CMS Final Rule PHASE 3

The surveyors perspective

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Behavioral Health and Dementia Care

New requirements for staff training and development

New regulation: §483.95(i) /F-Tag 949
Entirely new tag
Requirements

"A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).
[§483.95(i) will be implemented beginning November 28, 2019 (Phase 3)]"

***Appendix PP of State Operations Manual November 2017**

NEW YORK STATE | Department of Health

Behavioral Health Services

§483.40

Includes Treatment and Services for Dementia
Staff should be trained and proficient in providing services for residents with behavioral issues in the following care areas:

- *Activities*
- *Care Planning*
- *Dining*
- *Antipsychotic Drug Use.*
- *Sufficient and competent staff*

NEW YORK STATE | Department of Health

Behavioral Health Services

§483.40(a)

Sufficient and competent staff

F-741
This tag is specific to behavioral health services.

"The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and
[as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]"

Surveyors will review Lesson Plans, training records, individual employee training files.
They will conduct staff interviews regarding training.

***Appendix PP of State Operations Manual-November 2017**

NEW YORK STATE | Department of Health

Behavioral Health Services

§483.40

- *Activities*

Activities should be meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being. Activities should be resident centered and the person developing the activities should have training and background in behavioral health and dementia care.

Surveyors will make observations, review activity calendar, progress notes.
They will conduct interviews of all staff including CNAs, and activity staff.

Behavioral Health Services

Care Planning

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans

****F-659 §483.21(b)(3) (iii) Be culturally-competent and trauma–informed***
Will be implemented in Phase 3 November 2019

****GUIDANCE §483.21(b)(3)(ii)***
The facility must ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required.

**Appendix PP State Operations Manual-November 2019*

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Behavioral Health Services

Care Planning

Surveyors will interview staff about qualifications:

- *Training*
- *Certifications*
- *Resident Centered Care Planning and implementation*
- *Review and revisions of care plans based on resident behavior and interventions*

Surveyors will review:

- *Employee training records*
- *Behavioral notes*
- *Dementia Care protocols*
- *Medication Administration Records*
- *MDS Assessments, Comprehensive Care Plans*

Surveyors will observe:

- *Staff to resident interaction*
- *Activity programs*
- *Resident to resident interaction*
- *Dining*
- *Provision of Care*

Behavioral Health Services

F699
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)
§483.25(m) Trauma-informed care
The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
[§483.25(m) will be implemented beginning November 28, 2019 (Phase 3)]

Surveyors will conduct investigations similar to Behavioral Health Protocols and Dementia Care protocols However, assessment and care planning should be specific to this care area.

Abuse

F-Tag 607

§483.12(b)(4) Establish coordination with the QAPI program required under §483.75. [§483.12(b)(4) will be implemented beginning November 28, 2019 (Phase 3)]

All policies and procedures must be developed in coordination with the QAPI program. The QA/QAPI team must provide monitoring and oversight of the Abuse Prevention program. Including monitoring of training, investigating and timely reporting of incidents to NYSDOH and when appropriate local law enforcement agency.

During recertification survey, the team will interview residents about abuse. The team will review facility complaint history. Active cases may be incorporated into recertification survey. Abbreviated surveys conducted separately will follow the same investigative protocols as recertification surveys.

Accident and Incident reports should be complete, signed by person conducting investigation, date incident was reported to Administrator, NYSDOH, and law enforcement if necessary.
There should be evidence of attempts to corroborate or validate written statements from staff, and others.
The conclusion and determination of the investigation should be clearly stated and documented in the record.

New requirements for Infection Control Preventionist

Training and Certification

§483.80(b) Infection preventionist
[§483.80(b) and all subparts will be implemented beginning November 28, 2019 (Phase 3)]
The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:

- ***§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;***
- ***§483.80(b)(2) Be qualified by education, training, experience or certification;***
- ***§483.80(b)(3) Work at least part-time at the facility; and (this is under Final Review)***
- ***§483.80(b)(4) Have completed specialized training in infection prevention and control.***

- ***§483.80 (c) IP participation on quality assessment and assurance committee.***
  - *The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.*
  - *[§483.80(c) will be implemented beginning November 28, 2019 (Phase 3)]*

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Quality Assurance and QAPI

Now a team sport

F-Tag 837 Provider/Operators and Board's roles and responsibilities

§483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). [§483.70(d)(3) Governing body responsibility of QAPI program will be implemented beginning November 28, 2019 (Phase 3).]

**The facility must determine:*

- *A process and frequency by which the administrator reports to the governing body, the method of communication between the administrator and the governing body including, how the governing body responds back to the administrator and what specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported directly to the governing body;*
- *How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing, supplies, etc.).; and*
- *How the administrator and the governing body are involved with the facility wide assessment in §483.70(e) Facility assessment at F838.*

During the recertification survey the team leader will ask for the names of the governing body at the entrance conference. If significant issues arise during the survey interviews of members of the GOB may be requested.

***Appendix PP State Operations Manual-November 2017**

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Quality Assurance and QAPI

F-866 Data Collection and Monitoring

§483.75(c) Program feedback, data systems and monitoring.
(§483.75(c) will be implemented during Phase 3)
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

***Appendix PP State Operations Manual-November 2017**

Quality Assurance and QAPI

F-866 Data Collection and Monitoring
How will Surveyors determine Compliance?

During the recertification or abbreviated survey the survey team may identify and validate systemic problems in the facility. This includes concerns identified from offsite preparation that represent repeat deficient practice, and concerns or issues identified throughout the survey that will potentially be cited at a S/S of E or above. Once the surveyors have identified these problems they will conduct the QA/QAPI investigative task. The survey team will ask for documented evidence that the QA/QAPI team has:
Identified High Risk problems, Adverse Events,

*****Reports and Logs***
Incident and accident reports, wound logs, or other reports or records used to track adverse events are not protected from disclosure. Surveyors may request these documents as part of their normal investigation of other areas of concern throughout the survey to support their findings.

Quality Assurance and QAPI

F-866 Data Collection and Monitoring
How will Surveyors determine Compliance?

**Surveyors assessing QAA compliance must ask nursing homes to provide evidence of QAA compliance.*

- *Surveyors must **never** ask or demand that a nursing home show them "patient safety work product." If a nursing home states that all relevant QAA material has been placed in its PSES, or is protected PSWP, surveyors must ask to see the agreement the nursing home has with an AHRQ-approved PSO, to confirm that it has an approved protected PSES.*
- *If a nursing home has placed all evidence related to QAA compliance in its PSES as patient safety work product and does not also maintain a separate non-confidential system to provide evidence of compliance, or is unable to remove evidence of such compliance from its PSES, it may not be able to demonstrate its compliance to the surveyor.*

The surveyor will assess how the facility identifies issues that are high risk, care that is high volume, and adverse events. They will also look at what corrective action plans they have in place. Review of data driven documentation is required.

***Appendix PP State Operations Manual Guidance to Surveyors-November 2017.**

Quality Assurance and QAPI

F-867, F868
Quality Assurance and Improvement
How will Surveyors determine Compliance?

§483.75(d) Program systematic analysis and systemic action.
(§483.75(d) will be implemented during Phase 3)
§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

Surveyors will review documents relating to performance monitoring such as audit results, tools. Members of QA/QAPI team should be able to answer questions about the facility's performance improvement activities, how they measure success, how they track performance through audits, training. How successful is the plan, what needed revision? Dates should be documented on all reports.

Quality Assurance and QAPI

F-867, F868
Quality Assurance and Improvement
How will Surveyors determine Compliance?

Staff should be able to identify high-volume, high risk and problem-prone issues. Any Adverse Events? Any near misses? How are/were they identified? What was the corrective action? Did it work?
Surveyors will use CMS- 672 Resident Census and Condition forms to identify high volume and potentially high risk issues. Staffing and training records will be reviewed. Evidence that these items are also reviewed and used during QA/QAPI activities. How is QA/QAPI projects shared with staff?

Compliance and Ethics Program

[§483.85 and all subparts will be implemented beginning November 28, 2019

The regulation is very comprehensive and detailed.

F-895
The intent is for high level personnel staff to create a program that is designed to detect and prevent criminal civil and administrative violations and promote quality of care.

High level personnel means individuals who have control over facility operations, decision and policy making. This task cannot be delegated to individuals who do not participate in policy and procedure development. Have no real decision making capability regarding the operation and function of the facility.

The program must have written policy and procedures in accordance with the regulation.

Surveyors may ask for evidence of the Compliance Ethics Program at entrance conference at any time during the survey as deemed necessary.

QUESTIONS AND DISCUSSION