focus on Screening, Identifying and Addressing Behavioral Symptoms in Persons with Dementia
- Includes Decision Tree & Narrative Assessment/Care planning tool
- Includes examples of IJ and Harm Level deficiencies – Cross References F309

**Dementia Focused Surveys**

  - Antipsychotic Use
  - Training for Staff
  - Recognizing and management of behaviors

**New CMS Guidance**

- F155 CPR Guidelines (14-01-NH), eff. 1/23/15
  - When to Provide, and Training and Policy Requirements
  - Number of Required Personnel Discretionary
New CMS Guidance

- 15-16-NH (12/19/14): CMP Analytic Tool
  - Factors for CMP include Survey History, Repeated Deficiencies, Number of Deficiencies
  - CMS May Change at Time of Imposition
- Soon to be Released:
  - New Abuse and Neglect S&C Memo
  - New F525 SOM Guidance (SNF & Hospice Contracts) & New Hospice S&C Memo

On the Horizon....

MDS Focus Survey

- Pilot was conducted in five states and concluded in August of 2014
- Results have caused CMS to determine that full implementation will take place in 2015 for nation
- States will determine which facilities will be targeted in each state
Preliminary Findings of MDS Coding Errors

24 out of 25 facilities had coding errors identified during the survey.

Errors consisted of inaccuracies related to:
• Pressure ulcer coding
• Antipsychotic medication use
• Restraint use

MDS Focused Surveys

CMS is to release a summary of findings – preliminary reasons identified for coding errors:
• Coordinator turnover
• Training issues with new coordinators
• Timing issues
• Policy issues

Appendix PP of the SOM was updated November 26 including F 278 - Accuracy MDS

Pilot Surveys

Consisted of approximately 2 days of survey with 2 to 4 surveyors.
Surveyors met with the Administrator and requested an alphabetical census with room numbers and floor plan.
OBRA assessments were reviewed (typically 10 most recently completed and submitted assessments with any subsequent corrections).
Conditions Targeted in Pilot

Residents with conditions or devices used in previous 90 days:
- Pressure ulcers
- Indwelling catheters
- Restraints routine and prn use – excluding side rails
- UTIs
- Antipsychotic medication
- List of residents with falls in past 12 months

Sample of Reported Inaccuracies

- 25% of the MDSs reviewed for falls did not agree with the documentation in the medical record
- 18% of the MDSs reviewed for pressure ulcers did not agree with the documentation in the medical record
- 17% of the MDSs reviewed for restraints (other than side rails) did not agree with the documentation in the medical record
- 15% of the MDSs reviewed for late loss ADLs did not agree with the documentation in the medical record

Reminder – this was in a sampling of 25 facilities with 10 MDSs per facility reviewed. This information should be used with CAUTION!

MDS Focused Survey Recent Happenings

- As of February 13, 2015 – CMS has revised the survey structure to improve the effectiveness of the MDS/Staffing Focused survey.
- Surveys are to be rolled out in 2 phases
  - Regions and states will be informed in February which phase they will be assigned to
  - Each state will need to identify a “point of contact” (POC) as the primary recipient of information related to the surveys
- Surveyor training is to begin in April 2015
  - Each state must allocate 3 surveyors to complete the training
- Surveyors will receive approximately 4 hours of training (training is to build on previous experience of the surveyors)
- Michigan reported to CMS they will conduct 12 MDS focused surveys; 2-3 surveyors have been allocated for this process
Survey Outcomes

Non-compliance will result in
- Citations related to assessments (F272 to F287)
- Plan of correction will be required

Non-compliance could result in
- Extended survey – with routine survey team following up
- Civil monetary penalties (CMPs)

Staffing Reporting and Surveys

Surveyors will be expected to validate staffing information provided on the CMS 671 form.
Voluntary reporting of staffing data will be piloted in 2015

Questions?
Resources

5. Centers for Disease Control and Prevention, www.CDC.gov