CAH Swing Bed Management

CMS Survey

Webinar Series – Part 4
December 16, 2020

HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

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Disclaimer

- **This information was prepared with the best of intention using CMS such as State Operations Manual, in particular Appendix W and Appendix PP, Claims Processing Manual, Medicare Benefit Policy Manual and other resources for regulations and is not intended to grant rights or impose obligations. This training may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.**

List of Appendix

Medicare State Operations Manual

Appendix

- Contains list of all appendix (see next 2 slides)
- https://www.cms.gov/files/document/appendices-table-content.pdf

List of Appendix

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749 pages

306 pages

Appendix W for CAHs and Swing Bed

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

- See page 236 to 252 – C-1608 to C-1626 for SB regulations
- Anita Moore from Medicare is now in charge of CAHs
- Questions regarding CoP may be asked via email it to qsog_cah@cms.hhs.gov
- When answered via email, it gives the hospital an answer in writing which can be put in your files in case the issue comes up later with a surveyor

Appendix PP for Swing Bed/SNF & LTC

State Operations Manual

Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Table of Contents

(Rev. 173, 11-22-17)

Transmittals for Appendix PP

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Appendix W

New Swing Bed Tag Numbers Appendix W	
0350	C-1600
0351	C-1602
0352	C-1604
0355	C-1606
0361	C-1608
0373	C-1610
0381	C-1612
0386	C-1616
0388	C-1620
0402	C-1622
0404	C-1624
0410	C-1626

Appendix PP Content

- The Appendix PP applies to Long-Term Care. Only part of the index applies to SB which will be covered during this webinar
- The Appendix W (reviewed last week) refers to Appendix PP as applicable

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§483.5 Definitions
§483.10 Resident Rights
§483.12 Freedom from Abuse, Neglect, and Exploitation
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§483.24 Quality of Life
§483.25 Quality of Care
§483.30 Physician Services
§483.35 Nursing Services
§483.40 Behavioral health services
§483.45 Pharmacy Services
§483.50 Laboratory Radiology and Other Diagnostic Services
§483.55 Dental Services
§483.60 Food and Nutrition Services
§483.65 Specialized Rehabilitative Services
§483.70 Administration
§483.75 Quality Assurance and Performance Improvement
§483.80 Infection Control
§483.85 Compliance and Ethics Program
§483.90 Physical Environment
§483.95 Training Requirements

Appendix W for CAHs Acute & Swing Bed

- The following **applies to both** the CAH acute services and the swing bed services
- **NOTE**: Surveyors do not evaluate compliance with the 3-day qualifying stay requirement for SB
- Surveyors assess CAH compliance with the CoPs for all services, areas and locations in which the provider receives reimbursement for patient care services billed under its CMS Certification Number (CCN), as well as certain entities that provide services to the CAH on a contractual basis. These areas include all inpatient and outpatient services and practice locations, buildings and facilities (including, but not limited to, generators, electrical rooms, food services, HVAC, supply areas, sterilization areas, etc.).
- Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct the survey at other times. These survey hours may include weekends and times outside of daytime (Monday through Friday) working hours. When the survey begins at times outside of normal work times, the survey team modifies the survey, if needed, in recognition of patients' activities and the staff available.
- All CAH surveys are unannounced. Do not provide CAHs with advance notice of the survey. The SAs, Accreditation Organizations (AOs), and CMS may not make any communications or requests to a CAH that would amount to advance notice of a survey (with the exception of providing resurvey timeframes as stated in the SOM).

Tasks in the Survey Protocol

Tasks in the Survey Protocol

Listed below, and discussed in this document, are the tasks that comprise the survey protocol for CAH surveys.

Task 1	Off-Site Survey Preparation
Task 2	Entrance Activities
Task 3	Information Gathering/ Investigation
Task 4	Preliminary Decision Making and Analysis of Findings
Task 5	Exit Conference
Task 6	Post-Survey Activities

- Survey Modules for Specialized CAH services The modules for CAH distinct part psychiatric units and rehabilitation units and CAH swing beds are attached to this document (Appendix W).

- The survey team is expected to use all the modules that apply to the CAH being surveyed.
  - For example, if the CAH has swing beds, a distinct part rehabilitation unit, and a distinct part psychiatric unit, the team will use all three modules to conduct the survey of those activities.

Survey Team Size & Composition

- The SA (State Survey Agency) (or the CMS Regional Office (RO) for Federal teams) decides the composition and size of the team.
- In general, a suggested survey team for a full survey of a CAH would include 1-4 surveyors who will be at the facility for one or more days.
- Each survey team should include at least one RN with hospital/CAH survey experience, as well as other surveyors who have the expertise needed to determine whether the CAH is in compliance.
- Survey team size and composition are normally based on the following factors:
  - Size of the facility to be surveyed, based on average daily census;
  - Complexity of services offered, including outpatient services;
  - Type of survey to be conducted (such as new CAH, new SB service, annual survey, post complaint..)
  - Whether the facility has special care units or off-site clinics or locations;
  - Whether the facility has a historical pattern of serious deficiencies or complaints; and
  - Whether new surveyors are to accompany a team as part of their training.

Survey Team Coordinator Responsabilities

❑ Team Coordinator

- The SA (or the RO for Federal teams) should designate the Team Coordinator. The Team Coordinator is responsible for assuring that all survey preparation and survey activities are completed within the specified timeframes and in a manner consistent with this protocol, SOM, and SA procedures.

- **Responsibilities of the Team Coordinator** include:
  - Scheduling the date and time of survey activities;
  - Acting as the spokesperson for the team;
  - Assigning staff to areas of the CAH or tasks for the survey;
  - Facilitating time management;
  - Encouraging and facilitating on-going communication among team members;
  - Evaluating team progress;
  - Coordinating daily team meetings;
  - Coordinating any ongoing discussions with CAH leadership (as determined appropriate by the circumstances and SA/RO policy) and providing on-going feedback, as appropriate, to CAH leadership on the status of the survey;
  - Coordinating Task 2 Entrance Conference;
  - Facilitating Task 4 Preliminary Decision Making;
  - Coordinating Task 5 Exit Conference; • Ensuring that all survey team activities are conducted in accordance with CMS procedures;
  - Ensuring that the team completes all applicable forms prescribed by CMS, including Form CMS-2567.

  - See website below for explanation of the form where they document findings
  - https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/Definitions.pdf#:~:text=The%20survey%20report%2C%20or%20CMS%20Form%202567%2C%20is,is%20divided%20into%20two%20columns%20as%20illustrated%20below%3A

Task 1 - Off-Site Survey Prep

- **Task 1 - Off-Site Survey Preparation**

- The objective of this task is to analyze information about the CAH in order to identify areas of potential concern to be investigated during the survey and to determine if those areas, or any special features of the CAH (e.g., provider-based clinics, specialty units, services offered, etc.) require the addition of any specialty surveyors to the team.

- **The type of CAH information needed includes:**
  - Information from the provider file (to be updated on the survey using the Hospital/CAH Medicare Database Worksheet, Exhibit 286 – (see website below), such as the facility's ownership, the type(s) of services offered, whether the facility is a provider of swing-bed services, any distinct part units, the number, type and location of any off-site locations; and the number and categories of personnel.
  - Previous Federal and state survey results for patterns, number, and nature of deficiencies, as well as the number, frequency, and types of complaint investigations and the findings;
  - Information from CMS databases available to the SA and CMS. Note the exit date of the most recent survey;
  - Waivers and variances, if they exist. Determine if there are any applicable survey directive(s) from the SA or the CMS RO; and
  - Any additional information available about the CAH (e.g. the CAH's Web site, any media reports about the CAH, etc.)
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_286.pdf

Download this form if new to survey responsibility

Task 1 - Off-Site Survey Prep

- They gather copies of or have access to resources that may be needed. These may include:
  - CAH Regulations and Interpretive Guidelines (Appendix W);
  - Survey protocol and modules;
  - Immediate Jeopardy (Appendix Q);
  - Responsibilities of Medicare Participating Hospitals in Emergency Cases (Appendix V);
  - Hospital/CAH Medicare Database Worksheet (Exhibit 286);
  - Authorization by Deemed Provider/Supplier Selected for Accreditation
  - Organization Validation Survey (Exhibit 287);
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_exhibit_287.pdf
  - Worksheets, as applicable, for swing bed and CAH distinct part rehabilitation and psychiatric units.

Task 2 – Entrance Activities

Task 2 - Entrance Activities

- The objectives of this task are to explain the survey process to the CAH and obtain the information needed to conduct the survey.
- **General Procedures**
- **Arrival**
  - Upon arrival, surveyors should present their identification. The Team Coordinator should announce to the Administrator, or whoever is in charge, that a survey is being conducted. If the Administrator (or person in charge) is not on site or available (e.g., if the survey begins outside normal daytime, Monday – Friday working hours), ask that they be notified that a survey is being conducted.

- **Entrance Conference**
  - Conduct the entrance conference with administrative staff available at the time of entrance
  - The Team Coordinator should address the following:
    - Explain the purpose and scope of the survey;
    - Briefly explain the survey process;
    - Introduce survey team members, including any additional surveyors who may join the team at a later time.
    - Discuss the general area that each will be responsible for, and the various documents that they may request;
    - Clarify that all CAH areas and locations, departments, and patient care settings under the CAH CCN may be surveyed, including any contracted patient care activities or patient services;
    - Explain that all interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee;
    - Discuss and determine how the CAH will ensure that surveyors are able to obtain the photocopies of material, records, and other information as they are needed;

Task 2 – Entrance Activities

- **Entrance Conference (cont')**
  - Discuss and determine how the CAH will ensure that surveyors are able to obtain the photocopies of material, records, and other information as they are needed;
    - Surveyors will need to have access to one or more copying machines
    - If the CAH uses electronic medical records or uses electronic documents for its policies, procedures, or other activities, explain that surveyors will need access to one or more printers so they can personally print documents as needed;
    - Explain that if the CAH wishes, surveyors will make the CAH an additional copy of every document that surveyors copy;
  - Obtain the names, locations, and telephone numbers of key staff to whom questions should be addressed;
  - Explain that the survey team will not be providing the hospital with a list of all patients, staff, or visitors interviewed or records reviewed during the survey;
  - Discuss the approximate time, location, and possible attendees of any meetings to be held during the survey. The Team Coordinator should coordinate any meetings with facility leadership; and
  - Propose a date and time for the exit conference.

Task 2 – Entrance Activities

- **Entrance Conference (cont')**
  - The Team Coordinator will arrange with the CAH administrator, or available CAH administrative/supervisory staff to obtain the following:
    - A location (e.g., conference room) where the team may meet privately during the survey;
    - A telephone for team communications, preferably in the team meeting location;
    - A list of current inpatients, providing each patient's name, room number, diagnosis (es), admission date, age, attending physician, and other significant information as it applies to that patient.
  - The Team Coordinator will explain to the CAH representative that in order to complete the survey within the allotted time it is important the survey team is given this information as soon as possible, and request that it be no later than 3 hours after the request is made.
  - SAs may develop a worksheet to give to the CAH for obtaining this information;
    - A list of department heads with their locations and telephone numbers;
    - A copy of the CAH's organizational chart;
    - The names and addresses of all off-site locations operating under the same CCN;
    - The CAH's infection control plan;
    - A list of employees;
    - The medical staff bylaws and rules and regulations;
    - A list of contracted services; and
    - A copy of the CAH's floor plan, indicating the location of patient care and treatment areas.
  - The Team Coordinator will inform the CAH that this is not an all-inclusive list and other documents/manuals may be requested throughout the survey depending on potential issues that may be identified.
  - Will allow CAH staff to follow surveyors around but MUST NOT INTERFERE or DELAY (answer for staff at interview, not be present for patient/family survey, not discuss findings..)

Task 2 – Entrance Activities

- **Surveying CAHs with electronic health records (EHR)** and other documents, such as, policies, procedures, or data related to compliance efforts.
- During the entrance conference surveyors will establish with the CAH the process they will follow in order to have unrestricted access to the medical record.
- Inform the CAH as to whether the team will use one or a combination of the following:
  - Surveyors will directly access the CAH's EHR or other electronic documents. If this is the case, inform the CAH that it must provide surveyor(s) with passcodes that will provide sufficient system access permissions that ensure the surveyor's ability to retrieve complete medical records, including, when requested, information from built-in audit features that enable identification of the date, time, and author for entries or changes made to the record.
  - Inform the CAH that the surveyor(s) must have sufficient access to review any CAH documents needed to evaluate the CAH's compliance with the CoPs (for example policies, procedures, schedules, Infection Control information, etc.) - Whenever possible, the CAH must provide surveyors electronic access to records in a read-only format or other secure format to avoid any inadvertent changes to the record. The provider is solely responsible for ensuring that all necessary back up of data and security measures are in place.
    - Surveyors will utilize staff, such as nurses assigned to patient care units to review medical records, or Infection Control staff to review those activities.
    - In other situations the surveyor may request CAH staff to access policies, procedures, Infection Control information, committee minutes, etc.
    - Surveyors will request that experienced CAH EHR users with appropriate system permissions be assigned as "navigators" to assist surveyors with retrieval of medical record information and other electronically stored information as needed for evaluation of the CAH's compliance.
    - In CAHs that use hybrid mixes of electronic and paper medical record systems, CAH staff are expected to know which portions of the medical record are not captured in the EHR, to inform the surveyor of this, and to be able to retrieve those paper-based portions of the records as well.
    - **Note:** If a CAH declines to provide the requested means of access to the surveyor when requested, the surveyor will first remind the CAH that failure to provide access to records may, in accordance with 42 CFR 489.53(a)(5), be grounds for terminating the Medicare provider agreement.

Task 2 – Entrance Activities

- **CAH Tour**
  - Guided tours of the CAH are not encouraged and should be avoided

- **Initial On-Site Team Meeting** During the initial on-site team meeting, team members should: • Review the scope of services;
  - Identify all locations to be surveyed, including all off-site locations;
  - Adjust surveyor assignments, as necessary, based on new information;
  - Discuss issues such as change of ownership, sentinel events, construction activities, and disasters, if they have been reported;
  - Discuss any issues that have been observed or reported while surveyors have been at the CAH;
  - Make an initial patient sample selection (the patient list may not be available immediately after the entrance conference, therefore the team may delay patients completing the initial patient sample selection a few hours as meets the needs of the survey team); and
  - Set the next meeting time and date.

- **Sample Size and Selection**
  - A cross section of the patient population and services, to include contracted services (e.g.: Telemedicine: teleICU or telestroke, etc.) provided.
  - If the team finds it necessary during the survey to remove a patient from the sample (e.g., the patient refused to participate in an interview), replace this patient with another who fits a similar profile. Make the substitution as early in the survey as possible.
  - Whenever possible and appropriate, surveyors should interview patients that are in the facility during the time of the survey to assess the facility's compliance with the CoP. Open patient records should be selected whenever possible.
  - There are situations where closed records will be needed to assess compliance and there may be other situations where there are not adequate numbers of open records to assess compliance.
  - The sample needs to be no fewer than 20 inpatient records,
  - Additionally, select a sample of outpatients in order to determine compliance in outpatient and emergency services.

Task 2 – Entrance Activities

- **During the Survey**
  - Visit as many patient care settings as possible, including all on campus and off campus patient care locations
  - Observe what activities are taking place and assess the CoP that represent the scope and complexity of the patient care services as well as, any other CoP that apply to those locations.
  - Observation of the care environment must include assessing for safety risks in the patient care setting. The depth of assessment of the CoPs will be determined by what the surveyor observes at each location. The surveyor expands the survey activities as necessary.
    - On any Medicare survey, contracted patient care activities or patient services (such as dietary services, treatment services, diagnostic services, etc.)
    - The team meets at least daily in order to assess the status of the survey, to discuss each surveyor's findings, progress of completion of assigned tasks, areas of concern, and to identify areas for additional investigations.
    - Maintain open and ongoing dialogue with the CAH staff throughout the survey process. Informal discussions with CAH staff may be held in order to inform them of survey findings. This affords CAH staff the opportunity to present additional information or to offer explanations concerning identified issues.
    - Survey information must not be discussed unless the investigation process and data collection for the specific concerns is completed. Regular meetings with CAH leadership are not encouraged, but a meeting may be needed when a problem conducting the survey has arisen and the Team Coordinator needs to explain procedures to CAH leadership.
    - Additionally, CAH leadership may request a meeting with the Team Coordinator to address any concerns with the survey. If meetings with CAH leadership are held, the Team Coordinator must be the spokesperson for the team.
    - Surveyors should always maintain a professional working relationship with CAH staff.
    - Surveyors need to respect patient privacy and maintain patient confidentiality at all times during the survey.
    - Surveyors should maintain their role as representatives of a regulatory agency. Although non-consultative information may be provided upon request, the surveyor is not a consultant.

Task 3 – Info Gathering/Investigation

❑ Task 3 – Information Gathering/Investigation

❑ Guiding Principles

- Focus attention on actual and potential patient outcomes, as well as required processes.
- Assess the care and services provided, including the appropriateness of the care and services within the context of the regulations.
- Visit patient care settings, including inpatient units, outpatient clinics, anesthetizing locations, emergency departments, imaging, rehabilitation, etc
- Observe the actual provision of care and services to patients and the effects of that care, in order to assess whether the care provided meets the needs of the individual patient.
- Use the interpretive guidelines and other published CMS policy statements to guide the survey
- Use Appendix Q for guidance if Immediate Jeopardy is suspected

❑ Patient Review

- A comprehensive review of care and services received by each patient in the sample should be part of the survey.
  - Includes observations of care/services provided to the patient, patient and/or family interview(s), staff interview(s), and medical record review.
  - After obtaining the patient's permission, observe each sample patient receiving treatments (e.g., intravenous therapy, tube feedings, and wound dressing changes) and observe the care provided in a variety of treatment settings, as necessary, to determine if patient needs are met.

Task 3 – Info Gathering/Investigation

- **Task 3 – Information Gathering/Investigation (cont')**

- **Observations**
  - While completing a chart review, for instance, it may be possible to also observe the environment and the patients, staff interactions with patients, safety hazards, and infection control practices. When conducting observations, particular attention should be given to the following:
    - Patient care, including treatments and therapies in all patient care settings;
    - Staff member activities, equipment, documentation, building structure, sounds and smells;
    - People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as, those that are not present that should be present;
    - Integration of all services, such that the CAH is functioning as one integrated whole;
    - Whether quality assurance (QA) is a CAH-wide activity, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the CAH's central organized body managing the facility-wide QA program; and
    - Storage, security, and confidentiality of medical records
    - Environmental risks. Examples may include, but are not limited to, unattended cleaning carts, unattended hazardous cleaning solutions, unlocked medications, and ligature risks in areas where psychiatric patients may have care provided.
  - A surveyor must not touch or examine patients by themselves
  - If the surveyor believes that blankets or clothing are hiding bedsores, bruises, or incontinence, and with the patient's permission, they may remove the coverings and make a determination based on observation.

Task 3 – Info Gathering/Investigation

- **Task 3 – Information Gathering/Investigation (cont')**

- **Interviews**
  - Maintain detailed documentation of each interview conducted.
  - Document the interview date, time, and location; the full name and title of the person interviewed; and key points made and/or topics discussed.
  - To the extent possible, document quotes from the interviewee.
    - Interviews with CAH staff should be brief. Use a few well-phrased questions to elicit the desired information. For example, to determine if a staff member is aware of disaster procedures and his/her role in such events, simply ask, "If you smelled smoke, what would you do?"
    - When interviewing staff, begin your interviews with staff that work most closely with the patient.
    - Conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interview may include advanced directives and the CAH's grievance/complaint procedure.
    - Interviews with patients must be conducted in privacy and with the patient's prior permission.
    - Use open-ended questions during your interview.
    - Validate all information obtained.
    - Telephone interviews may be conducted if necessary, but a preference should be made for in-person interviews
    - Integrate the data from interviews with data gathered through observations and document reviews.

Task 3 – Info Gathering/Investigation

- **Task 3 – Information Gathering/Investigation (cont')**
- **Interviews (cont')**
  - Staff interviews should gather information about:
    - the staff's knowledge of the patient's needs,
    - plan of care, and
    - progress toward goals.
  - Problems or concerns identified during a patient or family interview should be addressed in the staff interview in order to validate the patient's perception, or to gather additional information.
  - Patient interviews should include questions specific to the patient's condition, reason for admission, quality of care received, and the patient's knowledge of their plan of care.
    - For instance, a surgical patient should be questioned about the process for preparation for surgery, the patient's knowledge of and consent for the procedure, pre-operative patient teaching, post-operative patient goals and discharge plan.

Task 3 – Info Gathering/Investigation

❑ Document Review

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching.
- This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission, and be modified, as patient care needs change.
- The record review for that patient who has undergone surgery would include a review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and postoperative anesthesia notes
- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice
- Personnel files to determine if staff members have the appropriate qualifications including educational requirements, have had the necessary training required, and are licensed, if it is required
- Privileging files to determine if the CAH complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers and types of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals to verify with the person in charge of an area that the policy and procedure manuals are current;
- Contracts, if applicable, to what requirements are provided under arrangements or agreements.
- Diet menus to ensure they meet the needs of the sample patients.

Task 3 – Info Gathering/Investigation

- **Electronic Documents Including EHR**
  - The goal of the surveyor's observation of how the EHR is used by CAH staff is to determine whether staff can enter into and retrieve the information necessary for their patient's care in a timely fashion.
    - Healthcare staff must be able to demonstrate their ability to access parts of the record necessary for the provision of care for their patients.
    - The focus of the review is determining staff competence in using the EHR system as opposed to the surveyor's ability to navigate the system.
  - Surveyors must investigate what happens when the computer is unavailable or offline, whether planned or unplanned. Some examples might include:
    - How to register, admit, transfer, move, or discharge patients.
    - How to order, determine, and record medications and administration of medications.
    - How to order or determine diets.
    - How to order, determine, and record treatments.
    - How to obtain laboratory reports and other testing results.

- **Photocopies**
  - Surveyors must make photocopies of all documents needed to support survey findings.
  - In order to ensure accurate copies of the documents needed, the survey team must either make their own copies or hand carry the material to the copy machine where they directly observe hospital staff make the requested copies and then take immediate possession of the copies.
  - If requested by the CAH, the surveyor should make the CAH a copy of all items photocopied. All photocopies need to be dated and timed as to when photocopied, and identified such as "CAH IV management policy-12/05/17 page 3" or "Patient # 6, progress note – 12/05/17."

- **Completion of Hospital/CAH Medicare Database Worksheet**
  - The worksheet will be completed by the surveyors using observation, staff interviews, and document review. The worksheet will not be given to the CAH staff to complete.
  - The worksheet is used to collect information that will later be entered into the Medicare Database.

Task 4 – Decision Making & Analysis Findings

Task 4 – Preliminary Decision Making and Analysis of Findings

- Each team member reviews his/her notes, worksheets, records, observations, interviews, and document reviews to assure that all investigations are complete and organized for presentation to the team
- Review their findings and concerns regarding the CAH's compliance and be prepared to present their findings during the meeting.
- The entire survey team that is at the CAH must be present therefore ensure availability of a conference call for team members who have already departed the survey
- The Team Coordinator will sequentially discuss the regulations in order as they appear in the regulations, CoP, Standard, or Tag, depending on what issues have been identified during the survey,
- Surveyors will share their findings, evaluate the evidence, and make team decisions regarding compliance with each requirement when that requirement is discussed,
- Team discussion is to include the official interpretation of the regulation as put forth in the interpretive guidelines for each regulation
- (Note: citations of non-compliance must be based on non-compliance with regulation; citations of non-compliance cannot be based on noncompliance with the interpretive guidelines)
- The team must ensure that their findings are supported by adequate documentation of observations, interviews, and document reviews, and includes any needed evidence such as photocopies

Task 4/5/6 – Decision Making & Analysis Findings

- **Task 4 (cont')**
- **Determining the Severity of Deficiencies**
  - When noncompliance with a condition of participation is noted, the determination of whether a lack of compliance is at the standard or condition level depends upon the degree (how severe, how dangerous, how critical, etc.) and manner (how prevalent, how many, how pervasive, how often, etc.) of the lack of compliance.
  - All noted noncompliance must be cited even when corrected on site during the survey.
  - On a complaint investigation where the CAH states that it has corrected the deficient practice/issue (noncompliance) that is the basis of the complaint, issues for the survey team to consider would include:
    - Is the corrective action superficial or inadequate, or is the corrective action adequate and systemic?
    - Is the deficient practice still present?
    - Has the CAH implemented the corrective intervention(s) or action(s)?
    - Has the CAH taken a QA approach to the corrective action to ensure monitoring, tracking and sustainability?
    - Have the CAH's corrective actions made it unlikely for the deficient practice to recur?
- **Exit Conference**
  - Discontinuation of an Exit Conference
    - If the provider is represented by counsel (all participants in the exit conference should identify themselves), surveyors may refuse to conduct the conference if the lawyer tries to turn it into an evidentiary hearing; or
    - Any time the provider creates an environment that is hostile, intimidating, or inconsistent with the informal and preliminary nature of an exit conference, surveyors may refuse to conduct or continue the conference. Under such circumstances, it is suggested that the Team Coordinator stop the exit conference and call the State agency for further direction.

Task 4/5/6 – Decision Making & Analysis Findings

- **Task 4 (cont')**
- **Recording the Exit Conference**

  - If the CAH wishes to audio record the conference, it must provide two tapes and tape recorders, recording the meeting simultaneously. In order for this to occur, the CAH must be able to supply a copy of the recording, or transmit a copy in a format the survey team can utilize (or if the survey team has the capability to record the discussion, the team can use its own recording device for its purposes)

- **General Principles**
  - The CAH's leadership determines which CAH staff will attend the exit conference
  - The identity of an individual patient or staff member must not be revealed in discussing survey results. – Also must not include any references by which identity might be deduced.
  - Because of the ongoing dialogue between surveyors and CAH staff during the survey, there should be few instances in which the CAH is unaware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.
  - The team will provide their report – they are not allowed to make general statements such as "Overall the CAH is very good"). They are trained to stick to the facts.
  - The CAH staff will have an opportunity to present new information or evidence of compliance after the exit conference for consideration after the survey.
  - If immediate jeopardy was identified, explain the significance and the need for immediate correction. Follow instructions in Appendix Q.
    - Appendix Q – To cite immediate jeopardy, surveyors determine that (1) noncompliance (2) caused or created a likelihood that serious injury, harm, impairment or death to one or more recipients would occur or recur; and (3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment or death to one or more recipients. See website for the form - March 5, 2019 – REVISED below
    - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf

Task 4/5/6 – Decision Making & Analysis Findings

❑ Conference Closure (Task 4 – cont')

- A statement of deficiencies (Form CMS-2567) will be mailed within 10 business days to the CAH
- The Form CMS-2567 is the document disclosed to the public about the CAH's deficiencies and what is being done to remedy them.
- The Form CMS-2567 is made public no later than 90 calendar days following completion of the survey. It documents specific deficiencies cited, the CAH's plans for correction and timeframes, and it provides an opportunity for the CAH to refute survey findings and furnish documentation that requirements are met.
- The CAH's written plan of correction (POC) must be submitted to the survey agency within 10 business days following receipt of the written statement of deficiencies

- The characteristics of an acceptable POC include:
  - Separately addressing each citation;
  - A Quality Assessment and Performance Improvement (QAPI) methodology for each citation and address improvements in the hospital's systems in order to prevent the likelihood of the cited deficient practice from recurring;
  - A procedure for implementing each corrective action taken;
  - A procedure for monitoring the corrective actions taken for each citation Providing the identity or position of the person who will monitor the corrective action and the frequency of monitoring;
    - Dates each corrective action for each citation was/will be completed;
    - The administrator or appropriate individual must sign and date the Form CMS-2567 before returning it to the survey agency.
  - The submitted plan of correction must meet the approval of the State agency, or in some cases the CMS Regional Office for it to be acceptable.

- All team members should leave the CAH together immediately following the exit conference.
- If the CAH staff provides further information for review, the Team Coordinator should decide the best way to conduct the further review. It is usually prudent for at least two individuals to remain.
- Failure to submit a POC may result in termination of the provider agreement as authorized by 42 CFR §§488.28(a) and 489.53(a)(1). After a POC is submitted, the surveying entity makes the determination of the appropriateness of the POC.

❑ CMS form 2567 for deficiencies - https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS2567.pdf

Interpretive Guidelines & Survey Procedures

- **Appendix PP**

- **Resident Rights**
  - **See Guidance & Procedure page 11 & 12**
  - **KEY ELEMENTS OF NONCOMPLIANCE** §483.10(b)(3)-(7)
  - To cite deficient practice at F551, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:
    - Ensure a competent resident's choice for a representative is honored or
    - Ensure that treatment of a same-sex spouse was the same as treatment of an opposite-sex spouse; or
    - Ensure the resident representative did not make decisions beyond the extent allowed by the court or delegated by the resident; or
    - Ensure the resident's wishes and preferences were considered when decisions were made by the resident representative; or
    - Ensure the decisions of the resident representative are given the same consideration as if the resident made the decision themselves; or
    - Honor the resident's authority to exercise his or her rights, even when he or she has delegated those rights, including the right to revoke a delegation of rights; or
    - Ensure the resident representative was reported as State law required when not acting in the best interest of the resident; or
    - Ensure a resident who was found incompetent by the court is provided with opportunities to participate in the care planning process.
  - **What is your P&P on determining if the patient is competent to represent him/herself, how to identify if there is a representative, how we communicate with representative etc…..**

Interpretive Guidelines & Survey Procedures

❑ Planning and implementing care

- See Intent & Guidance page 16

- **Procedures §483.10(c)(2)-(3)**

- During observations, interviews, and record reviews, surveyors must:
  - Interview the resident, and/or his or her representative to determine the level of participation in care planning.
  - Identify ways staff involve residents and/or their representative(s) in care planning
  - Determine if care plan meetings are scheduled to accommodate residents and/or their representative
  - Determine how facility staff addressed questions or concerns raised by a resident or his or her representative, including if they are addressed at times when it would be beneficial to the resident, such as when they are expressing concerns or raising questions
  - Determine if the resident and representative were unable to participate, did facility staff consult them in advance about care and treatment changes.
  - Interview staff to determine how they inform residents or their representative of their rights and incorporate their personal preferences, choices, and goals into their care plan
  - When the resident request is something that facility staff feels would place the individual at risk (i.e., the resident chooses not to use the walker, recommended by therapy), is there a process in place to examine the risk/benefit and guide decision-making?
  - Review the resident's medical record to determine if facility staff included an assessment of the resident's strengths and needs and whether these, as well as the resident's personal and cultural preferences, were incorporated when developing his or her care plan
  - Determine how facility staff observes and responds to the non-verbal communication of a resident who is unable to verbalize preferences (i.e., if the resident spits out food, is this considered to be a choice and alternative meal options offered).

- **Discuss P&P re: patient/family/representative involvement in care planning**

Interpretive Guidelines & Survey Procedures

- **Planning and implementing care**
  - **Key Elements**
  - Develop and implement a care plan that:
    - Is comprehensive and individualized;
    - Is consistent with the resident's goals and right to be informed and participate in his/her treatment;
    - Meets each of the medical, nursing, mental and psychosocial needs identified on the resident's comprehensive assessment;
    - Includes measurable objectives, interventions and timeframes for how staff will meet the resident's needs. Develop and implement a care plan that describes all of the following:
    - Resident goals and desired outcomes;
    - The care/services that will be furnished so that the resident can attain or maintain his/her highest practicable physical, mental and psychosocial well-being;
    - The specialized services to be provided as a result of the PASARR evaluation and/or the comprehensive assessment if applicable;
    - The resident's discharge plan and any referrals to the local contact agency;
    - Refusals of care and action taken by facility staff to educate the resident and resident representative, if applicable, regarding alternatives and consequences.
    - Standards of care are followed
    - "Professional standards of quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency.

Interpretive Guidelines & Survey Procedures

❑ Planning and implementing care (cont')

- **Probes**

- Was a comprehensive plan of care developed within a few days of admission?
- Is there evidence of participation in the care planning process by required IDT members?
- Ask required members of the IDT how they participate in the development, review and revision of care plans.
- Based on the resident's goals and needs, were other appropriate staff or professionals' expertise utilized to develop a plan to improve the resident's functional abilities? For example:
  - Did an occupational therapist recommend needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?
  - Did the dietitian and speech therapist determine the optimum textures and consistency for the resident's food that is nutritionally adequate and compatible with the resident's oropharyngeal capabilities and food preferences?
- Is there evidence of attending physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls, written communication)?
- How do staff make an effort to schedule care plan meetings at the best time of the day for residents and if applicable, the resident representatives?
- How do staff make the care plan process understandable to the resident and resident representative, if applicable?

Interpretive Guidelines & Survey Procedures

❑ Planning and implementing care (cont')

- **Probes**

- Ask the resident and resident representative, if applicable if he or she actively participates in the care planning process?
  - If not, what have been the barriers to participation?
- Ask the resident and if applicable, the resident representative if he or she has requested the participation of additional individuals care planning process. If so, was the request respected?
- In what ways does staff involve the resident and if applicable, the resident representative in care planning?
- If staff determine that the resident and/or resident representative involvement in care planning is not practicable, is the reason and the steps the facility took to include the resident and/or resident representative documented in the medical record?
- Is there evidence that the care plan is evaluated for effectiveness and revised following each required assessment, except discharge assessments, and as needed?

Interpretive Guidelines & Survey Procedures

❑ Planning and implementing care

- **Probes**
  - Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?
  - Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?
  - Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?
  - Does the care plan describe specialized services and interventions to address PASARR recommendations, if came from a NH and PASSARR is applicable?
  - Is there evidence that the care plan interventions were implemented consistently across all shifts?
  - Is there a process in place to ensure direct care staff are aware of and educated about the care plan interventions?
  - Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.
  - Evaluate whether the care plan reflects the facility's efforts to find alternative means to address care of the resident if he or she has refused treatment.

Interpretive Guidelines & Survey Procedures

❑ Choice of attending physician

- See Definition & Guidance page 19-20
- **Probes**
  - Through interviews with facility staff and residents and/or their representatives, determine how residents or their representative are informed of and are supported in:
    - His or her right to choose a physician;
    - How to contact their physician and other primary care professionals responsible for their care;
    - His or her options to choose an alternate physician or other primary care professional.
      - If his or her physician is unable or not willing to provide necessary care and services, determine if facility staff worked with the resident to choose another physician.
  - **Discuss plans to make this work**

Interpretive Guidelines & Survey Procedures

❑ Respect & Dignity

- See Intent, Definition & Guidance page 21-22

- **Procedure**
  - If facility staff refused to allow a resident to retain his or her personal possession(s), determine if such a restriction was appropriate due to insufficient space, protection of health and safety, and maintaining other resident rights, and whether the reason for the restriction was communicated to the resident.
  - Examples of noncompliance may include, but are not limited to:
    - Residents, their representatives, or family members have been discouraged from bringing personal items to the facility.
    - A decision to refuse to allow a resident to retain any personal belongings was not based on space limitations or on a determination that the rights, health or safety of other residents would be infringed.
  - Observe residents in their rooms and common areas and interview residents, if possible, to determine if their environment accommodates their needs and preferences.
  - Observe staff/resident interactions to determine if staff interact in a manner that a resident with limited sight or hearing can see and hear them.
  - Determine if staff keep needed items within the resident's reach and provide necessary assistance to help maintain the resident's independence.
  - Determine if the resident has the call system within reach and is able to use it if desired.
  - Examples of noncompliance may include, but are not limited to:
    - Storing a wheelchair or other adaptive equipment out of reach of a resident who is otherwise able to use them independently, such as a wheelchair stored across the room for a resident who is able to self-transfer or storing eyeglasses out of reach for a resident.
    - Having areas of worship inaccessible to residents with mobility limitations
    - Not providing a riser on a toilet to maintain independence.

Interpretive Guidelines & Survey Procedures

❑ Visitors and "Reasonable clinical and safety restrictions"

- See Definition & Guidance page 28-29

- **Procedure**
  - Through interviews with residents, their representative, family members, visitors and others as permitted under this requirement, determine if they know that they are able to visit 24-hours a day, subject to a resident's choice and reasonable restrictions as defined above.
  - Review the facility's written visitation policy and procedures to determine whether they support the resident's right to visitors and whether they explain those situations where visitors may be restricted due to clinical or safety concerns.
  - If a concern is identified, interview facility staff to determine how they ensure 24-hour or immediate access as permitted under these requirements.
  - Examples of noncompliance may include, but are not limited to:
    - Facility staff restrict visitors according to the facility's convenience.
    - Facility staff restrict the rights of a resident to receive visitors, even though this would not affect the rights of other residents.
    - Facility staff restrict visitors based on expressed wishes of an individual who is a health care power of attorney who does not have the authority to restrict visitation.
    - A posting or inclusion in the resident handbook or other information provided by the facility, of visiting hours not in compliance with this regulation.

Interpretive Guidelines & Survey Procedures

❑ Visitors and "Reasonable clinical and safety restrictions" – (cont')

- **Procedure**
  - Through interviews with residents and/or their representatives, determine how they were informed of their visitation rights and related policies and procedures, including their right to consent to receive or deny visitors he or she designates, any clinical or safety restriction, or limitation on such rights imposed by the facility.
  - Determine if the facility has ensured visitation rights consistent with resident preference.
  - Examples of noncompliance may include, but are not limited to:
    - Prohibiting a resident from having visits from his or her spouse or domestic partner, including a same-sex spouse or partner.
    - Facility staff did not inform a resident, the family, and/or resident representative of their visitation rights, including any restrictions or limitations of these rights that may be imposed by the facility or the resident, the family, and/or resident representative;
    - Facility staff denied, limited or restricted a resident's visitation privileges contrary to their choices, even though there were no clinical or safety reasons for doing so.

Interpretive Guidelines & Survey Procedures

❑ Informed of the Medicare/Medicaid coverage

- Facility staff must notify residents of services or items that they may be charged for, if they are not required by the resident's care plan
- What does Medicare cover
- What could be out of pocket
- How to apply for Medicaid if needed

- Facilities must issue the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to residents/beneficiaries prior to providing care that Medicare usually covers, but may not pay for, because the care is: • not medically reasonable and necessary; or • is considered custodial.

- See next slide for NOMNC (Notice of Medicare Non-Coverage)

- If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. In most cases when all covered services end for coverage reasons, a SNF provider will issue:
  - NOMNC; or •
  - NOMNC and the SNFABN

- The SNF:
  - Must file a claim when requested by the beneficiary; and
  - May not charge the resident for Medicare covered Part A services while an expedited review and final decision is pending.

Interpretive Guidelines & Survey Procedures

- A Medicare provider or health plan must give an advance, completed copy of the **Notice of Medicare Non-Coverage (NOMNC)** prior to the termination of Medicare beneficiaries/enrollees receiving
  - Skilled nursing (SB or SNF)
  - ***No later than two days before*** the termination of services.

- Do not use the NOMNC if coverage is being terminated for any of the following reasons:
  - When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
  - When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
  - When beneficiaries are moving to a higher level of care
  - When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
  - When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
  - When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

- See copy as a download on site below and copy of the NOMNC and the Detailed forms for QIO in the website below – also includes Medicare Advantage
- https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

Interpretive Guidelines & Survey Procedures

❑ Privacy and confidentiality

- See Definition & Guidance on page 60-62
- **Procedure**
  - Observe for situations where facility staff may not be honoring the resident's privacy, including during visits, treatment, or leaving medical records out for public view
  - During interviews with residents, their representatives, visitors or families determine if their privacy has been honored by facility staff
  - Interview the representative of the Office of the State Long-Term Care Ombudsman who serves residents of the facility, to determine if the facility allows him/her to examine the resident's records with the permission of the resident or resident representative or as otherwise authorized by State law
  - Are there signs regarding care information posted in view in residents' rooms? If these are observed, determine if such signs are there by resident or resident representative direction. If so, these signs are allowable
  - Is personal resident information communicated in a way that protects the confidentiality of the information and the dignity of residents?
  - f concerns are found, interview staff regarding facility policy or procedures regarding protecting resident privacy and confidentiality.

Interpretive Guidelines & Survey Procedures

- **Specialized Rehabilitative Services**

- **Includes but not limited to PT, OT, SLP, RT**
  - Be provided if admitting patients that require the service
  - Can be employed or contracted
  - They are "specialized" in that they are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel.
  - The facility must provide or arrange for the provision of specialized rehabilitative services to all residents that require these services for the appropriate length of time as assessed in their comprehensive plan of care.
  - Restorative services are not considered Specialized Rehabilitative Service Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.
- **Probes – PT, OT, SLP, RT**
  - See Appendix PP page 608-613
    - Requires physician orders based on assessed needs & part of the comprehensive plan
    - How did these services maintain, improve, or restore muscle strength, balance, range of motion, functional mobility or prevent or slow decline or deterioration in the individual's muscle strength? How is it decreasing the amount of assistance needed by the individual to perform a task?
    - Do these services assist an individual in minimizing pain to enhance function and independence?
    - How are these services maintaining, improving or restoring gross and fine motor coordination, including sensory awareness, visual-spatial awareness, and body integration?
    - ETC

Interpretive Guidelines & Survey Procedure

❑ Nutrition & Hydration

- Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids).
- Based on a resident's comprehensive assessment, the facility must ensure that a resident—
  - (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;
  - (2) Is offered sufficient fluid intake to maintain proper hydration and health.
- Make sure a nutrition assessment is done and recommendations followed for the patient to maintain acceptable parameters of nutritional status
  - Information about *how to assess* nutritional status was deleted
- New standard talks about offering sufficient fluids to maintain proper hydration
- Patient's preferences should be incorporated as much as possible
- Ensure that staff is able to prevent and identify physical S&S of dehydration as well as lab results reflected by dehydration
- A member of the Food and Nutrition Services staff must participate on the interdisciplinary team

Interpretive Guidelines & Survey Procedures

❑ Admission, Transfer and Discharge Rights

- In the following limited circumstances, facilities may initiate transfers or discharges:
  1) The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs
  2) The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.
  3) The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.
  4) The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility
  5) The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility
  6) The facility ceases to operate

- Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility.
- Discharges following completion of skilled rehabilitation may not always be a resident initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.
- Surveyors must determine whether a transfer or discharge is resident or facility-initiated.
- The discharge assessment, and treatment plan should support the decision for discharge

Interpretive Guidelines & Survey Procedures

❑ Admission, Transfer and Discharge Rights (cont')

❑ Non-payment as Basis for Discharge

- Occurs when:
  - The resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or
  - After the third party payor denied the claim and the resident refused to pay.
  - It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third party paperwork
  - When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending. Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. Appeal procedures vary by State.
  - A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand
- **Procedure for Transfer/Discharge:**
  - Review nursing notes and any other relevant documentation to see if appropriate orientation and preparation of the resident prior to transfer and discharge has occurred.
  - Through record review and interviews, determine if the resident received sufficient preparation prior to transfer or discharge, and if they understood the information provided to them.
  - Were the resident's needed/requested possessions transferred with the resident to the new location?
  - Ask resident or his or her representative if they understand why the transfer or discharge occurred.

Interpretive Guidelines & Survey Procedures

❑ Discharge Planning

- **Intent**
  - This requirement intends to ensure that the facility has a discharge planning process in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

  - **Guidance**
  - Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan.
  - It involves the interdisciplinary team (as defined in §483.21(b)(2)(ii) working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting.
  - Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge.
  - It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions.
  - A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition.
  - An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.

Interpretive Guidelines & Survey Procedures

❑ Discharge Planning

- **Discharged to another SNF/NF, HHA, IRF, or LTCH**
- If a resident will be discharged to another SNF, an IRF, LTCH, or HHA, the facility must assist the resident in choosing an appropriate post-acute care provider that will meet the resident's needs, goals, and preferences.
- Assisting the resident means the facility must compile available data on other appropriate post-acute care options to present to the resident. Information the facility must gather about potential receiving providers includes, but is not limited to:
  - Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and
  - Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.
  - The listing of potential providers and data compiled must be relevant to the resident's needs, and be aligned with the resident's goals of care and treatment preferences.

- Use Choice Letter format

Interpretive Guidelines & Survey Procedures

❑ Social Services

- §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

- Facilities must identify the need for medically-related social services and ensure that these services are provided.

- It is not required that a qualified social worker necessarily provide all of these services, except as required by State law.

- Examples of medically-related social services include, but are not limited to the following:
  - Advocating for residents and assisting them in the assertion of their rights within the facility in accordance with §483.10, Resident Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Transitions of Care, §483.20, Resident Assessments (PASARR), and §483.21, Comprehensive Person-Centered Care Planning;
  - Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs;
  - Assisting or arranging for a resident's communication of needs through the resident's primary method of communication or in a language that the resident understands;
  - Making arrangements for obtaining items, such as clothing and personal items;

Interpretive Guidelines & Survey Procedures

❑ Social Services (cont')

- Examples of medically-related social services include, but are not limited to the following: (cont')
  - Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
  - Transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);
  - Providing or arranging for needed mental and psychosocial counseling services;
  - Identifying and seeking ways to support residents' individual needs through the assessment and care planning process;
  - Encouraging staff to maintain or enhance each resident's dignity in recognition of each resident's individuality;
  - Assisting residents with advance care planning, including but not limited to completion of advance directives (For additional information pertaining to advance directives, refer to §483.10(g)(12) (F578)), Advance Directives);
  - Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident; and
  - Meeting the needs of residents who are grieving from losses and coping with stressful events

Interpretive Guidelines & Survey Procedures

❑ Social Services (cont')

- Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following:
  - Lack of an effective family or community support system or legal representative;
  - Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations;
  - Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);
  - Difficulty coping with change or loss (e.g., change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one); and
  - Need for emotional support.

Interpretive Guidelines & Survey Procedures

❑ Dental Services

- The facility must assist residents in obtaining routine and 24-hour emergency dental care.
- (a) Skilled nursing facilities.
  - A facility-
  - (2) May charge a Medicare resident an additional amount for routine and emergency dental services;
  - (3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;
  - (4) Must if necessary or if requested, assist the resident—
    - (i) In making appointments; and
    - (ii) By arranging for transportation to and from the dental services location; and
  - (5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

Other

- **CAH to write P&Ps re:**
  - **Freedom from Abuse & Neglect,**
  - **Restraints and**
  - **Advance Directive**
  - **Infection Prevention and Control and Antibiotic Stewardship Programs**
  - **QAPI Processes**

  - Recommend that CAHs review their P&P for acute and review the Appendix PP to determine a P&P that meet both Appendix W and Appendix PP

- **Documentation**

  - Recommend you write a P&P of what constitutes your assessments (see Appendix W, §483.20(b) , frequency, who can use, documentation regarding forms used, purpose, expectation etc…

- **Sample P&Ps to meet CoP in a Swing Bed program**

  - As discussed last week, I will provide you with sample P&Ps once updated for your review and if needed, followed by a zoom mtg for Q&A/Comments

Next webinar (# 5) SB training is Wed. January 6 – 1*:00 PM ET*

Title: Managing SB: From Admission to Discharge