



Nursing Home Facility Assessment Tool and State Operations Manual Revisions


Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communication's Group here at CMS, and I am your moderator today.

I'd like to welcome you to this Medicare Learning Network Call on the Nursing Home Facility Assessment Tool and State Operations Manual Revisions. During this call, we'll learn about the new Facility Assessment Tool to help identify and develop the specific assessment of your facility. Also find out about frequently asked questions related to revision of the State Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities Final Rule.

A question-and-answer session follows the presentation. Before we get started, you received a link to the presentation in your confirmation email. These materials are available at the following URL, go.cms.gov/NPC. Again, that URL is go.cms.gov/NPC.

At this time, I'd like to turn the call over to Michelle Laughman, a Health Insurance Specialist within the Division of Nursing Homes at CMS.

Presentation

Michelle Laughman: Thank you.

As Leah mentioned, our first presentation will be on a new Facility Assessment Tool. Our speakers for this presentation will be Jay Weinstein, a Health Insurance Specialist within the Division of Nursing Homes; Angel Davis, a Health Insurance Specialist in the Quality Improvement and Innovation Group and the nursing home subject matter expert for the Quality Innovation Network-Quality Improvement Organization, QIN-QIO Program; Kelly O'Neill, a Program Manager at Stratis Health; and Marilyn Reiersen, a Senior Program Manager at Stratis Health.

Jay, I will now turn it over to you.

Facility Assessment Tool Introduction

Jay Weinstein: Thank you, Michelle. Hello, my name is Jay Weinstein. I work in the Division of Nursing Homes here at the Centers for Medicare and Medicaid Services as a Health Insurance Specialist. I am a licensed Nursing Home Administrator who previously administrated nursing homes in Maryland. I helped write the guidance for Section 483.70(e) Facility Assessment.

The three major components of the regulation are:

- Section 483.70(e)(1), the facility's resident population
- Section 483.70(e)(2), the facility's resources
- Section 483.70(e)(3), a facility-based and community-based risk assessment utilizing an all-hazards approach

The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. We believe that each facility needs to have the flexibility to decide the best manner in which to conduct that assessment as long as it addresses or includes the factors or items set forth above.

Since this is a new requirement, we have been working with our partners in the Quality Improvement group to develop a tool that can help facilities meet this new requirement. We have been seeking feedback on this tool, and we'll now share it with you. This will be just a sample and is not required for use. And we'll review the basic regulatory requirements. Facilities should feel free to adopt it for their own use.

And now, I turn the presentation over to Angel Davis.

Angel Davis: Thank you, Jay. Again, CMS heard the request from nursing homes that an optional template would be helpful to help add some context as to what this assessment might include and how nursing homes might structure and utilize it.

CMS asked the QIN National Coordinating Center to draft the tool given their experience in long-term care and an organizational assessment in using findings for quality improvement. We hope you find this tool useful.

QIN-QIOs are working with nearly 80 percent of nursing homes in the country on the National Nursing Home Quality Improvement Collaborative. So most of you already know that they are a great resource for you and your quality improvement work and in helping you to prepare for or enhance your work in many of the areas addressed in the revised regulations released last October.


Please contact your QIN-QIO if you haven't already for quality improvement assistance. And now, I will turn it over to Marilyn Reiersen with the National Coordinating Center.

How the Tool Was Created

Marilyn Reiersen: Thanks, Angel and Jay. I am Marilyn Reiersen and I'm part of the Quality Innovation Network National Coordinating Center team.

Today, I will introduce an optional template that you may wish to adopt as you determine the best way to comply with the regulations. I will share more about the tool's design, its purpose, and intent. I will also share more about a pilot that we conducted to gather feedback to further enhance the tool prior to public release. And then my colleague Kelly O'Neill will further discuss the tool.

As we begin, you can look at slide 6. As we began to conceptualize the tool, we met with our CMS colleagues and came up with several guiding principles that are noted on slide 6.



We know it was important to reflect the facility assessment requirements that are described in the regulations, yet we wanted to keep the tool as simplified as possible. We wanted the tool to help nursing facility teams in planning for their assessment. But because we know every facility is unique, it was important to make the optional tool so that each nursing facility team could modify, adapt, add, and individualize it for their own facility to meet the intent of the regulations. We also thought it would be helpful to support the translation of the assessment findings into a plan, which we'll talk more about in a little while. Lastly, we want to remind you that use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance.

One slide 7, the purpose and the intent of the Facility Assessment Tool are noted. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both the day-to-day operations and emergencies. The assessment may be used to make decisions about your direct care staff needs as well as your capabilities to provide services to the residents in your facility.

Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.

The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require.

I'm now on slide 8. Over the past several months, our Quality Innovation Network National Coordinating Center team has been meeting with our CMS colleagues, both in the Division of Nursing Homes Survey and Certification Group and in the Center for Clinical Standards and Quality, Quality Improvement and Innovation Group.

The Facility Assessment Tool was developed using an iterative process. We conducted a pilot test of the tool where we shared a draft version of this tool with national partner groups and stakeholders representing organizations, including nursing homes, administrators, director of nursing, medical directors, consumers, and surveyors.

We also got feedback from 17 nursing homes in seven states with a mix of homes and rural and urban areas of varying sizes, and also varied ownership and profit, not-for-profit status.

We compiled the feedback from both the partner and stakeholder organizations and the nursing homes and we used the comments and feedback to make revisions and enhancements to the tool. I will share some of that feedback shortly. But first, it may be helpful to provide an overview of the tool.

You should have received a link to the tool along with the link to the slides for the call today. Slide 9 describes the different components of the Facility Assessment Tool. The first two pages of the tool serve as an introduction followed by the optional template that contains three parts.

The first part is the resident profile. It includes numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care.



The second part of the tool focuses on services and care offered based on resident needs. And it includes types of care your resident population requires. The focus is not to include individual level care plans in the facility assessment.

Third – the third part of the tool is about the facility resources needed to provide competent care for residents, including staff, staffing plan, staff competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and any other information that you may choose to include.

Lastly, the optional Facility Assessment Tool has two attachments. The first attachment is a listing of references to the facility assessment that appear in the October of 2016 Reform of Requirements for Long-Term Care Facilities.

And a note that additional information can be found in the Survey and Certification Memos and Appendix PP in the State Operations Manual.

The second attachment is a sample process that your facility may wish to consider in conducting the assessment.

On slide 10 – and 11 – we have included a few highlights from the pilot test. There was agreement that it was helpful in providing direction for the assessment. Nearly all of the respondents agreed that the tool was aligned with the regulations and interpretive guidance, that it included clear descriptions of what was being asked, and that it provided helpful examples. It was also noted that it could be used to determine what resources are necessary to care for residents. There was also agreement that lists and examples in the tool were helpful to help the teams think more in-depth and not look over key areas.

A couple of the quotes we've included on slide 10. One nursing home said, "It makes us analyze what our resources are and lack of resources to meet the needs and requests of our clientele." Another said, "It triggers a pause for leadership to comprehensively look at the facility's operations and compare that to its stated goals, identified challenges, etc.

There was also agreement that Attachment 2, the suggested process for conducting the assessment, including the synthesis and use of findings sections, were helpful. And there was mention that describing acuity can be challenging. Some commenters asked for more information in the staffing section, and others asked for less. There were some requests for algorithms or resident classification systems to determine staffing needs, patterns, etc. And some comments that the first assessment may take a little bit longer, but then after that, completing the assessment should be quicker.

We received many helpful comments to strengthen the tool. And as I mentioned, we made a number of revisions and enhancements based on that feedback.

Kelly O'Neill, my colleague on the National Coordinating Center team, will now walk you through the tool in a little more detail.



Details on the Tool's Features

Kelly O'Neill: Thanks, Marilyn, and hello to everyone on the phone. This is Kelly O'Neill with the National Coordinating Center team. I'm on slide 12 which contains the link for the Facility Assessment Tool.

The tool is provided in Microsoft Word so that you can save and complete it electronically. If you are unable to use the link for some reasons, the tool is located on the QIO Program website. The direct link for the tool is gioprogram.org/facility-assessment-tool. I'll say that one more time, gioprogram.org/facility-assessment-tool.

So hopefully you've had a chance to look at the tool and perhaps have it with you today to glance at while I talk about it. This is a detailed tool, but keep in mind, it is not a one-size-fits-all. It is meant to be tailored by your organization, and you may need it more or less detailed in some areas.

You will likely note that you have been doing many components of the assessment already. There are really not a lot of new areas of assessment in the tool. So while it is detail-orientated and comprehensive to help guide you, remember that at a high level, the tool basically asks three questions. Who are our residents? What are their needs? And what do we have that meets their needs? Or what do we need to get or work to improve?

I will review each section of the facility assessment document. But in the interest of time, will not cover every question.

Slide 13. The introductory section of the tool mentions several guidelines for conducting the assessment. You will likely gather data from a variety of sources to help guide your decisionmaking. The interpretive guidelines indicate that you should involve in the assessment process, the Administrator, a representative of the governing body, the Medical Director, and the Director of Nursing. But you will likely want to include others that also care about this process and that could offer valuable information, such as other department leaders, direct care staff, residents, and families, for example.

The interpretive guidance notes that while a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.

You will be expected to review and update the assessment annually or when there are significant changes. Significant changes might include if you decide to start accepting residents on ventilators, for example, if you haven't done that before. You would want to assess the human and other resources that would be needed to provide competent and person-centered care for those residents.

The assessment can help you make decisions about staffing and other resources and to serve as a record for such decisions.

Also in the guidelines, we referenced Appendix PP and how surveyors would use the facility assessment. Appendix PP states that, "If systemic care concerns are identified that are related to the facility's planning, the surveyor would then review the facility assessment to determine if these concerns were considered as part of the facility assessment process."



Marilyn mentioned Attachment 2, and we encourage you to look at that for a sample process for conducting the assessment. Consider reviewing that before you start your assessment.

So now we'll get into the tool itself. And slide 14 lists the items in Part 1 of the tool, which helps you to answer who are our residents and what are their needs?

The information you are asked for includes number of licensed beds, your average daily census or range, the average number of persons admitted and discharged on weekdays and weekends. Note that we often suggest that you enter a range or an average. These numbers are not something that you would update frequently, unless of course if you decide to make some substantial changes.

And you'll also note that we frequently will say, "consider if it would be helpful to," and then we suggest additional information that you might want to gather in order to make this assessment more useful.

Data element 1.3 on the tool asks you to indicate common diseases and conditions that your residents present with or may develop during their stay. The intent here is not to have you list every possible diagnosis or condition that there is, but rather to document the common conditions that you see as these will help you assess the types of resources necessary to care for your residents with these conditions.

During the pilot testing, we saw users cross out conditions that they do not see and add others.

Data element 1.4 asks for a description of your process to make admission or continuing care decisions for persons that have condition that you are less familiar with and may not have previously supported. And this likely comes up for all of you, and this is a way for you to assess if you have process steps in place to help you make the best decisions possible.

The acuity section, which is element 1.5, provides examples of three different ways to help you to describe the overall acuity of your resident population. And again, this is to help you understand potential implications regarding the intensity of care and services needed. Ideally, of course, acuity can help to inform staffing needs.

The examples we suggested for describing acuity include looking at RUG-IV categories, special treatments and conditions, or needs with regard to activities of daily living. Now, you might have a different methodology that works for your organization, and you could insert that information into this tool.

And you'll see on the tool that 1.6 and 1.7 ask for additional information about your resident's needs that may impact the care that you provide.

Slide 15, Part 2 of the tool, focuses on the services and care that are offered based on your residents' needs. So the intent here is that you identify the types of care or practices that are needed based on your resident needs, conditions, and preferences that you just described in Part 1.

So this can help you to reflect on the resources needed in Part 3 of the tool. So hopefully you see how this is all building together in order to provide these types of care. And you're not asked to quantify how often each of these are needed or to aggregate all resident care plans here.



During pilot testing, we saw users add items or cross others out if their residents do not need that type of care.

So far we've moved through the first two components of the assessment, who are our residents and what their needs. And next we'll move on to resources. What do we have that meets their needs, and what do we need to get or to improve upon?

So Part 3 of the tool, and I'm on slide 16, includes identification of resources needed to provide competent care. Now, again, keep in mind that your organization may need more or less detail in some of these areas.

The first data elements in Part 3 help you to assess staffing resources. So what types of staff and other health care professionals and medical practitioners do you need? Then based on your resident population and their needs for care and support, what is your general staffing plan?

So we provided two examples. One that looks at overall number or average or range of staff needed by certain positions, and another example that helps you to consider a plan for staffing by shifts or by hours per resident days.

And again, if you have a better way to generally plan for sufficient staffing, you could insert that into your assessment.


Data element 3.3 is for you to consider as the interpretive guidance states that the assessment should consider a review of individual staff assignments and systems for coordination and continuity of care for residents within and across these staff assignments. So this is getting at your general process for staff assignments, how you match your staff with residents.

Item 3.4 gives you an opportunity to describe the staff training and education and competencies that are necessary to provide care and support for you residents. Lists of training topics and competencies are provided for your consideration. And there are some requirements, which I know you're well-aware of, for training and competencies that are in the regulation, and it might be helpful for you to review some of the specific references to those, and we've included most of those in Attachment 1 of this document.

Slide 17. Items 3.6 and 3.7 on the tool are around working with medical practitioners. So how do you recruit and have the right type and number of practitioners that are knowledgeable in the care of your residents and how do you work with them to ensure high quality care?

Element 3.8 looks at physical environment and building or plant needs. So we created a table for you to list resource categories, specific resources within each category, and then a column, if it's applicable for you, to describe your process to ensure that you have adequate supply, appropriate maintenance, or replacement of physical or material resources.

And finally, there are four data elements under the category of Other that include contracts, memoranda of understanding or other agreements with third parties, health information technology resources, and a question about your infection control program to help make the connection between that program and the facility assessment because there's a specific mention of that in the reg.



Data element 3.12 is for you to address the required facility-based and community-based risk assessment. Note that it's not necessary for facilities to have the same risk assessment information in multiple documents. So it is acceptable to refer to the risk assessment of your emergency preparedness plan required at 483.73.

So that is the Facility Assessment Tool. And next, I will talk about two attachments that you might find helpful. We've mentioned those briefly already.

Slide 18 talks about Attachment 1, and this again includes some of the key mentions of the facility assessment requirement that was in the October 2016 Reform of Requirements for Long-Term Care Facility Regulation. And note that we didn't repeat every mention of the assessment in the regulation, but we think we got most of them, and that you should also use other resources to ensure that you're in compliance.

And the next three slides, 19 through 21, describe a sample process for conducting the assessment. The steps include planning for the assessment, conducting the assessment, synthesizing and using the results, and then evaluating your process and determining what you might do differently the next time that you complete your assessment. We've provided a fair amount of detail in the sections for the plan and using the result sections and hope you find that helpful.

Some of the key strategies during the planning phase include designating a leader, involving a team. So again, including people representative of the various positions that care about the items in the assessment and about how the findings will be used. And then making sure that leadership supports the process. Make sure that your leaders are tangibly involved in understanding and acting on the findings.

During the pilot, we noted that organizations tended to complete the assessment as a team, so they would assign sections to certain individuals and then they came together to review and discuss their results. Nursing homes that tested the tool indicated that they completed the assessment over time. So they didn't sit down and do it all at once. And the amount of time taken was proportional to the amount of information or data that they already had pulled together.

One organization told us that they had – basically had all the information already. So pulling it together in the assessment took only a few hours.

As Marilyn mentioned – I'm on slide 20 – many of the pilot testers indicated that the section on synthesizing and using the findings was particularly helpful. So once you have completed the assessment and reviewed the findings, we've suggested several questions for your team to consider. And discussion on these questions can help guide your decisionmaking on whether you have adequate and sufficient staffing, if you have training or competency needs, if you have areas for quality improvement, or if you need other resources, and if you have any budget considerations to address based on the findings of your assessment.

Slide 21. Questions 8 and 10 in the sample process, so that's still in Attachment 2, are to help you determine if you're prepared to respond to questions the surveyor might ask. And in those questions, we've listed the questions that were taken from the interpretive guidance. And the questions will also help you evaluate the process you used to conduct your assessment and identify if you want to make any changes in your process for the assessment going forward.



And the last item suggests that you establish a process for how you will update the assessment in the future.

Slide 22. Hopefully you'll find this to be a helpful tool to evaluate your resident population and identify the resources needed to provide person-centered care and services your residents require. Because every facility is unique, we present this as an optional tool so that your team can modify and individualize it for your facility to make it the most useful for you and also to meet the intent of the regulation.

So as nursing homes complete their facility assessments over the next year, we definitely want to learn more from you about what is most helpful, what works best to guide you in decisionmaking, and we look forward to hearing about that through different channels.

So thank you very much. And back to you, Michelle.

Frequently Asked Questions—State Operations Manual Appendix PP Revisions

Michelle Laughman: Thank you, everyone. Our next presentation will focus on some of the frequently asked questions related to the State Operations Manual Appendix PP Revisions. Subject matter experts from the Division of Nursing Homes will highlight some of the questions and topic areas that had been received via the Nursing Home Survey Development mailbox. Not all of the regulatory sections will be covered during this presentation.

Our first presenter will be Lisa Tripp.

Lisa Tripp: Good afternoon, everybody. I am Lisa Tripp. I'm Technical Director for Long-Term Care Enforcement in the Division of Nursing Homes and I'm a former attorney for the Office of General Counsel for the U.S. Department of Health and Human Services. I was one of the team members that developed the revised abuse guidance. And if you've had a chance to take a look at it, you know that the guidance has been greatly expanded.

One of the areas that we received a lot of questions about concerns the regulations at 42 CFR 483.12(b)(5) that were promulgated in response to Section 1150B of the Affordable Care Act. This is the section that requires the reporting to law enforcement and the State Survey Agency when covered individuals develop a reasonable suspicion that a crime has been committed against residents in a nursing home.

This requirement imposes different obligations on facilities and covered individuals, which I will outline momentarily. The law is intended to protect residents and ensure that crimes committed against people receiving care in nursing homes do not go uninvestigated by law enforcement.

And you may know the Office of Inspector General recently issued an early alert concerning these requirements.

I'm going to go over some key points about this regulation, and then we will review the two slides that I have provided for this topic today.



Okay, here are some key points about these requirements. Number one, we've been surveying for 1150B requirements for years, and if you want to take a look at a very helpful document, there is a Survey and Certification Memo – we call it an S&C memo – it's 11-30-NH. That provides a lot of very helpful information.

But because we did not have regulations promulgated at that time, we were citing deficiencies only based on the existing regulations. Well, now, we have new regulations that have been promulgated for the statutory provision. And they are going to be in effect as of November 28, 2017.

The key tag for this requirement is going to be F608. But it is possible that investigations regarding compliance in this area could yield deficiency citations in other tags, as appropriate, in the individual case.

So there's some important concepts with respect to 1150B. One of the first ones is it applies to covered individuals and also requirements apply to facilities. So let's take a look at covered individuals under 1150B. Covered individuals must report to law enforcement and the State Survey Agency when they have a reasonable suspicion that a crime has been committed against a resident or someone receiving care at the facility.

So who are covered individuals? Well, they're owners, operators, employees, managers, agents, and contractors of the facility.


All right. Facilities have specific obligations pursuant to the statute and the regulations. And those obligations include: They have to notify covered individuals annually of the reporting requirements, they've got to post notice of employee rights, and they cannot retaliate against those who report under this section. But, and I think this is important to note, facilities can also be cited if they fail to develop and implement policies and procedures to ensure reporting is done under 1150B.

So "crimes" refers to crimes against residents or someone receiving care at the facility committed by anyone. We list some crimes that would be likely to exist in every jurisdiction, but it is advisable to consult with the local law enforcement given the variation in crimes that occurs in different states. And I should say the definition of crimes in different states.

Okay, when must a reasonable suspicion of a crime be reported? That depends on whether the resident suffered serious bodily injury. If serious bodily injury occurred, the report must be immediately, after forming the reasonable suspicion of a crime, but not later than 2 hours. If no serious bodily injury occurred, then the requirement is to report not later than 24 hours.

Where an alleged violation of abuse, neglect, misappropriation of resident property, or exploitation also gives rise to a reasonable suspicion of a crime, reports will be made to the Administrator, to the State Survey Agency, and to local law enforcement as well.

So what we've provided to you is a very helpful slide that delineates the differences between the 1150B requirements and in the slide that's the suspected crimes column on the left compared to the alleged violations column – and that's tag F609 – on the right, so that you can understand the similarities and the differences between these regulatory requirements.



And we've also provided a definition of serious bodily injury for you, which 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; or requiring medical intervention, such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse, which is defined in our guidance and in the statute.

And so with that, I'll turn it over to my colleague Cathleen Lawrence to talk about transfer, admission, and discharge.

Cathleen Lawrence: Good afternoon. I'm Cathleen Lawrence, a nurse... We've made this distinction to aid in applying the regulations, specifically the new requirement to send a copy of a transfer or discharge notice to the ombudsman.

A facility-initiated transfer or discharge is a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

A resident-initiated transfer or discharge, means the resident or, if appropriate, the resident's representative has provided verbal or written notice of intent to leave the facility. Leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.

So we've received number of questions about the new requirement – send a copy of the transfer/discharge notice to the ombudsman, which slide 27 addresses.


The new requirement to notify the ombudsman and the notice requirements in general, only apply to facility-initiated transfers and discharges, not resident-initiated transfers and discharges.

The purposes of sending a copy of a transfer or discharge notice to the ombudsman is to provide added protection to residents and keep the ombudsman informed of facility practices and activities. The copy of the notice must be sent to the ombudsman when the facility initiates the transfer or discharge. This includes emergency transfers to an acute care facility. In general, notice must be sent to the ombudsman at the same time that notice is provided to the resident and resident representative. Ideally, 30 days in advance.

However, for emergency transfers, notice may be provided to the resident and resident representative as soon as practicable, and notice to the ombudsman may also be sent when practicable, such as in a list of residents on monthly basis.

There's no specific form for facilities to use with sending a list of residents to the ombudsman. But the list must meet the requirements related to contents of the notice. Again, providing a notice of transfer or discharge and sending a copy of the notice to the ombudsman are not required for resident-initiated transfers or discharges.

For short-stay residents such as those completing skilled rehabilitation, the discharge could be facility or resident-initiated, depending on circumstances, which leads us to the next slide.



So on slide 28, you'll see how we explain how to determine whether a transfer or discharge is facility- or resident-initiated. While short-stay residents who have completed skilled rehabilitation may often be considered resident-initiated discharges, this is not automatically the case. The discharge of the resident must meet the definition of a resident-initiated transfer or discharge, and evidence in the medical record must support that the transfer or discharge was resident-initiated.

There should be documentation or evidence of the resident or resident representative, verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the residents or, if appropriate, his/her representative containing details of discharge planning and arrangements for post-discharge.

Now, Debra Lyons will talk about Comprehensive Care Planning.

Debra Lyons: Hi. Thanks, Cathleen. Hello, my name is Debra Lyons, and I would like to share a few of the frequently asked questions we received for the Comprehensive Care Planning regulation section at 483.21, specifically questions related to the Baseline Care Plan.

On slide 29, you'll see that one question we've received asks, how can providers meet the 48-hour requirement if admission occurs on the weekend?

The regulations do not specify how to create the Baseline Care Plan or the logistics surrounding it. Facilities will have to devise a process that ensures that new admissions have their Baseline Care Plan done within the required 48 hours. It may be necessary for the Baseline Care Plan to be developed over the course of several shifts. For example, if a new admission arrives at 11:40 p.m. on a Friday, the Baseline Care Plan must be complete by 11:40 p.m. on Sunday.

On slide 30, you see that we've gotten questions asking, what must be included in the Baseline Care Plan? The regulation at 483.21(a) states, the Baseline Care Plan must: (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to, (A) initial goals based on admission orders, (B) physician orders, (C) dietary orders, (D) therapy services, (E) social services, and (F) PASARR recommendations, if applicable. It is expected that the admission orders will be used, along with information gathered by the admitting nurse, which will include input from the resident or, if applicable, the representative.

And now on slide 31, you see a question that asks, can the Baseline Care Plan be written before admission or before talking to the resident? The regulations do not address this specifically. It may be possible to begin development of parts of the Baseline Care Plan before the actual admission based on information received from the transferring provider. However, any information identified before admission must be verified by the admission orders and the admitting nurse's observations and interviews of the resident. The bottom line is, the Baseline Care Plan must reflect the immediate needs of the resident.

And lastly, on slide 32, we have a question about the Baseline Care Plan summary, which asks, is a verbal summary of the Baseline Care Plan acceptable? The guidance at F655 states: "The facility must provide the resident and representative, if applicable, with a written summary of the Baseline Care Plan."



Now I'm going to turn it back over to Cathleen Lawrence who will address questions related to pharmacy. Thank you.

Cathleen Lawrence: Hello, this is Cathleen again to discuss some Pharmacy Services topics, beginning at slide 33.

There are two new PRN requirements which were added to safeguard the health of residents, address the concern that PRN orders for psychotropic and antipsychotic medications may remain in place for an extended period without being reviewed by the resident's physician, and ensure that benefits and side effects of these medications are evaluated between required physician visits. These requirements are not intended to discourage use of these medications when they are needed for the resident's benefit. The new category of psychotropic medications includes medications in the categories of antipsychotic, anti-depressant, anti-anxiety, and hypnotic medications.

The new requirements for PRN orders comprise one requirement for PRN orders for psychotropic medications, excluding antipsychotic medications, and one requirement for PRN orders for antipsychotic medications only.

The newly revised interpretative guidance at F757 and F758 contains a table, which you can see on slide 34. The table shows the differences between the requirements for PRN orders for psychotropic medications and PRN orders for antipsychotic medications.

We've received a number of questions regarding the new PRN requirements. As you can see from the table, PRN orders for psychotropic medications are limited to 14 days, but the order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it's appropriate to extend the order. The rationale for extending the order should be documented in the medical record. There is no exception to the 14-day limit for PRN orders for antipsychotic medications.

If the physician or practitioner believes a resident still needs a PRN order for the antipsychotic medication, a new order must be written, but the resident must first be evaluated to determine if the new order is appropriate.

For PRN orders for antipsychotics, there are no exceptions with regard to medical condition for specific medications.

We've received question also about the evaluation of a resident prior to writing a new order for PRN antipsychotic medication...last slide in the section, slide 35. And the new interpretative guidance provides information on the purpose of the evaluation, as well as what information should generally be ascertained from the evaluation. The attending physician or prescribing practitioner must directly examine the resident and assess the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed.

The evaluation and documentation should address whether the antipsychotic is still needed on a PRN basis, what the benefit of the medication is to the resident, and whether the resident's expressions or indications of distress have improved as a result of the medication.



As stated, the evaluation must be performed by the attending physician or prescribing practitioner. Therefore, staff reporting on the resident's condition to the attending physician or practitioner does not meet the intent of the regulation.

Lastly, the regulation and guidance do not preclude the use of telemedicine by the attending physician or prescribing practitioner to examine a resident.

Synora Jones will now talk about the new Qualified Dietitian requirement.

Synora Jones: Hello, my name is Synora Jones, and I will be going over the frequently asked questions surrounding Food and Nutrition at 483.60, Qualified Dietitian or Other Clinically Qualified Nutrition Professional.

So 483.60 is required that facilities include sufficient staff with appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services. So we want to take into consideration the residents' assessments; their individual plans of care; the number, acuity, and diagnosis of the facility's residents population.

So we are requiring that facilities employ a qualified dietitian or other clinically qualified nutritional professional, either on a full-time, part-time, or on a consultant basis. We also have minimum qualifications for dietitians who will be working in the SNF or NF facility.

So your qualified dietitian or other clinically qualified nutritional professional will be one that holds a bachelor's or higher degree, which would be granted by a regionally accredited college or university in the United States, or it could be an equivalent foreign degree with completion of the academic requirements of a program and nutrition or dietetic accredited by an appropriate national accreditation organization, which would be recognized for this purpose. And, that person would be one that has completed at least 900 hours of supervised dietetic practices under the supervision of a registered dietitian and/or nutritional professional. A qualified dietitian would also be one who is licensed or certified as a dietitian or nutritional professional by their state in which they are performing those services.

So for dietitians that were hired or contracted prior to November 28th, 2016, they would be able to meet these requirements no later than 5 years after November the 28th, 2016. And that would be, 5 years later, 2021, November 28th. For dietitians who are hired after November 2016, they will have 1 year to repeat those – complete those requirements. So if the facility has a full-time dietitian or other clinically qualified nutritional professional, the facility is not required to hire a director of Food and Nutrition Services.

****Post-Call Clarification: Dietitians hired after November 28, 2016, will have 1 year to meet those requirements.****

So if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must have frequent, scheduled consultations with a qualified dietitian or other clinically qualified nutrition professional.

Slide 36. If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the Director of Food and Nutrition Services, and this person **would**



be a certified Dietary Manager or a Food Service Manager that is **certified, has** similar national certifications for food service management and safety from a national certifying body, **and has** an associate's or higher degree in Food Service Management or in Hospitality if the core study includes food service or restaurant management from an accredited institution of higher learning.

****Post-Call Clarification: If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the Director of Food and Nutrition Services, and this person would have to be a certified Dietary Manager or a Food Service Manager that is certified, or has similar national certifications for food service management and safety from a national certifying body, and/or has an associate's or higher degree in Food Service Management or in Hospitality if the core study includes food service or restaurant management from an accredited institution of higher learning.****

So in states that have established standards for food service management or dietary management, they must meet the state requirements for food service management or Dietary Managers and receive frequently scheduled consultations from a qualified dietitian and/or other clinically qualified nutritional professional.

I will now be turning it over to Deb Lyons, who will be going over QAPI.

Debra Lyons: Thank you, Synora. It's me again. Thank you very much. Let me share with you some frequently asked questions about Quality Assurance and Performance Improvement, or QAPI.


On slide 38, you see we've received a question about what needs to be in place now. As you may know, QAPI has provisions that were effective with Phase 1, which went into effect last November 28th, 2016; Phase 2 implementation, which will be upcoming this November 28th, 2017; and provisions for Phase 3, which will be effective November 28th, 2019.

So currently, facilities are expected to have a Quality Assessment and Assurance Committee, which is composed of a Director of Nurses, a Medical Director or designee, and three other staff, one of which must be an Administrator, owner, board member, or other individual in a leadership role.

The requirement for the Infection Preventionist, and I do apologize for the typo on the slide, is not going into effect until Phase 3. The QAA committee must meet at least quarterly, or as needed, to identify which QAA activities are necessary, and to develop and implement appropriate plans of action to correct identified quality deficiencies.

On slide 39, you see that the question is, what changes will go into effect on November 28th, 2017? Facilities will be expected to present their QAPI Plan to state or Federal surveyors. The interpretive guidance, which has been released in draft form, defines the QAPI plan the following way. A QAPI plan described the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies and opportunities for improvement.

Guidance goes on to say that the QAPI plan should be tailored to reflect the specific units, programs, departments, and unique population each facility services.



On slide 40, you see that we've been asked if CMS will provide a template for the QAPI Plan. While there is no required format for the plan, our partners at the Lake Superior Quality Innovation Network has developed a how-to guide for participants in the National Nursing Home Quality Care Collaborative, which you can access in the link in your slides. Additionally, you can find other tools and resources which may help you establish your QAPI program at the Nursing Home QAPI website link on your slide.

And so now, I'm going to turn it over to Megan Hayden, who will address infection control. Thank you.

Megan Hayden: Thank you, Deb. My name is Megan Hayden. I'm a nurse consultant. I'm going to go over three questions related to infection control.

And the first question is on slide 41. Is documentation of the information we have provided in correspondence regarding our antibiotic stewardship policies and the practitioner's continued use of antibiotics without a valid cause enough for us to prove due diligence on the part of the facility?

So this question came to us from a facility that does not have in-house prescribers, and was finding that regardless of the information provided to them on good antibiotic stewardship practices, the providers were not following facility guidance or policy and were prescribing antibiotics without a valid cause. Furthermore, prescribers were not using antibiotic use protocols.

The facility wanted to know if documentation of the education to the prescribers would be enough for compliance with the program. Our response is that requirements at 42 CFR 483.80(a)(3) require the existence of antibiotic use protocols and a system to monitor antibiotic use.

Yes, prescribers must be educated on the facility's Antibiotic Stewardship Program. And the facility must have a system to monitor antibiotic use.

There are several problems with the situation I just described, though. First, the antibiotic use protocols, and that is infection assessment tools and indication for prescription, which are part of the Antibiotic Stewardship Program, are not being implemented by prescribers, and this physician practice falls under F881, which is the Antibiotic Stewardship Program.

The program requires monitoring of antibiotic use, which was described, since the facility is aware that there are providers that are prescribing inappropriately. This means that the facility would need to take corrective actions to remedy the situation. Otherwise, there's not full compliance to the program.

Second, you describe unnecessary antibiotic use, and this physician practice would fall under F757, which is drug regimens free from unnecessary drugs.

So moving on to slide 42. The next question is, does the Antibiotic Stewardship Program apply only to the use of antibiotics or would such a program also apply to the use of antifungals and antivirals, which would be included under the broader title of an antimicrobial stewardship program? And then, furthermore, does the program apply to all formulations of antibiotics?



So the response that is appropriate is that it's best practice to include all antimicrobials in a stewardship program, and this would enhance the care of residents.

The long-term care requirements, although found at 42 CFR 483.80(a)(3), state that the facility must establish an Infection Prevention Control Program that must include an Antibiotic Stewardship Program and that antibiotic use protocols and a system to monitor antibiotic use. So this requirement is limited to antibiotics and not to all antimicrobial such as antifungals or antivirals.

Even though the regulatory language is very specific to antibiotics, it is non-specific on the dosages and formulations of antibiotics. As a result, all dosages and formulations fall under the Antibiotic Stewardship Program.

And finally, the third question is on slide 43, does an Infection Preventionist have to be certified, and by what date is this required?

So the requirements for the qualifications and role of the Infection Preventionist are effective November 28th, 2019. But now on to the qualifications for the Infection Preventionist.

So the regulation at 42 CFR 483.80(b) lists four requirements that must be met to be in compliance with the regulation. The question was specific to the second requirement that states that the IP must be qualified by education, training, experience, or certification. Therefore, the Infection Preventionist does not have to be certified in, say, infection prevention and control, but in order to meet that second requirement, the IP must have had to be qualified by one of the other three components, which are education, training, or experience.

As with the Phase 3 requirement, guidance will be published in the future.

And I'm going to turn it back over to Leah to go on to the question-and-answer component.


Question & Answer Session

Leah Nguyen: Thank you, Megan. We will now take your questions. As a reminder, this event is being recorded and transcribed. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are asking question, so anything you say or any background noise will be heard in the conference.

If you have more than one question, press star, one, to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster. Your first question comes from the line of Theresa Edelstein.



Theresa Edelstein: Thank you. Good afternoon everyone. This is just quick question. I could not find the attachments to the Facility Assessment Tool. Are there links somewhere that I missed?

Kelly O'Neill: Hi, thank you for the question. This is Kelly O'Neill. The attachments are included right in the Facility Assessment Tool document.

Theresa Edelstein: Okay. In the back?

Kelly O'Neill: Yes, in the back of the tool.

Theresa Edelstein: Okay, got it. Thank you very much.

Kelly O'Neill: Sure.

Operator: Your next question comes from the line of Chris Crouch.

Chris Crouch: Yes, Chris Crouch, Bethesda, Saint Louis Missouri. Do we need a formal policy and procedure for the assessment and reassessment process?

Leah Nguyen: Hold on a moment.

Karen Tritz: So this is Karen. So, quick question to clarify your question. Are you referring to the assessment and reassessment for the facility assessment discussed today? Or are you talking about a policy and procedure for assessment/reassessment of the residents?

Leah Nguyen: Hello, are you there?

Operator: The caller's line was disconnected. Your next question comes from the line of Doug Beardsley.

Doug Beardsley: Yes, thank you. This is Doug Beardsley from Care Providers in Minnesota. I have a question on the facility-designated Director for Food and Nutrition Services requirements? If the state already has a state – for example, a certified Food Manager Program where it's a 3-year certification with re-certification— it is a standard that's required for a Restaurant Manager or restaurant owner—would that be sufficient to meet that designation if you have the supportive services of a dietitian?

Synora Jones: Hi, Doug. Yes, this is Synora. Yes, someone that has a similar national certification for food service management and safety from a national certifying body, that is accepted.

Doug Beardsley: The question is, if it's a state-certified program?

Synora Jones: Yes.

Doug Beardsley: Okay. Thank you very much.

Leah Nguyen: Thank you.



Operator: Your next question comes from the line of Barbara Thompson.

Barbara Thompson: Good morning, this is Barbara Thompson. I have question for Synora Jones, and it is in regards to the qualifications for food and nutrition in absence of a full-time dietitian. Does the ServSafe certificate, does that cover enough to be considered. Since that does not have any management, that's a restaurant indication, would that cover the regulation?

Leah Nguyen: Hold on for a moment.

Synora Jones: Okay, so your certified Food Manager – okay your ServSafe, is that what you're referring to?

Barbara Thompson: Yes. The ServSafe certificate.

Synora Jones: Right, the ServSafe is a manager certification required training in the importance of food and safety. And it is good for personal hygiene, time and temperature control, and all of that. But for food safety regulations and more. But these are important topics. However, while ServSafe manager certification is one way to ensure the Food Service Managers are current in their knowledge of food safety, it isn't the only way that they would ensure this. However, ServSafe does not address food service management, which is your managing operation, which is a requirement under the regulation of 483.60(a)(2)(c),, which is requiring that they have cert...

Barbara Thompson: Thank you very much.

Synora Jones: You got it? Okay.

Leah Nguyen: Thank you.

Barbara Thompson: Yes, that's exactly what I wanted to hear, because the management piece was missing. So thank you very much for the clarification. I appreciate it.


Operator: Your next question comes from the line of Gail Brocious.

Gail Brocious: We had a question about a resident leaving AMA, although it may be resident-initiated, we wanted to know if there were any requirements about that.

Cathleen Lawrence: Hello, this is Cathleen. So, I think you're right that in general an AMA would be more of a resident-initiated situation. So, you would be looking more for a compliance with the tags related to discharge planning. And so you would expect to see documentation related to what occurred with the resident, as far as attempts to chart a discharge plan and talk with the resident.

And so, it would most likely, assuming that the evidence in the medical record supports it, it would be more of a resident-initiated situation. So the notice requirements would not apply.

Gail Brocious: So we would not have to notify the ombudsman, generally.



Cathleen Lawrence: Generally, right.

Gail Brocious: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Tony Hanlon.

Tony Hanlon: Hi, this is Tony Hanlon. I've been trying to figure out on this antibiotic stewardship, when we're being held accountable for the medical practices of a physician, where is that drug aligned on the facility if they're trying to do antibiotic stewardship and the physician is ordering medication when the facility is only following orders that the physician is providing the service to? How is the facility being responsible and being punished for that?

Leah Nguyen: Hold on one moment, please.

Karen Tritz: So this is Karen. Thanks very much for your question. I think, you know, the issue that you raised is a really important one in terms of the facility's responsibilities in this area and how it interacts with prescribers. And I know a lot of folks are really interested in this issue.

We do not want to make a broad sweeping generalization on this call to say, no, the facilities will never be held accountable for anything, any of their prescriber activities, or they are always held accountable for prescriber activities. I think the circumstances and the specifics matter.

So I think what we'd like to do with this question is, we will take it in and I think we will include it in a frequently asked questions document that we're developing and can release. Because we want to be able to take the time to describe the nuances more fully in writing for folks because it is a really important issue, and we don't there to be any misunderstandings about it.

Tony Hanlon: Can I ask one more question real quick?

Leah Nguyen: Could you email your question in – I'm sorry. Could you email the question into the address listed on slide 45 for us?

Tony Hanlon: On slide 45?

Leah Nguyen: Yes, slide 45.

Tony Hanlon: Sure.

Leah Nguyen: Okay. Thank you.

Tony Hanlon: Can I ask one more question real quick?



Leah Nguyen: Sure.

Tony Hanlon: If I now have to now lay off my Dietary Manager because of these requirements for the new education requirements, and she's been working for me for over 20 years. How many other people are we going to be laying off because of these requirements? And they've been dedicated to these facilities. Is this – is there a grandfathering into this for these people? Or are we just going to have to tell them goodbye because CMS decided they're not worthy?

Synora Jones: Okay. Let's just talk about that for one second. For the qualified dietician, okay. So for number one, we talked about the degree. So they had the degree, the bachelor's degree, master's degree in nutrition, other related academic professions. Also, they've completed at least 900 hours. So they have the hours because they have the experience. They've been a dietician in your facility, accepted by your state for 20-something years, as you said. So...

Tony Hanlon: Right.

Synora Jones: ... the license and certified dietician is acceptable is based...

Tony Hanlon: I already have a Dietician employed part-time. My Dietary Manager is the problem here. Based on this, she doesn't have the certifications that you're requiring, the associate's degree, the other things that you're saying that my certified Dietary Manager, she doesn't have this stuff. So now I got to tell her she is not qualified to work in the facility.

Synora Jones: Okay. So your Dietary Manager has up to 5 years, which would be November 28th, 2021, to meet those requirements.

****Post-Call Clarification: Requirements for Dietary Manager – Dietary Managers must be certified as a dietary manager, such as by the Association of Nutrition and Foodservice Professionals (ANFP) and in states that have established standards for food service managers, meets State requirements for food service managers or dietary managers, and must receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. ****

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jennifer Gorman-Fecco.

Jennifer Gorman-Fecco: Hi. I just had a question. I actually have two. But on the 48-hour Care Plan, it specifies that we have to have the Care Plan created within 48 hours, which is not specific to them signing it. So your example of coming in on a Friday and having it created by Sunday, if we come in Monday and review that with them and sign it, are we in compliance?

Michelle Laughman: Deb Lyons, are you still on the call? Can you take that?

Debra Lyons: I am on the call. The regulations only address that it has to be completed within 48 hours of the resident's admission.



Jennifer Gorman-Fecco: Yes.

Debra Lyons: So I would think that, you know, what appears to be reasonable is that it is signed on Monday. But, again, the regulations specify that it's developed within 48 hours of their admission.

****Post-Call Clarification: There are no requirements for residents to sign the Baseline Care Plan. If a facility wants to have the resident sign the Baseline Care Plan, it would be acceptable to do this beyond 48 hours of admission, as long as there is evidence that the Baseline Care Plan was in place and implemented within 48 hours of admission.****

Jennifer Gorman-Fecco: Okay.

Debra Lyons: Okay?

Jennifer Gorman-Fecco: Just while I have you on, can I ask one more question about the ombudsman and the discharges?

Leah Nguyen: Sure.

Jennifer Gorman-Fecco: Okay. Well, we're aware of TCU 20-day unit. So they come here knowing that the maximum amount of time that they're going to be here is 20 days. So when we're discharging them or they have, you know, an episode where we have to transfer them back to the ER, and they're short-stay people, I was just confused on that slide. Do we have to send the notice to the ombudsman after that occurs? And if we're sending the ombudsman, you know, information, that has like their medical record number on it, what not, how do we know that that's protected and they're HIPAA compliant? Or what are they doing with the data?

Cathleen Lawrence: Okay, this is Cathleen. I'll try to address ...


Jennifer Gorman-Fecco: Thank you.

Cathleen Lawrence: ... your question. As far as the emergency transfers, those are considered facility-initiated. So if you're unable to meet their needs for some reason, medical condition changes, you have to transfer them. So those, you are required to notify the resident representative and send a copy to the ombudsman.

We have given an exception for the timing because it's an emergency so you could send those residents who are transferred emergently on a monthly list to the ombudsman. It does need to contain the information that – about the transfer so that it meets the contents of the notice requirements.

And I would assume there are – you send notices now to the ombudsman. So whatever HIPAA-compliant message that you use for that would apply to this as well. And then you mentioned the discharges. It sounds more like an expected discharge because the resident no longer needs the services. So that ...

Jennifer Gorman-Fecco: Correct. I mean ... Most of them – most the time they go home and sometimes they go on to ...



Cathleen Lawrence: Right.

Jennifer Gorman-Fecco: ... longer stay unit.

Cathleen Lawrence: Okay.

Jennifer Gorman-Fecco: Which is outside of our facility.

Cathleen Lawrence: Right. In that case, in general, that would – should be a resident-initiated discharge. It may not always be, depending on the circumstances.

But if it is resident-initiated, the evidence in the medical record should support that, you know, should show discharge planning, discussions with the resident and their family, that would show that it's been – that the resident agrees to that and that it's their goal also to be leaving. So in that case, you would not need to provide notice.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Gina Higgins.

Gina Higgins: Yes, I have question. The PASARR screening that's required for the Baseline Care Plan. We often get residents that come right from the emergency room and, therefore, they don't have their PASARR screening completed.

They usually come here and do the screening. So technically, we're going to be out of compliance every time that happen. So how do we let the emergency room know that we can't take somebody when they need to come to a facility?

Debra Lyons: So this is Debbie. So the regulation says that the Baseline Care Plan has to include the minimum health care information necessary to properly care for the resident.

So if a PASARR screen has been completed and there are recommendations, that, you know, that needs to be a part of the Baseline Care Plan, because basically that's saying that this person requires specialized, you know, specialized care to meet their needs.

If the facility does not have that, you know, that information available, I think that the “if applicable” would apply. But as soon as you were to receive that information, it certainly needs to be a part of the Baseline Care Plan. Does that make sense?

****Post-Call Clarification: The Baseline Care Plan regulations at 483.21 (a)(1)(ii)(F) require PASARR recommendations to be included in the Baseline Care Plan, if available. However, it is important to understand that the PASARR regulations at 483.20(k)(1) and (2) require that the PASARR be conducted with results transmitted to the receiving facility prior to admission unless an exception at 483.20(k)(2) applies.****



Operator: Your next question comes from the line of Peggy Stockel.

Peggy Stockel: Yes. Hello, this is Peggy from Stonehill Franciscan Services in Dubuque, Iowa. And we have a question on the PRN 14-day. Does that apply to hospice?

Maybe she didn't hear me.

Peggy Stockel : Hello, this is Peggy Stockel from Stonehill Franciscan Services in Dubuque, Iowa. Can you hear me?

Leah Nguyen: Yes.

Cathleen Lawrence: Yes, yes. We got your question. Thank you. This is Cathleen.

Peggy Stockel: Oh, okay, good. The PRN ...

Cathleen Lawrence: Right. I heard...

Peggy Stockel: The PRN 14-day...

Cathleen Lawrence: Right, whether it applies...

Peggy Stockel: I'm sorry, there's feedback.

Leah Nguyen: Oh, we can hear you. We have your question.

Peggy Stockel: Oh, okay.

Cathleen Lawrence: Can you hear us? Okay. Can you hear us clearly?

Peggy Stockel: Yes.


Cathleen Lawrence: Okay.

Peggy Stockel: Yes.

Cathleen Lawrence: So, yes. That requirement applies to all residents. So it's ...

Peggy Stockel: In hospice?

Cathleen Lawrence: Right. So if it's antipsychotic medication that you're talking about and they have a PRN order for an antipsychotic, it cannot be renewed or a new order cannot be put in for the same medication without an evaluation because of the concerns about side effects of those medications.



Peggy Stockel: Sure, sure. Okay, all right. And then I just have another question regarding the ombudsman and the discharge. So if a resident is sent to the ER, we have to send notice to the ombudsman, the state ombudsman?

Cathleen Lawrence: Right. That is the requirements for any facility-initiated transfer or discharge.

Peggy Stockel: Okay. Okay.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Judy Belcher.

Judy Belcher: This is Judy, and I'm in Batesville, Arkansas.

ER transfers for emergency care versus transfers to a different hospital for temporary testing and all that, is that included in transfers as well? And the ombudsman must be notified? Because the ER is still a treatment, and often they just return back to our facility.

So does it – we have to notify the ombudsman of all those kinds of transfers out that they're being treated for something we didn't – that our facility initiated that they see a specialist or anything else?

Cathleen Lawrence: Okay, I'll try to answer, Judy. That applies to other situations. But, so for emergency transfers to the hospital where you're not sure of the outcome, if they're going to be staying at the hospital or not, you do have to notify the ombudsman, you can notify them on monthly basis to say all the residents that were transferred in a month, and you can notify the ombudsman all at once on a list, you know, with the required information, why they were transferred, all of that.


Well, now, if they're going for testing, something like that, that – we would not expect notification to the ombudsman for that situation.

****Post-call clarification: For planned visits outside of the nursing home, which could include planned outpatient surgery, dialysis, or other scheduled doctor's office visits or testing, notice to the resident, resident representative, and ombudsman is not required since these planned visits are not intended to be addressed by the requirements at F622 or F623. Keep in mind that sending a resident for testing that is unplanned and part of a visit to an ER would still be considered a facility-initiated transfer or discharge and subject to the notice requirements.****

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kim Tyson.

Kim Tyson: Kim Tyson from Minnesota. I'm just questioning on the reg for Baseline Care Plan. What I'm reading from the reg is it says that we have to provide the resident Baseline Care Plan. It does not specifically



say that it has to be in writing in the actual regulation, but you're saying it does. Could you clarify that for me, please?

Debra Lyons: Correct. All of our interpretative guidance has been reviewed by our Office of General Counsel and we basically – you have to provide the resident or the representative with a summary of the Baseline Care Plan. And verbal would not, you know, would not meet the intent of the requirement. You know what I mean? So we just determined through our, you know, internal discussions with our OGC and with stakeholders and so on, that it must be written.

****Post-Call Clarification: Per the preamble found in the [Final Rule](#) for the Reform of the Requirements for Long-Term Care, the intent of requiring a summary is to actively engage the resident, to the extent practicable and consistent with the resident's choices, in their care planning process. Additionally, per 483.10(g)(3), Resident Right to Access Personal and Medical Records, facilities must provide information in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. This regulation also supports that the summary must be written.****

Operator: Your next question comes from the line of Kim Cox.

Kim Cox: Yes, this is Kim Cox in Tennessee. I am seeing a few discrepancies in different states in the top, the citations for the abuse. For example, the regulation is saying, report in 2 hours if it's abuse or serious bodily injury, and then in 24 if the alleged violations does not involve abuse or no serious bodily injury. So my question is, for example, let's say you had an allegation of misappropriation. which is considered abuse, and obviously no serious bodily injury, would you expect that to be reported within the 2-hour timeframe or the 24-hour timeframe?


Lisa Tripp: Hi, thanks very much for your call. I think the best way to answer your question, I think the best way to answer this is to look at the chart that we provided and ask the questions separately for each column. So depending on whether or not a reasonable suspicion of a crime has developed, that would dictate whether or not you have to comply with the requirements in the left-hand column under F608. So if there has been a reasonable suspicion of a crime developed, then that must be reported. If there is no serious bodily injury, there is a 24-hour window to report to the state agency or to – and to law enforcement.

And then – but if you're – so if you're in that category, you have to follow those requirements. And then you also ask yourself the question, all right, let's look at the column for F609 and see what's required there. And so in that case, the facility has an obligation to report all alleged violations of abuse, neglect, exploitation, and mistreatment. And the window is 2 hours – it's immediately, but not later than 2 hours if it involves abuse or results in serious bodily injury. And if neither of those things applied, then the answer is within 24 hours.

Kim Cox: Thank you.

Operator: Your next question comes from the line of Jeri Reinhardt.

Jeri Reinhardt: Hello. This is Jeri Reinhardt from Minnesota. I have been reading the Critical Element Pathways, specifically looking at how they relate to facility assessment. As I was doing this, I came across the



pathway for sufficient and confident nursing. And one of the questions that was – is to be asked of nursing assistants is, did you participate in the facility assessment? And if you did, what of your suggestions were inputted?

My question is, that's not mentioned in the guidance to survey as a requirement, nor is it in the rules. And if we have a nursing assistant who says, no, I didn't participate, how will that be interpreted for a citation, when the clinical element pathway is asking questions outside of the boundaries of the guidance or the actual language of the requirements?

Leah Nguyen: Just one moment, please.

Evan Shulman: Hi, this is Evan Shulman. So we're not specific to – there's no requirement for a nurse aide to participate in the facility assessment, although we recommend it. We can take another look to see how that translates back to the interpretive guidance and any potential citations. But there's, again, there's no requirement that specifically states a CNA must participate in the development of the facility assessment.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Christine Smith.


Christine Smith: Yes, this is Christine Smith. I have a question about the requirement for reporting for suspected crime. Can a covered individual, for an example, an employee report to the Administrator and then the Administrator notifies law enforcement, unless the employee or other covered individuals do it?

Lisa Tripp: I think – this is a good question. And I would encourage you to take a look at our guidance in terms of our discussion about how we can – you can have group reporting, okay? But the technical statutory requirement is that covered individuals report. And so we've tried to implement that in an efficient manner by discussing in the guidance how facilities can arrange for reporting in a manner that covers all reported – all covered individuals.

Leah Nguyen: Thank you. Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Baker Donaldson.

Howard Sollins: Hi, this is Howard Sollins. I also have some questions about the abuse and neglect, the reporting. The chart refers under Suspected Crimes to reasonable suspicion, whereas under Alleged Violations, you had – there's not a standard like that. So we get questions all the time about the ability of facilities to do a preliminary investigation. Now, not talking about things where you see bruising or other things where there's no question. But when you're talking about something like misappropriation of property, and a family member says, "You haven't been able to find my mother's hearing aid. I believe it must have been stolen." So is that an alleged violation and so now you're reporting to the police that you couldn't find a hearing aid? Is it based on as soon as they make the allegation? You know, and obviously, I just hear a lot of confusion out across the country about the ability of facilities to determine the reasonableness of an allegation or is it just hundreds of reports to the police because of the things like this across the country.



Leah Nguyen: Hold on one moment.

Lisa Tripp: Okay. Thanks so much for your question. This is Lisa Tripp. I just wanted the piggyback off of your – the end of your comment, you had indicated would we have to make every sort of report of misappropriation to law enforcement. I just want to highlight the fact that there is a reasonable suspicion requirement vis-à-vis 1150B and the requirements to report to the law enforcement. And so what is reasonable, of course, is something that is determined based on the particular facts of the given case.

And with respect to alleged – the F609 requirements, allegations of misappropriation, there is not, as you noted, that there is not a reasonableness standard like there is with F609. Having said that, I don't want to sort of answer a hypothetical question, because, again, surveyors are going to look to all of the information. But as the way the law is written, if there is an alleged abuse or misappropriation and so forth, that does trigger the reporting requirements under F609. But there has to be the reasonable suspicion under F608 to trigger the 1150B requirements to report for law enforcement.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address listed on slide 45. For information on evaluating today's event, see slide 46.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the Nursing Home Facility Assessment Tool and State Operations Manual Revisions. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.