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*Healthy People. Healthy Communities.*

# Certification Bureau Highlights

**Public Protection | Communication | Consistency | Accurate Reporting | Continuous Education**

**current topics >>>**

**Quality, Safety & Oversight Memos**

**19-15-EMTALA** 7/2/2019  
*Frequently Asked Questions on the Emergency Medical Treatment and Labor Act (EMTALA) and Psychiatric Hospitals*

**05-26 (Revised) EMTALA** 6/27/2019  
*Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002*

**19-14-Hospitals, CAHs** 6/4/2019  
*State Operation Manual (SOM) Emergency Medical Treatment and Labor Act (EMTALA) and Death Associated With Restraint or Seclusion Complaint Investigation Timeline Revisions*

**19-13-Hospitals** 5/3/2019  
*Draft Only-Guidance for Hospital Co-Location with other Hospitals or Healthcare Facilities*

## *Rules for Sidewalks & Sprinkler Inspections*

*By: DJ Rankosky, DC*

Now that we have come through a long cold winter and another wet spring and into summer, it is time to start looking at your sidewalks and egress to the public way. Egress to the public way is important to consider for your resident and patient population, many of whom are immobile or unsteady on their feet.

Walking surfaces in the means of egress must be an all-weather, hard-packed surface. So what does this mean? The walking surface can't be changing with rain, snow and fluctuation in temperatures. It must remain level, and slip resistant with whatever weather comes around. It must be able to be cleared of snow, or dirt, or even grass and weeds that tend to sprout and grow out of every nook and cranny they can find.

One of the most common citations regarding egress pathways is changes in elevation. NFPA 101 Life Safety Code 2012 Edition, Section 7.1.6.2, states, "Abrupt changes in elevation of walking surfaces shall not exceed ¼ inch. Changes in elevation exceeding ¼ inch, but not exceeding ½ inch shall be beveled with a slope of 1 in 2. Now this could mean several things. We all know concrete can heave in changing seasons, so be on the lookout for your egress pathways with long runs of concrete. Using salt on concrete over years can also cause it to break, and pit, causing tread differences greater than ¼ or ½ inch. And also, you must keep grass and weeds from taking hold in between sections of your concrete. When this grows over time, it could leave you with obstructions and large bumps in your means of egress. I have seen and cited each of these examples on survey.

Besides concrete, we have also seen examples of packed gravels and different types of road mixes used for means of egress. But honestly, I have yet to see one that was smooth enough to say there wasn't more than ¼ inch of tread differences on the surface. Many times, during our winters in Montana with freezing and

## Sidewalks, continued.....

thawing, these surfaces were not kept clear enough of snow and ice to say it was truly slip resistant. These surfaces are just too rough to shovel all the snow away.

So take some time, walk each of exit egress pathways to the public way, keeping in mind the code. Is this tread difference greater than ¼ inch? Can I keep it clear of snow and ice? Is it rain and water resistant to rutting and pitting? Your survey could come during varying seasons year to year, and what may look fine one year, may be very poor the next.

The next topic I would like to discuss is your quarterly sprinkler inspections. Many of the vendors taking care of your sprinkler systems in Montana seemed to be over-whelmed, too busy, or are having a hard time keeping employees. This can have an impact on your survey, and we are seeing a few recurring problems with sprinkler system inspections.

The code says inspections must be quarterly. As the authority having jurisdiction, the Certification Bureau considers quarterly to be a 90 day cycle. So inspections must be completed on a 90 day cycle, plus a ten day grace period. What we have seen recently, are late inspections, beyond 100 days. Some vendors were considering quarterly to be, for example, January of the first quarter, then not being inspected again until June of the following quarter. This is far beyond a 90 day cycle. It is the facility's responsibility to ensure the vendor get back to the building on that 90 day cycle. Please stay in touch with your vendor and schedule your inspections on time. If you leave it up to your vendor to schedule, they may not make it on time.

There are also some issues with periodic tests not being completed on inspections. Dry systems especially seem to have these periodic tests getting missed on surveys. Along with annual partial trip tests, dry systems are required to have a full trip test every third year. Every ten years, there must be a sample of dry system sprinkler heads taken for testing. Every five years, whether your system is wet or dry, your system gauges must be recalibrated or replaced as well.

I would encourage every facility to go over each and every inspection form with your vendor. Make sure every part of the form is filled out, and information such as when the last five year internal inspection was completed, gauge replacement or calibration was conducted, or if the three year full trip test date is on the form and when it was completed, and/or brought forward into each survey year. This information is necessary and required for each survey.

And lastly, please make sure to be documenting your system pressures at the standpipe, monthly for wet systems, and weekly for dry systems.



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## *Abuse & Neglect Reporting for Nursing Homes and CAHs*

*By: Tammie Berg, RN*

An effective abuse prevention program ensures the residents of the facility are protected against abuse, neglect, misappropriation of property, and exploitation.

Appendix PP of the CMS State Operations Manual define Abuse at §483.5 as *“the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.”*

Neglect is defined at §483.5 as *“the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.”*

## *Abuse & Neglect, continued...*

Examples of neglect include, but are not limited to the following: nurse aides unable to respond to call lights or complete assignments due to insufficient numbers of staff in the facility, resulting in harm due to the inability to implement the care plan and resulting in inadequate supervision; lack of orientation, due to lack of processes in place, for temporary agency staff regarding information to carry out the residents care and needs; and lack of hot water for shower/baths resulting in residents refusing to shower/bathe and the facility's lack of response to maintenance staff who had previously identified equipment failures.

An alleged violation is defined as *“a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.”*

The requirements for CAHs can be located in Appendix W, under the Swing Bed Requirements at §485.645(d)(3). The requirements and guidelines for Nursing Homes can be located under §483.12(c) of Appendix PP. The CAH guidelines refer us to §483.12(c) of Appendix PP of the Nursing Home regulations.

The regulation at §483.12(c)(1) of Appendix PP states the reporting requirements for Nursing Homes and CAHs are; all allegations *“are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.”* In other words, all allegations must be reported within the above time frames to the “administrator or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency and adult protective services.”

*An individual (e.g., a resident, visitor, facility staff) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as “abuse,” “neglect,” “mistreatment,” or “exploitation” in order to trigger the Federal requirements at §483.12(c). Rather, if facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered to be reportable and require action under §483.12(c).* It is the responsibility of the facility to ensure staff are trained and knowledgeable regarding the requirements of reporting.

The regulation at §483.12(c)(2)(3) of Appendix PP also states the allegation(s) must be thoroughly investigated and the results of the investigation reported within 5 days following the date of the allegation. The facility must ensure the protection of the resident during the investigation process. If the allegation is substantiated, the report needs to show any corrective action taken by the facility.

The regulation also states the facility must also develop, train staff on, and implement policies and procedures in the prevention of abuse. Components of an abuse prevention program are, but not limited to screening, training, prevention, identification, investigation, protection and reporting/response.

The facility must ensure QAPI is involved in the abuse prevention program. Involvement of QAPI can assist in ensuring there is a systemic approach to reporting and investigating abuse. QAPI should be involved in the development and implementation of policies and procedures for abuse prevention.

Nursing homes utilize the abuse reporting portal to meet their reporting obligations and CAHs are to send in the paper form for swing bed patients to meet the reporting requirements. The following information should be included with each report:

- The facility information
- The type of incident being reported
- The date and time the facility became aware of the incident
- Details of the allegation (who, what, where, etc.); details of any harm to the resident, including mental anguish; and steps the facility took to ensure the resident(s) are protected
- Details of the alleged victim and perpetrator, and any witnesses,
- Whether law enforcement and/or other agencies were notified.

# Psychiatric Residential Treatment Facilities (PRTF)

By: Kaye Tedesco, RN

PRTFs are surveyed by the State Agency at a minimum of every five years. PRTFs provide inpatient psychiatric treatment of individuals up to age 21 years. If an individual continues to need services past age 21 years, the individual needs to be discharged to an adult psychiatric facility prior to their 22<sup>nd</sup> birthday.

The regulations governing PRTFs are found in appendix N of the CMS State Operations Manual (SOM). Subpart G/COP shows the regulations for use of restraints or seclusion in PRTFs. Some of the highlights include:

A. Restraints can be personal, mechanical, or chemical, and are defined as:

1. Personal Restraint is defined as an “application of physical force without the use of any device, for the purpose of restraining the free movement of a resident’s body.”
2. Mechanical Restraint is defined as “any device attached or adjacent to the resident’s body that they cannot easily removed and restricts freedom of movement or normal access” to their body.
3. Chemical Restraint is defined as any drug that:
  - a. “Is administered to manage a resident’s behavior in a way that reduces the safety risk to the resident or others.”
  - b. The drug “has a temporary effect of restricting the resident’s freedom of movement.
  - c. The drug “is not a standard treatment for the resident’s medical or psychiatric condition.”

B. Seclusion is defined as: an “Involuntary confinement of a resident alone in a room or area, from which the resident is prevented from leaving.”

Facility staff are required to be physically present, and the resident continuously monitored when in restraints or in seclusion. During a survey, Surveyors will determine whether a PRTF has a Standard Level or a Condition Level deficiency. Standard Level means it does not limit the facility’s ability to provide adequate care and does not affect the resident’s health or safety. Condition Level is noncompliance which causes a severe risk to a resident’s health or safety. A PRTF could have noncompliance with a single standard level or several Standard levels within the condition. Guidance for facilities can be found in Appendix N mentioned previously, and through a Frequently Asked Questions document issued by CMS in 2017 (S&C 17-28-PRTF

## ask the bureau >>>

Q: What is iQIES and what can the providers expect during the iQIES transition?

A: QIES, CASPER and ASPEN is set to undergo updates and enhancements, which was set to begin in March 2019. The system will be Cloud-based, and will not change how providers currently submit data to CMS. On February 28, 2019 CMS sent an email to Long-Term Care Hospitals (LTCH) which indicated that within a few weeks, all LTCH users will be required to access the enhanced assessment submission and processing (ASAP), Internet Quality Improvement & Evaluation System (iQIES), to submit patient assessments and view reports. On March 25<sup>th</sup>2019, the system was activated for the LTCH providers. Other providers will be contacted as CMS is prepared to roll out their section.

System Enhancement details include:

- Users will no longer require a virtual private network (VPN) or CMSNet to access this system. iQIES is Internet-facing and maintains the latest system architecture and security standards.

- System enhancements will support a flexible and user-friendly data reports system for providers, allowing for greater ease in using real-time data for care planning and quality monitoring and improvement purposes.

- Users will be able to access important information for work anywhere, at any time, on mobile devices, laptops, and tablets due to built-in adaptability with increased accessibility.

## The Person-Centered Care Plan

By: Tina Smith, NHA, LTC Supervisor

Have you ever assisted with the admission of a parent into a long-term care facility? The flood of emotions and anger a parent may have may be overwhelming to parent and children. A child wants to know the parent is cared for in a manner that meets the individual’s needs, overall.

As we enter an era where a younger population is being admitted to skilled nursing facilities, maintaining independence and control of their life is essential for a resident to feel satisfied in their daily routine. Self-directed care is important for a

# The Person-Centered Care Plan, continued...

facility to embrace. You may ask, what is self-directed care? It is an emerging trend in the world of health care in which individuals plan and receive personal and medical care in a manner they desire. Initially, the philosophy started when individuals wanted to stay in the community. Now the trend has started to trickle into the skilled nursing setting, as the individuals are admitted into the skilled nursing setting. These resident's want to continue to direct their own care as much as possible. We have heard about individualized care for years, but today, the philosophy of individualized care is changing.

Person-centered care, per the State Operations Manual, Appendix PP, shows person-centered care means **“to focus on the resident as the focus of control, and support the resident in making their own choices, and having control over their daily lives.”** Under the regulatory area of §483.10(c)(2)-(3), F553, a person-centered care plan means **“To ensure facility staff facilitates the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident’s goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting.”**

Each facility across our state uses a different strategy to attempt to offer “person-centered” individualized choices, although they vary in quality and scope. Individuals want to direct their own care, regardless of their age, physical disabilities, or mental capacities. A person typically knows what they like or don't like, even when the person has severe cognitive deficits. They may attempt to communicate their needs by acting out, rather than verbalizing a need. Frequently, interpretations of these actions are necessary. Refusing to eat an entire meal may be as simple as the resident does not like the Brussel sprouts on their plate.

According to a study completed in 2015, conducted by the American Association of Retired Persons (AARP), and at that time, 90% of seniors wanted to remain living in their homes as they aged. The U.S. Department of Health and Human Services estimates that 70% of people turning 65 will need long-term care at some point in their lives.<sup>1</sup> With that being said, is Montana ready for the everchanging needs of the population we serve today? Montana’s population growth rate in 2019 was 1.15%. The 2010 census confirmed that 989,415 people were living in Montana, an increase of 9.7% from the findings of 2000. The Montana population surpassed 1 million for the first time in 2012, and it now stands at 1.03 million.<sup>2</sup> With this growth, care facilities are considering how they will capture the needs, preferences, and maintain the quality of the service they provide, as care expectations are growing with the population.

It was found the Certification Bureau surveyors cited Care Plan Development, Timing, Revision, and Baseline Care Plan deficiencies frequently on Health Recertification surveys. Statistics showed: from 7/1/16 to 7/1/17, and combining the citation categories together, there were 57 deficiencies cited. From 7/1/17-7/1/18 there were 51 citations, and from 7/1/18-7/1/19 there were 55 citations. Care plan deficiencies cited fall in the top ten citations cited, yearly. To show you how important The Centers for Medicare and Medicaid Services (CMS) feel care plans are, the State Operations Manual (SOM), Appendix PP, last revised on 11/22/17, shows the care plan is referenced 40 times in the first 40 pages of the SOM. This doesn't include the regulations specifically documenting care plan expectations.

Looking at the regulations, prior to November 2017, the regulations required care be individualized, and based on a care plan, but the new regulations add emphasis. The new regulations define person-centered care and require facilities learn more about who the resident is as a person, provide greater support for resident preferences, and give residents increased control and choice. Under the new regulations, facilities must develop and implement a baseline care plan for a new resident within 48 hours of admission. The care planning process itself calls for greater resident involvement and participation. In addition, the certified nursing aide responsible for the resident, and a member of the food and nutrition services staff, must participate in the care planning process.<sup>3</sup> Staffing also plays a large role in the success of the care plan process, as staff must know what the care plan includes, and how to interpret and use the plan successfully.

Everyone asks, what should a care plan include? Well, that is up to the resident or responsible party, and the facility. The care plan process should start with a resident's history, so staff know who the person is by their life experiences, work, education and interests, hobbies etc. It may include resident desires in terms of daily routines, meal times, safety deficits, foods they like or don't like, and their diet expectations. It would include specific care needs, identified by the resident and facility, which staff are to provide, and how often. Plans may include equipment utilized, communication, ADL abilities/disabilities, goals, activity preferences, etc.

# The Person-Centered Care Plan, continued...

As you can see, the list can be extensive. The surveyors encounter care plans which are not person centered, but generic, preprinted or generated from a program, which do not reflect who the resident really is, as a person, and the care plan may not meet the minimum standards. There are many resources available for the development of person-centered care plans, and as we see and experience facilities embracing change across the state, in their attempt to provide new care expectations, we are encouraged that our ability, as a State, will rise-up to meet the changing demands of our industry.

To obtain regulatory information on the care plan requirements, you may refer to the CMS State Operations Manual, Appendix PP, revised 11/22/17, and refer to the following three primary regulatory areas, which are: F655 – Baseline Care Plan, F656 – Development/Implement Comprehensive Care Plan, F657 – Care Plan Timing and Revision. Although these three areas define the basic requirements of the care plan, a resident’s care plan is addressed extensively throughout the Appendix P, and in numerous regulatory areas.

<sup>1</sup> “Self-Directed Long-Term Care,” <https://www.gtindependence.com/wp-content/uploads/2015/02/gt-independence-logo-stroke-2x.png>; 2015.

<sup>2</sup> “Montana Population 2019,” <http://worldpopulationreview.com/states/montana-population/>, US Census, 2019.

<sup>3</sup> “CMS Releases New Nursing Facility Regulations: Both Pluses and Minuses for Nursing Facility Residents,” <https://www.medicareadvocacy.org/cms-releases-new-nursing-facility-regulations-both-pluses-and-minuses-for-nursing-facility-residents/>, Undated.

## Bureau Chief Buzz

*By: Todd Boucher, Bureau Chief*

The Centers for Medicare and Medicaid Services (CMS) started to require more enforcement for certain severity and scope in September 2016. The changes included more fines with certain deficiencies and at different severity and scope. These fines known as Civil Money Penalties (CMP), are collected for deficiencies written against long term care facilities. A portion of the money is provided to each state to allow for CMP Reinvestment into the long-term care facilities in each state. The State of Montana has a program headed up by the DPHHS Senior and Long-Term Care Division. Shaunda Hildebrand, Bureau Chief, coordinates the state review of submittals and then sends them on to CMS for final approval.

CMS has approved the following Montana programs in 2018:

- Montana Department of Labor & Industry - Providing Related Training Instruction for Healthcare - \$19,750
- Montana Hospital Association – Enhanced Elder Care through Innovative Education – \$198,815
- Wibaux County Nursing Home – Memory Care - \$5, 274

To apply for CMP funds, please see the application at <https://dphhs.mt.gov/sltc/csb/provider#287023784-nursing-facilities-and-swing-bed-services> . CMS also provides some tools and examples of programs they have approved in the past as

## Care Plan

D E T A D P U J M Y N E E D S  
T I R P S E C N E R E F E R P  
R N V S O R H L D U V Z A J K  
E T O Y B S N O I T I R T U N  
A E S C J O A F C L S H R Y R  
T R T H E N L N A S N I A T E  
M V I O C A P U T E E S N I V  
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E N I L E S A B X H O Z X I K  
I S S E I T I V I T C A R E G  
L A T N E M Z Y L E M I T U L

BASELINE  
DEFICITS  
INTERVENTIONS  
MOBILITY  
NUTRITION  
PLAN  
REVISED  
TRANSFERS

CARE  
HISTORY  
MEDICATIONS  
NEEDS  
OBJECTIVES  
PREFERENCES  
THERAPIES  
TREATMENTS

## *Bureau Chief Buzz, continued...*

well at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment.html>.

Some specific CMS approved examples include:

- Connecticut - Training for long term care facilities in Emergency Preparedness – Training - \$204,780
- Pennsylvania – Reduction in the Use of Restraints - Direct Improvements to Quality of Life - \$977,900
- South Dakota – Project to Improve Person Centered Care within LTC Facilities – Person Centered Care - \$8,586
- Hawaii - In an effort to broaden the understanding and use of the POLST form in Hawaii, this project will translate the POLST form into a variety of local languages – Consumer Information - \$4,995

## *final thoughts...*

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