PROACTIVE LTC CONSULTING

Long Term Care Surveys: Looking Back and Looking Forward

KAHCF Quality Summit

Presented By: Shelly Maffia RN, MSN, MBA, LNHA, QCP, CHC, CLNC, CPC
Director of Regulatory Services

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QAPI PROGRAMS IN THE LTC SETTING

Ready to take your QAPI program to the next level?

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Shelly Maffia

MSN, MBA, RN, LNHA, QCP, CHC, CLNC, CPC

Shelly Maffia is a Registered Nurse and licensed Nursing Home Administrator with extensive experience in the long-term care setting. She holds AANAC's QAPI Certified Professional (QCP) credential, is certified in healthcare compliance through the Healthcare Compliance Association (HCCA), is an AAPC Certified Professional Coder (CPC), and is a Certified Legal Nurse Consultant. She is a member of the American Association of Legal Nurse Consultants (AALNC), the National Alliance of Certified Legal Nurse Consultants, the American Association of Professional Coders (AAPC), the American Association of Post-Acute Care Nursing (AAPACN), the American Health Information Management Association (AHIMA) and the Healthcare Compliance Association (HCCA).

Shelly specializes SNF regulatory compliance and nursing home quality improvement. She provides frequent consultation and training to nursing facilities across the nation on regulatory compliance, reimbursement compliance, and quality improvement. She has presented extensively on survey preparedness, QAPI, Achieving 5-Star QMs, Infection Prevention and Control, PDPM, and ICD-10-CM coding.

She serves as the Director of Regulatory Services with Proactive Medical Review & Consulting, LLC.

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Objectives

1. Become familiar with the top survey citations and trends.
2. Recognize the top ten cited deficiencies in Kentucky.
3. Identify best practice recommendations to prevent the top cited deficiencies.

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Survey Trends

- Deficiency Counts
- Top Citations
- IJ Deficiencies
- Overdue Surveys

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Deficiency Counts

FY2022

Deficiency Count Report

Region	Deficiencies by Scope & Severity											
	B	C	D	E	F	G	H	I	J	K	L	Total
(I) Boston	189	77	3,776	1,188	924	293	34	3	62	19	13	6,579
(II) New York	76	48	2,283	596	979	74	2	0	30	45	33	4,166
(III) Philadelphia	130	298	7,478	3,070	1,358	314	9	2	71	33	3	12,766
(IV) Atlanta	233	110	7,085	2,256	2,533	352	47	0	589	222	97	13,524
Alabama	1	0	203	65	138	4	0	0	8	2	17	438
Florida	28	13	2,252	581	729	45	1	0	154	15	11	3,829
Georgia	4	13	935	271	535	57	0	0	62	33	24	1,934
Kentucky	0	3	237	62	183	27	1	0	77	20	9	619
Mississippi	0	3	301	60	102	16	4	0	32	1	0	519
North Carolina	197	74	1,868	944	394	134	37	0	120	87	8	3,863
South Carolina	0	1	440	102	193	33	0	0	27	9	3	808
Tennessee	3	3	849	191	259	36	4	0	109	55	25	1,534
(V) Chicago	175	584	19,324	5,195	5,483	1,849	48	15	523	130	143	33,469
(VI) Dallas	124	150	6,971	5,892	2,549	286	44	0	332	195	25	16,578
(VII) Kansas City	72	192	5,999	1,874	2,480	401	13	0	200	71	21	12,313
(VIII) Denver	11	22	1,816	1,060	935	335	43	6	33	24	25	4,310
(IX) San Francisco	227	41	8,985	3,441	2,364	334	26	0	62	52	45	15,557
(X) Seattle	14	31	2,353	1,063	661	219	16	3	27	25	13	4,425
National Total	1,251	1,553	66,060	26,635	20,266	4,467	282	29	1,909	816	418	123,686

FY2023

Deficiency Count Report

Region	Deficiencies by Scope & Severity											
	B	C	D	E	F	G	H	I	J	K	L	Total
(I) Boston	54	25	1,198	385	393	114	8	0	23	7	4	2,211
(II) New York	20	14	662	227	542	22	1	0	15	2	10	1,535
(III) Philadelphia	32	45	2,201	891	827	75	0	0	12	7	0	4,090
(IV) Atlanta	66	41	1,990	552	1,238	94	13	0	190	55	6	4,245
Alabama	1	3	94	13	98	0	0	0	10	2	2	223
Florida	4	12	757	229	390	19	1	0	55	15	0	1,491
Georgia	1	4	376	92	164	11	0	0	4	10	0	662
Kentucky	0	0	4	1	95	0	0	0	7	0	0	107
Mississippi	0	6	109	30	66	8	0	0	14	0	0	233
North Carolina	59	14	426	153	167	30	9	0	57	15	0	949
South Carolina	1	1	86	12	96	10	0	0	12	3	0	221
Tennessee	0	1	138	22	133	16	4	0	31	10	4	359
(V) Chicago	43	256	6,936	1,704	2,421	703	10	0	152	29	25	12,279
(VI) Dallas	22	24	2,230	1,043	1,233	90	6	0	129	68	19	5,670
(VII) Kansas City	27	74	1,833	718	1,340	97	0	0	73	16	3	4,181
(VIII) Denver	3	12	564	332	435	100	11	2	6	11	5	1,481
(IX) San Francisco	76	10	3,323	1,154	1,019	83	1	0	26	10	6	5,720
(X) Seattle	6	11	861	274	305	54	1	0	14	8	2	1,636
National Total	347	512	21,818	8,180	9,753	1,440	51	2	640	213	82	43,038

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Average # of Deficiencies

FY2022

Average Number of Deficiencies Report

Region	Average # Deficiencies per Survey by Scope & Severity												
	B	C	D	E	F	G	H	I	J	K	L	Total	# of Surveys
(I) Boston	0.3	0.1	5.1	1.7	0.5	0.2	0.1	0.01	0.02	0.01	0.02	8.1	520
(II) New York	0.2	0.1	3.3	1.0	0.7	0.09	0.0	0.0	0.02	0.1	0.04	5.1	434
(III) Philadelphia	0.1	0.2	5.2	2.1	0.3	0.1	0.0	0.0	0.02	0.01	0.0	8.1	1,033
(IV) Atlanta	0.1	0.05	3.1	1.0	0.4	0.1	0.01	0.0	0.1	0.1	0.03	4.9	1,308
Alabama	0.01	0.0	1.4	0.4	0.5	0.0	0.0	0.0	0.0	0.0	0.1	2.3	78
Florida	0.04	0.02	3.6	0.9	0.3	0.04	0.0	0.0	0.1	0.01	0.01	5.0	453
Georgia	0.01	0.03	2.5	0.7	0.4	0.1	0.0	0.0	0.1	0.03	0.02	3.9	231
Kentucky	0.0	0.02	2.2	0.8	0.6	0.2	0.0	0.0	0.4	0.1	0.1	4.4	51
Mississippi	0.0	0.04	2.7	0.4	0.3	0.04	0.02	0.0	0.1	0.0	0.0	3.6	83
North Carolina	0.4	0.2	3.5	1.7	0.4	0.2	0.04	0.0	0.1	0.1	0.0	6.7	331
South Carolina	0.0	0.01	2.3	0.5	0.4	0.1	0.0	0.0	0.01	0.1	0.02	3.5	139
Tennessee	0.02	0.01	3.8	0.9	0.5	0.1	0.01	0.0	0.3	0.2	0.1	5.9	158
(V) Chicago	0.1	0.2	4.6	1.3	0.9	0.2	0.01	0.0	0.03	0.01	0.02	7.3	2,274
(VI) Dallas	0.1	0.1	2.3	2.2	0.4	0.04	0.01	0.0	0.04	0.02	0.0	5.2	1,641
(VII) Kansas City	0.1	0.2	4.3	2.3	0.8	0.2	0.01	0.0	0.04	0.03	0.01	7.6	834
(VIII) Denver	0.03	0.04	3.3	1.8	0.6	0.5	0.1	0.01	0.04	0.03	0.03	6.4	438
(IX) San Francisco	0.3	0.04	6.6	3.2	0.7	0.1	0.02	0.0	0.01	0.02	0.02	10.9	709
(X) Seattle	0.1	0.1	7.0	3.3	0.8	0.3	0.02	0.0	0.1	0.1	0.03	11.8	208
National Total	0.1	0.1	4.1	1.8	0.6	0.2	0.01	0.0	0.04	0.03	0.02	7.0	9,555

FY2023

Average Number of Deficiencies Report

Region	Average # Deficiencies per Survey by Scope & Severity												
	B	C	D	E	F	G	H	I	J	K	L	Total	# of Surveys
(I) Boston	0.3	0.1	5.7	1.9	0.5	0.3	0.03	0.0	0.02	0.01	0.01	8.9	168
(II) New York	0.2	0.1	3.8	1.5	0.4	0.1	0.0	0.0	0.03	0.01	0.1	6.2	137
(III) Philadelphia	0.1	0.1	5.4	2.2	0.3	0.1	0.0	0.0	0.01	0.01	0.0	8.2	315
(IV) Atlanta	0.1	0.1	3.3	0.9	0.4	0.1	0.02	0.0	0.1	0.1	0.0	5.0	423
Alabama	0.1	0.2	4.3	0.5	1.5	0.0	0.0	0.0	0.0	0.0	0.0	6.5	11
Florida	0.02	0.1	3.9	1.1	0.3	0.03	0.01	0.0	0.1	0.1	0.0	5.5	193
Georgia	0.01	0.04	2.6	0.6	0.5	0.1	0.0	0.0	0.0	0.1	0.0	3.9	94
Kentucky	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	3
Mississippi	0.0	0.2	2.0	0.4	0.2	0.1	0.0	0.0	0.05	0.0	0.0	2.8	44
North Carolina	0.5	0.2	3.6	1.4	0.4	0.2	0.1	0.0	0.2	0.1	0.0	6.7	78
South Carolina	0.05	0.05	2.5	0.4	0.3	0.1	0.0	0.0	0.1	0.0	0.0	3.6	22
Tennessee	0.0	0.1	4.1	0.8	0.4	0.2	0.0	0.0	0.3	0.3	0.0	6.1	18
(V) Chicago	0.04	0.2	4.6	1.2	0.8	0.3	0.0	0.0	0.04	0.0	0.0	7.0	925
(VI) Dallas	0.04	0.03	2.6	2.4	0.3	0.03	0.0	0.0	0.1	0.04	0.01	5.5	546
(VII) Kansas City	0.1	0.2	4.1	1.9	0.8	0.1	0.0	0.0	0.1	0.01	0.0	7.3	295
(VIII) Denver	0.03	0.1	3.5	1.6	0.4	0.4	0.04	0.01	0.02	0.04	0.02	6.1	145
(IX) San Francisco	0.3	0.03	6.8	3.0	0.5	0.1	0.0	0.0	0.02	0.02	0.01	10.8	259
(X) Seattle	0.05	0.1	6.2	2.7	0.8	0.1	0.01	0.0	0.04	0.03	0.02	10.1	103
National Total	0.1	0.1	4.3	1.7	0.5	0.3	0.01	0.0	0.04	0.03	0.01	7.1	3,316

Source: QCOR CASPER (03/26/2023)

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Overdue Annual Surveys

% of Facilities with Late Surveys Nationally

- 15 months = 31.4%
- 18 months = 22.4%
- 24 months = 11.7%
- 36 months = 9.8%
- 48 months = 0.6% (88 facilities)

States with over 25% of facilities who have not surveyed in over 3 years

- Idaho (70%)
- Maryland (67.1%)
- Kentucky (65.0%)
- Alabama (36.4%)
- Tennessee (33.1%)
- California (26.9%)
- Colorado (26.1%)
- Oregon (25.6%)
- Mississippi (25.1%)

Source: QCOR CASPER (04/09/2023)

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Overdue Annual Surveys

% of Facilities with Late Surveys Kentucky

- 15 months = 87% (241 facilities)
- 18 months = 81.6% (226 facilities)
- 24 months = 71.1% (197 facilities)
- 36 months = 65% (180 facilities)

Source: QCOR CASPER (04/09/2023)

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National Top 10 Citations – FY2023 Recertification Surveys

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15123		Total Number of Surveys=3120
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,208	8.0%	38.7%
F0880	Infection Prevention & Control	1,030	6.8%	33.0%
F0689	Free of Accident Hazards/Supervision/Devices	814	5.4%	26.1%
F0656	Develop/Implement Comprehensive Care Plan	794	5.3%	25.4%
F0761	Label/Store Drugs and Biologicals	762	5.0%	24.4%
F0684	Quality of Care	721	4.8%	23.1%
F0695	Respiratory/Tracheostomy Care and Suctioning	605	4.0%	19.4%
F0677	ADL Care Provided for Dependent Residents	594	3.9%	19.0%
F0657	Care Plan Timing and Revision	514	3.4%	16.5%
F0758	Free from Unnec Psychotropic Meds/PRN Use	512	3.4%	16.4%

Source: QCOR CASPER (03/19/2023)

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Kentucky Citations – FY2023 Recertification Surveys

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=279		Total Number of Surveys=4
F0880	Infection Prevention & Control	2	0.7%	50.0%
F0888	COVID-19 Vaccination of Facility Staff	1	0.4%	25.0%
F0600	Free from Abuse and Neglect	1	0.4%	25.0%
F0761	Label/Store Drugs and Biologicals	1	0.4%	25.0%
F0606	Not Employ/Engage Staff w/ Adverse Actions	1	0.4%	25.0%
F0554	Resident Self-Admin Meds-Clinically Approp	1	0.4%	25.0%
F0695	Respiratory/Tracheostomy Care and Suctioning	1	0.4%	25.0%

Source: QCOR CASPER (04/09/2023)

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Kentucky Top 10 Citations – FY2022 Recertification Surveys

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=281		Total Number of Surveys=51
F0880	Infection Prevention & Control	25	8.5%	49.0%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	20	7.1%	39.2%
F0656	Develop/Implement Comprehensive Care Plan	18	6.0%	35.3%
F0761	Label/Store Drugs and Biologicals	14	5.0%	27.5%
F0835	Administration	8	2.5%	15.7%
F0657	Care Plan Timing and Revision	8	2.8%	15.7%
F0689	Free of Accident Hazards/Supervision/Devices	8	2.8%	15.7%
F0600	Free from Abuse and Neglect	6	2.1%	11.8%
F0867	QAPI/QAA Improvement Activities	6	1.8%	11.8%
F0684	Quality of Care	5	1.8%	9.8%

Source: QCOR CASPER (03/26/2023)

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National Top 10 Citations – 2023 Complaint Surveys

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15123		Total Number of Surveys=22624
F0689	Free of Accident Hazards/Supervision/Devices	1,109	6.7%	4.9%
F0684	Quality of Care	740	4.5%	3.3%
F0609	Reporting of Alleged Violations	596	3.7%	2.6%
F0600	Free from Abuse and Neglect	563	3.3%	2.5%
F0880	Infection Prevention & Control	541	3.4%	2.4%
F0677	ADL Care Provided for Dependent Residents	482	3.0%	2.1%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	416	2.6%	1.8%
F0656	Develop/Implement Comprehensive Care Plan	361	2.3%	1.6%
F0610	Investigate/Prevent/Correct Alleged Violation	360	2.3%	1.6%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	355	2.3%	1.6%

Source: QCOR CASPER (03/19/2023)

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Kentucky Citations – 2023 Complaint Surveys

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=279		Total Number of Surveys=22
F0600	Free from Abuse and Neglect	2	0.7%	9.1%
F0609	Reporting of Alleged Violations	2	0.7%	9.1%
F0835	Administration	1	0.4%	4.5%
F0656	Develop/Implement Comprehensive Care Plan	1	0.4%	4.5%
F0602	Free from Misappropriation/Exploitation	1	0.4%	4.5%
F0689	Free of Accident Hazards/Supervision/Devices	1	0.4%	4.5%
F0692	Nutrition/Hydration Status Maintenance	1	0.4%	4.5%
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records	1	0.4%	4.5%
F0684	Quality of Care	1	0.4%	4.5%

Source: QCOR CASPER (04/09/2023)

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Kentucky Citations – 2022 Complaint Surveys

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=281		Total Number of Surveys=186
F0656	Develop/Implement Comprehensive Care Plan	26	8.2%	14.0%
F0689	Free of Accident Hazards/Supervision/Devices	26	8.2%	14.0%
F0600	Free from Abuse and Neglect	23	6.4%	12.4%
F0657	Care Plan Timing and Revision	16	5.7%	8.6%
F0609	Reporting of Alleged Violations	13	4.3%	7.0%
F0610	Investigate/Prevent/Correct Alleged Violation	11	3.9%	5.9%
F0835	Administration	9	2.8%	4.8%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	7	2.5%	3.8%
F0880	Infection Prevention & Control	5	1.8%	2.7%
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records	5	1.8%	2.7%

Source: QCOR CASPER (04/09/2023)

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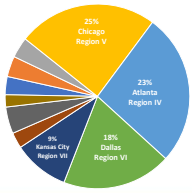
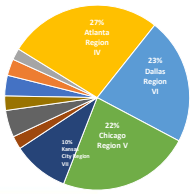
IJ Deficiencies

FY2022 % of Total IJ Citations



FY2023 % of Total IJ Citations



Source: QCOR CASPER (03/19/2023)

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National Top 10 IJ Citations

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15123		Total Number of Surveys=617
F0689	Free of Accident Hazards/Supervision/Devices	227	1.3%	36.8%
F0600	Free from Abuse and Neglect	133	0.7%	21.6%
F0880	Infection Prevention & Control	64	0.3%	10.4%
F0684	Quality of Care	64	0.3%	10.4%
F0835	Administration	50	0.3%	8.1%
F0760	Residents are Free of Significant Med Errors	36	0.2%	5.8%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	34	0.2%	5.5%
F0610	Investigate/Prevent/Correct Alleged Violation	32	0.2%	5.2%
F0678	Cardio-Pulmonary Resuscitation (CPR)	29	0.2%	4.7%
F0609	Reporting of Alleged Violations	24	0.1%	3.9%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	24	0.1%	3.9%

Source: QCOR CASPER (03/19/2023)

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Kentucky FY2023 IJ Citations

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=279		Total Number of Surveys=3
F0835	Administration	1	0.4%	33.3%
F0656	Develop/Implement Comprehensive Care Plan	1	0.4%	33.3%
F0600	Free from Abuse and Neglect	1	0.4%	33.3%
F0689	Free of Accident Hazards/Supervision/Devices	1	0.4%	33.3%
F0692	Nutrition/Hydration Status Maintenance	1	0.4%	33.3%
F0684	Quality of Care	1	0.4%	33.3%
F0609	Reporting of Alleged Violations	1	0.4%	33.3%

Source: QCOR CASPER (03/19/2023)

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Kentucky FY2022 IJ Citations

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kentucky Active Providers=291		Total Number of Surveys=25
F0656	Develop/Implement Comprehensive Care Plan	14	3.9%	56.0%
F0623	Administration	12	3.2%	48.0%
F0657	Care Plan Timing and Revision	11	2.8%	44.0%
F0600	Free From Abuse and Neglect	10	2.5%	40.0%
F0689	Free of Accident Hazards/Supervision/Devices	10	3.2%	40.0%
F0837	Governing Body	6	1.4%	24.0%
F0867	QAPI/QAA Improvement Activities	6	1.4%	24.0%
F0610	Investigate/Prevent/Correct Alleged Violation	5	1.4%	20.0%
F0607	Develop/Implement Abuse/Neglect Policies	3	0.7%	12.0%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	3	0.7%	12.0%
F0609	Reporting of Alleged Violations	3	1.1%	12.0%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	3	0.7%	12.0%
F0880	Infection Prevention & Control	2	0.7%	8.0%
F0740	Provision of Medically Related Social Service	2	0.7%	8.0%
F0684	Quality of Care	2	0.4%	8.0%
F0842	Resident Records - Identifiable Information	2	0.4%	8.0%
F0697	Respiratory/Tracheostomy Care and Suctioning	2	0.7%	8.0%
F0580	Androids	1	0.4%	4.0%
F0550	Chooses/Be Notified of Room/Roommate Change	1	0.4%	4.0%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1	0.4%	4.0%
F0602	Free From Misappropriation/Exploitation	1	0.4%	4.0%
F0692	Nutrition/Hydration Status Maintenance	1	0.4%	4.0%
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records	1	0.4%	4.0%
F0865	QAPI Prgm/Plan, Disclosure/Good Faith Attempt	1	0.4%	4.0%
F0557	Respect, Dignity/Right to have Prsnl Property	1	0.4%	4.0%
F0841	Responsibilities of Medical Director	1	0.4%	4.0%
F0740	Treatment/Svcs: Mental/Psychosocial Concerns	1	0.4%	4.0%

Source: QCOR CASPER (04/09/2023)

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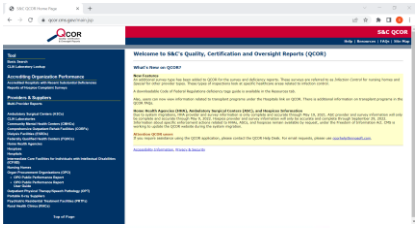
CMS QCOR Website



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Citation Examples & Best Practice Recommendations

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F884 Reporting - NHSN

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F 884 Reporting - NHSN

(g) COVID-19 Reporting. The facility must—

(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to--

(i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19;

(ii) Total deaths and COVID-19 deaths among residents and staff;

(iii) Personal protective equipment and hand hygiene supplies in the facility;

(iv) Ventilator capacity and supplies in the facility;

(v) Resident beds and census;

(vi) Access to COVID-19 testing while the resident is in the facility;

(vii) Staffing shortages; and

(viii) Other information specified by the Secretary.

(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public.

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Deficiency Example – Scope/Severity of F

- Facility failed to report complete information about COVID-19 to CDC's NHSN during a seven-day period that reporting was required by regulation.
- The CMS determined that between 10/10/22 and 10/16/22, the facility did not report complete the information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC.

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F884 – Facility Best Practice

- Establish routine reporting days, signed off on a calendar.
- More than 1 staff person trained as "backup" on the NHSN reporting process
- Print/screen shot and save reports before and after submission
- Review process to monitor compliance

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F880 Infection Control

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26

KY Deficiency Examples

- Review of the facility's Infection Control Audits revealed numerous instances of non-compliance among staff members. There were no corrective action tasks identified during the review.
  - Review of the facility's Infection Control Audits/Hand Hygiene Quality Assurance Audits revealed multiple instances of non-compliance by staff members. However, there was no documented evidence of corrective actions taken and no evidence the facility's Administration, who were responsible for reviewing the audits, changed the plan of correction or increased frequency of the audits.

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KY Deficiency Example – Scope/Severity of F

- Observations revealed Dietary Aide failed to perform hand hygiene multiple times during meal service.
- Observations at 3 different times during medication administration revealed LPN failed to perform hand hygiene; failed to discard pills that had been dropped on the medication cart; failed to don gloves when administering eye drops; and failed to disinfect a stethoscope and blood pressure (BP) cuff after use on a resident.
- Observation revealed Receptionist failed to doff gloves after she handled contaminated COVID-19 rapid test cards. Further, the receptionist placed the cards on a tissue barrier; however, she did not clean and sanitize the surface of the desk before placing items on the desk.
- Observation revealed RN placed a contaminated blood glucose monitor into a basket of clean supplies and onto clean surfaces without disinfecting them after removal of the glucometer.

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KY Deficiency Example – Scope/Severity of J

- Observation revealed CNA walked out of room where Resident had been moved, after testing positive for COVID, and walked up the hallway. CNA was observed to be wearing the contaminated full PPE of gown, mask, eye protection, and shoe covers that had been worn while in the room. Continued observation revealed CNA walked up the hallway and touched the community linen cart with a contaminated gloved hand. Additionally, CNA was observed to wear the contaminated shoe covers from the room up the hallway and into the community nourishment room.
  - Additional observations revealed LPN, while performing pre-meal blood glucose tests, either failed to wash her hands before donning gloves to conduct the testing, and/or failed to allow the glucometer to air dry after disinfection, as required before storage.
  - Additional observations revealed a CNA & Kentucky Medication Aide (KMA) failed to
  - don (put on) appropriate PPE when giving care to Resident who was on transmission
  - based precautions (TBP).

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F880 – Regulatory Language

- §483.80 Infection Control
- The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F880 – Regulatory Language

- §483.80(a) Infection prevention and control program.
- The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
  - §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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F880 – Regulatory Language

- §483.80(a) Infection prevention and control program.
- The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
  - §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
    - (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
    - (ii) When and to whom possible incidents of communicable disease or infections should be reported;
    - (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
    - (iv)When and how isolation should be used for a resident; including but not limited to:
      - (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
      - (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
    - (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
    - (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F880 - Regulatory Language

- §483.80(a) Infection prevention and control program.
- The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
  - §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- §483.80(e) Linens.
  - Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
- §483.80(f) Annual review.
  - The facility will conduct an annual review of its IPCP and update their program, as necessary.

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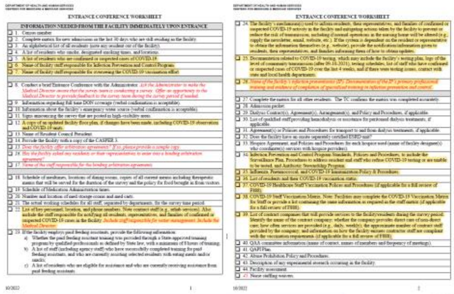

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LTC Survey Initial Pool Process Resident/Representative Interviews

- Do you have easy access to a sink with soap to wash your hands?
- Do staff assist you with washing your hands, if needed?
- Have you had a fever lately?
- Have you had a respiratory infection, urinary tract infection, or any other infection recently?
  - Tell me about the infection?
  - Are you currently having any symptoms?
  - How was it treated?
  - Are you still being treated?
- If a resident is on transmission-based precautions, ask the following questions:
  - Are staff and visitors wearing gowns, gloves, and/or masks when entering your room?
    - If not, please describe what has been occurring.
  - Are there any restrictions on where you can and can't go in the facility?
    - Do you know the reason for these restrictions?
  - Have staff explained why you are on precautions and how long you will be on the precautions?
  - Are there any restrictions for visitors coming into your room?
  - Have you had any changes in your mood since being placed on isolation, and if so, please describe?

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LTC Survey Initial Pool Process Resident Observations

- Is personal protective equipment/PPE (e.g., gloves, gowns, masks) readily accessible in resident areas (e.g., nursing units, therapy rooms)?
- If a resident is on transmission-based precautions, are appropriate PPE supplies outside of the resident's room and signage indicating the resident is on transmission-based precautions clear and visible prior to entering the room (signage must also comply with confidentiality and privacy)?
- Does the resident have signs or symptoms of an infection (e.g., wheezing, altered breathing, confusion, delirium, redness, swelling)?
- If visible, does the resident's medical device insertion site have redness, swelling or drainage? If drainage present (document color/amount/type/odor).
- If visible, does the resident's wound dressing have drainage, redness or swelling?

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Infection Prevention & Control CE Pathway (CMS-20054)

Infection Prevention, Control & Immunizations

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Infection Control Surveyor Review

- Standard and transmission-based precautions
- Resident care for COVID-19
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Visitor entry
- Staff and resident COVID-19 testing
- Suspected or confirmed COVID-19 reporting to residents, representatives, and families
- Laundry services
- Antibiotic stewardship program
- Infection Preventionist
- Influenza, pneumococcal, and COVID-19 immunizations

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Infection Control Survey Sample

- 3 Staff
  - At least 1 who was confirmed positive or s/s COVID-19
- 3 Residents
  - 1 who was confirmed positive or s/s COVID-19
  - 1 on transmission-based precautions for reason other than COVID-19
- 5 residents for influenza, pneumococcal, & COVID-19 immunizations

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Infection Control Focus Areas

- Standard & transmission-based precautions
- Hand hygiene
- PPE use
- Source control for COVID-19
- Resident care for COVID-19
- IPCP Policies, procedures, & education
- Infection Surveillance
- Visitor entry
- COVID-19 reporting
- COVID-19 testing
- Laundry services
- ATB stewardship program
- Infection Preventionist
- Immunizations

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Common Infection Control Citations

- Improper PPE use
- Failing to screen properly
- Hand hygiene & changing gloves during care (wound care, incontinence care, etc.)
- Not covering clean laundry cart
- Hand hygiene
- Touching medication with bare hands
- Glucometer cleaning/disinfection
- Catheters/oxygen tubing touching floor
- Not maintaining line list

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Infection Control Best Practices

- Effective screening for symptoms
- Quick response to symptoms
  - Testing
  - Isolation/Quarantine
- Staff Training
  - Correct type/use of PPE (Mask use)
  - Facility "zones" and type of isolation/quarantine in place
- Management of residents with dementia/wandering
- Tracking/trending (Mapping of infections on facility map?)
- Continuous review process to monitor compliance/care observation

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Elopement

F689 Supervision and Assistive Devices to Prevent Accidents
(Also cited under F 600 and 610)

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KY Deficiency Examples – Scope/Severity of J

- Facility failed to ensure each resident received adequate supervision and monitoring to prevent elopement for 1 resident.
- Resident activated the pull fire alarm on the hall, causing the magnetic locking mechanism on the facility doors to automatically disengage. This allowed Resident to exit the facility without the staff's knowledge and supervision. Per the facility's protocol, facility staff proceeded to check all rooms and closed doors, discovering Resident was not on his/her unit. The facility's receptionist observed Resident outside the building, walking towards a fast-food restaurant located approximately 350 feet from the front of the facility. Staff were immediately deployed to retrieve Resident and returned him/her to the facility.

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KY Deficiency Examples – Scope/Severity of J

- The facility's failure to have an effective system in place to ensure residents were supervised and monitored to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified in 2022 and determined to exist7 months prior at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F689. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F689.
- The facility implemented corrective action which was completed prior to the State Survey Agency's investigation. Based on validation of the facility's corrective actions it was determined to be Past Jeopardy

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KY Deficiency Examples – Scope/Severity of J

- Facility failed to ensure 1 resident was provided a safe environment. The facility also failed to ensure each resident received adequate supervision and monitoring to prevent elopement. Additionally, the facility did not follow their elopement policy by failing to call a Code 99 to ensure an accounting of all residents in response to the exit door alarm sounding. The facility's failure to have an effective system in place to ensure an accounting of all residents after a door alarm sounded to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident.
- Immediate Jeopardy (IJ) was identified in the areas of 42 CFR 483.21 Comprehensive Person-Centered Care Planning, F-656 Develop and Implement the Care Plan at a Scope and Severity (S/S) of a J; and, at 42 CFR 483.25 Free of Accidents/Hazards/Supervision, F-689 at a S/S of a J along with Substandard Quality of Care.

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KY Deficiency Examples – Scope/Severity of J

- Facility failed to have an effective system in place to ensure each resident received adequate supervision to prevent abuse for 2 residents.
- The facility admitted Resident #1 with diagnoses to include Alzheimer's Dementia, Anxiety, Depression, and High-Risk Heterosexual Behaviors. Record review revealed the resident had severely impaired cognition and had a Power of Attorney (POA).
- The facility admitted Resident #2 with diagnosis to include Alzheimer's Dementia, Dementia with Behavioral Disturbances and Mood Affect Disorder. Record review revealed the resident had severely impaired cognition and had a state appointed Guardian.

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KY Deficiency Examples – Scope/Severity of J

- Interview and record review revealed Resident #2's sexually inappropriate behaviors on 4 different dates. However, there was no documented evidence the facility increased monitoring or supervision of the residents or revised the care plan to include sexual type behaviors directed towards others. Subsequently Resident #1 entered Resident #2's room. Resident #2 had his/her pants and underwear pulled down and Resident #1 touched Resident #2's genital area. However, there was no documented evidence the facility identified the need to increase monitoring or supervision of Resident #1 after a room change and thirty (30) minutes of one (1) to one (1) supervision.
- Record review revealed Resident #1 was involved in a Resident-to-Resident incident where another resident kissed him/her on the lips. Continued review of Resident #1's Behavior Monitoring sheets, dated (2 different dates), revealed Resident #1 had wandered into other resident rooms; however, there was no documented evidence of interventions to prevent or reduce further occurrences such as increased monitoring or supervision.

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F 689 – Regulatory Requirements

- §483.25(d) Accidents.
- The facility must ensure that:
  - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
  - §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

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F 689 – Intent

- The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
  - Identifying hazard(s) and risk(s);
  - Evaluating and analyzing hazard(s) and risk(s);
  - Implementing interventions to reduce hazard(s) and risk(s); and
  - Monitoring for effectiveness and modifying interventions when necessary.

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Elopement

- Occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so
- Places at risk of heat/cold exposure, dehydration, medical complications, drowning, or being struck by motor vehicle
- Facility policies must clearly define mechanisms & procedures for assessing/identifying, monitoring, & managing residents at risk for elopement
- Must have care plan interventions for at risk residents to address potential for elopement
- Disaster & emergency preparedness plan should include plan to locate a missing resident

(CMS Appendix PP of State Operations Manual)

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Facility Best Practices

- Policies must clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement.
- The resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement.
- A facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

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Facility Best Practices

- Maintenance should have a monitoring schedule for checking all wander risk alarm systems, doors and alarm panels, and should complete the checks consistently.
- Residents exhibiting any exit seeking behaviors should have increased monitoring put in place (? 1:1)
- Staff must have thorough training on the need to respond to alarms immediately, to complete a head count when alarms sound, and to do an immediate search of the area outside the door that alarmed, with 2 staff going in opposite directions until they meet.

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Elopement Prevention

Risk Factors
- Elopement history
- Expresses desire to leave/return home
- Impaired cognition
- Adjustment difficulties
- Alcohol or drug abuse
- Anxiety
- Impaired vision
- Inability to recognize familiar people, places, objects
- Psychiatric history
- Smoking

Individualized Interventions
- Electronic monitoring/alarm system
- Environmental modifications
- Protected list of names & photos of at risk residents
- Psychosocial interventions
- Regular rounds
- Structured activities

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Elopement Prevention Facility Practices

- Assessing security of environment
- Door alarms & wander control systems
- External environmental risk factors
- Elopement drills
- Protected list of names, photographs, identifying information for at risk residents

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Elopement Management

- IDT review of residents who attempt to leave facility
  - Why and where were they trying to go?
  - Re-evaluate assessments
  - Determine patterns to exit seeking behaviors
  - Review & revise interventions
  - Update plan of care
  - Evaluate & document effectiveness of interventions

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Managing Elopement Incident

- Respond to sounding door alarms
- Complete full facility head count if unable to determine reason for sounding alarm
- If resident determined to be missing after head count:
  - Search facility
  - Search facility grounds
  - Interview staff
  - Broaden radius of search
  - Notifications – NHA/DON, family, physician, police, state agency
  - Assess wander protection system
  - Contact emergency rooms
  - Convene emergency team meeting

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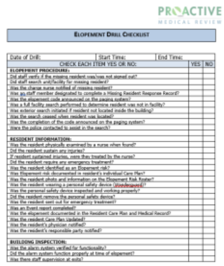
Elopement Drill


PROACTIVE MEDICAL REVIEW

ELOPEMENT DRILL CHECKLIST

Date of Drill:	Start Time:	End Time:

CHECK EACH ITEM YES OR NO:	YES	NO
ELOPEMENT PROCEDURE:		
Did staff verify if the missing resident was/was not signed out?		
Did staff search unit/facility for missing resident?		
Was the charge nurse notified of missing resident?		
Was an staff member designated to complete a Missing Resident Response Record?		
Was the elopement code announced on the paging system?		
Was a full facility search performed to determine resident was not in facility?		
Was exterior search initiated if resident not located inside the building?		
Was the search ceased when resident was located?		
Was the completion of the code announced on the paging system?		
Were the police contacted to assist in the search?		
RESIDENT INFORMATION:		
Was the resident physically examined by a nurse when found?		
Did the resident sustain any injuries?		
If resident sustained injuries, were they treated by the nurse?		
Did the resident require any emergency treatment?		
Was the resident identified as an Elopement risk?		
Was Elopement risk documented in resident's individual Care Plan?		
Was the resident photo and information on the Elopement Risk Roster?		
Was the resident wearing a personal safety device (Wanderguard)?		
Was the personal safety device inspected and working properly?		
Did the resident remove the personal safety device?		
Was the resident sent out for emergency treatment?		
Was an Event report completed?		
Was the elopement documented in the Resident Care Plan and Medical Record?		
Was the resident Care Plan Updated?		
Was the resident's physician notified?		
Was the resident's responsible party notified?		
BUILDING INSPECTION:		
Was the alarm system verified for functionality?		
Did the alarm system function properly at time of elopement?		
Was there staff supervision at exits?		

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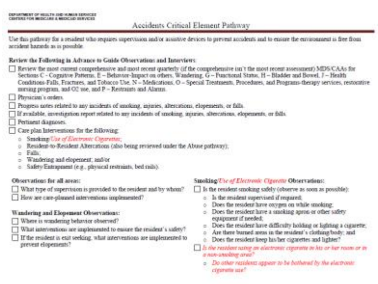
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accidents Critical Element Pathway

Use this pathway for a resident who requires supervision and/or assistive devices to prevent accidents and to ensure the environment is free from accident hazards as is possible.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C - Cognitive Patterns, E – Behavior-Impact on others, Wandering, G – Functional Status, H – Bladder and Bowel, J – Health Conditions-Falls, Fractures, and Tobacco Use, N – Medications, O – Special Treatments, Procedures, and Programs-therapy services, restorative nursing program, and O2 use, and P – Restraints and Alarms.
- ☐ Physician's orders.
- ☐ Progress notes related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ If available, investigation report related to any incidents of smoking, injuries, altercations, elopements, or falls.
- ☐ Pertinent diagnoses.
- ☐ Care plan Interventions for the following:
  - Smoking/*Use of Electronic Cigarettes*;
  - Resident-to-Resident Altercations (also being reviewed under the Abuse pathway);
  - Falls;
  - Wandering and elopement; and/or
  - Safety/Entrapment (e.g., physical restraints, bed rails).

Observations for all areas:

- ☐ What type of supervision is provided to the resident and by whom?
- ☐ How are care-planned interventions implemented?

Wandering and Elopement Observations:

- ☐ Where is wandering behavior observed?
- ☐ What interventions are implemented to ensure the resident's safety?
- ☐ If the resident is exit seeking, what interventions are implemented to prevent elopements?

Smoking/*Use of Electronic Cigarette* Observations:

- ☐ Is the resident smoking safely (observe as soon as possible):
  - Is the resident supervised if required;
  - Does the resident have oxygen on while smoking;
  - Does the resident have a smoking apron or other safety equipment if needed;
  - Does the resident have difficulty holding or lighting a cigarette;
  - Are there burned areas in the resident's clothing/body; and
  - Does the resident keep his/her cigarettes and lighter?
- ☐ *Is the resident using an electronic cigarette in his or her room or in a non-smoking area?*
  - *Do other residents appear to be bothered by the electronic cigarette use?*

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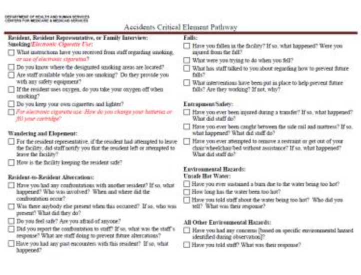
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accidents Critical Element Pathway

Resident, Resident Representative, or Family Interview:

Smoking/*Electronic Cigarette Use*:

- ☐ What instructions have you received from staff regarding smoking, *or use of electronic cigarettes*?
- ☐ Do you know where the designated smoking areas are located?
- ☐ Are staff available while you are smoking? Do they provide you with any safety equipment?
- ☐ If the resident uses oxygen, do you take your oxygen off when smoking?
- ☐ Do you keep your own cigarettes and lighter?
- ☐ *For electronic cigarette use: How do you change your batteries or fill your cartridge?*

Wandering and Elopement:

- ☐ For the resident representative, if the resident had attempted to leave the facility, did staff notify you that the resident left or attempted to leave the facility?
- ☐ How is the facility keeping the resident safe?

Resident-to-Resident Altercations:

- ☐ Have you had any confrontations with another resident? If so, what happened? Who was involved? When and where did the confrontation occur?
- ☐ Was there anybody else present when this occurred? If so, who was present? What did they do?
- ☐ Do you feel safe? Are you afraid of anyone?
- ☐ Did you report the confrontation to staff? If so, what was the staff's response? What are staff doing to prevent future altercations?
- ☐ Have you had any past encounters with this resident? If so, what happened?

Falls:

- ☐ Have you fallen in the facility? If so, what happened? Were you injured from the fall?
- ☐ What were you trying to do when you fell?
- ☐ What has staff talked to you about regarding how to prevent future falls?
- ☐ What interventions have been put in place to help prevent future falls? Are they working? If not, why?

Entrapment/Safety:

- ☐ Have you ever been injured during a transfer? If so, what happened? What did staff do?
- ☐ Have you ever been caught between the side rail and mattress? If so, what happened? What did staff do?
- ☐ Have you ever attempted to remove a restraint or get out of your chair/wheelchair/bed without assistance? If so, what happened? What did staff do?

Environmental Hazards:

Unsafe Hot Water:

- ☐ Have you ever sustained a burn due to the water being too hot?
- ☐ How long has the water been too hot?
- ☐ Have you told staff about the water being too hot? Who did you tell? What was their response?

All Other Environmental Hazards:

- ☐ Have you had any concerns [based on specific environmental hazard identified during observation]?
- ☐ Have you told staff? What was their response?

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PROACTIVE LTC CONSULTING

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Abuse

- F 600 Free from Abuse, Neglect, Misappropriation, Exploitation
- F 610 Investigation of Abuse or Neglect Allegations

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KY Deficiency Examples – Scope/Severity of J

- Facility failed to protect residents from abuse and neglect for 1 resident. The facility willfully deprived Resident of his/her personal belongings (clothing, grooming/hygiene and dental supplies) for 1 week.
- These belongings were necessary to attain or maintain his/her mental and psychosocial well-being necessary to avoid mental anguish or emotional distress. Resident stated he/she felt this behavior was abuse, as well as staff, who described this behavior as abusive. Staff were aware Resident was upset and cried during this time. However, the resident's belongings were not returned until 1 week later. Resident stated this was done in an attempt to make him/her move to another room. The resident stated that he/she was not able to change clothes, to perform personal hygiene, and was unable to perform oral care. Resident stated he/she was very upset and hurt by the facility's actions and cried the entire weekend. The resident stated he/she told the housekeeping staff not to touch his/her belongings. Resident stated he/she asked repeatedly to speak to the Administrator, as well as asked daily to have his/her personal belongings returned. The facility's failure to provide Resident with his/her personal belongings and failure to follow their policy to ensure all residents were free from abuse and neglect has caused or is likely to cause serious injury, serious harm, or death to residents.

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KY Deficiency Examples – Scope/Severity of K

- Facility failed to ensure 4 residents, who were all cognitively impaired and lacked the capacity to consent to sexual relations, were protected from sexual abuse. In addition, it was determined the facility failed to protect 2 residents from physical abuse.
- Review of the facility's investigation documentation revealed 2 residents were found by staff in Resident's room. Both residents were observed to have their pants down to mid-thigh, and Resident had his/her hand on other resident's thigh. Resident was placed on one (1) to one (1) supervision; however, the facility failed to ensure the other Resident was provided increased supervision for his/her safety and the safety of other residents.
- Review of the facility's investigation documentation revealed revealed Resident was involved in a second (2nd) allegation of abuse when Resident was found behind the door in another Resident's room with his/her clothing disheveled and other resident was lying on the bed pulling at the waist of his/her pants. Review of the residents ' medical record and interviews with staff revealed the facility failed to provide increased supervision for the residents, to ensure their safety, as well as the safety of other residents.

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KY Deficiency Examples – contd.

- Review of the facility's investigation documentation and interview with facility staff revealed Resident was observed in a second (2nd) sexual abuse allegation. Resident was found in Resident's room actively engaged in sexual intercourse. Per record review, there was no documented evidence the facility provided increased monitoring and/or supervision to ensure the safety of Resident and other residents.
- In addition, Resident wandered into another Resident's room. Staff found Resident with water on his/her face and observed the other Resident holding an empty cup. Staff also observed both residents pulling each other's hair, and immediately separated the residents. Resident was placed on one (1) on one (1) monitoring following the incident and referred to psych for evaluation. However, the facility failed to provide increased supervision and monitoring for the other Resident .

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F600 Free from Abuse, Neglect, Misappropriation, Exploitation

- §483.12 Freedom from Abuse, Neglect, and Exploitation
- The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
- §483.12(a) The facility must—
- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

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F600 Key Updates to Guidance

- Clarifications regarding facility reportable events
  - Examples of situations that are reportable vs. not reportable
  - What information needs to be reported
  - Reporting timelines
- Reminds that not all resident-to-resident altercations result in abuse
- Must take steps to ensure resident is protected from abuse, including evaluating whether resident has capacity to consent to sexual activity.
- Prior to citing as past-noncompliance, surveyors must investigate thoroughly to determine if facility took all appropriate actions to correct noncompliance & determine date on which facility had returned to substantial compliance

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F609 Reporting of Alleged Violations

Type of Abuse	Required to Report	Not Required to Report
Sexual Contact	• Unwanted touching of breasts or perineal area • Sexual activities where one resident indicates the activity is unwanted through verbal or non-verbal cues • Sexual activity or fondling where one of resident's capacity to consent is unknown • Sexual assault or battery (ex. Rape, sodomy, coerced nudity) • Instances where alleged victim is transferred to hospital for exam and/or treatment of injuries resulting from possible sexual abuse • Forced observation of masturbation or pornography • Forced, coerced, or extorted sexual activity • Other unwanted actions for purpose of sexual arousal or gratification resulting in degradation or humiliation of another resident	• Consensual sexual contact between resident who have capacity to consent to sexual activity • Affectionate contact such as hand holding, hugging, or kissing with resident who indicates consent to action through verbal or non-verbal cues • Sexual activity between residents in a relationship, married couples, or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal cues

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Response to Alleged Sexual Abuse

- If an allegation of sexual abuse has been reported, the facility must immediately:
  - Protect the alleged victim(s) involved,
  - Evaluate whether resident has the capacity to consent to sexual activity
  - Report the alleged violations to the Administrator and appropriate State and local authorities, and
  - Begin an investigation of the allegation.
- Do not tamper with evidence while conducting investigation
  - Examples of tampering include, but are not limited to:
    - washing linens or clothing,
    - destroying documentation,
    - bathing or cleaning the resident until the resident has been examined (including a rape kit, if appropriate), or otherwise impeding a law enforcement investigation.

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F600 §483.12 Freedom from Abuse Capacity and Consent

- If suspect resident may not have capacity to consent to sexual activity, must take steps to ensure that the resident is protected from abuse
  - These steps should include evaluating whether the resident has the capacity to consent to sexual activity.

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Consensual Sexual Interactions

- Can an individual who lacks competency maintain the capacity to consent to sexual activity?
- Who gets to determine one's ability to consent?
- Competency vs. Capacity in Law
  - **Competency:** A legal finding conducted to allow the court to determine an individual's mental capacity.
  - **Capacity:** The ability to understand the nature and effect of one's acts in a specific moment in time.

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Considerations Concerning Evaluation of Capacity to Consent

- Unless adjudicated as lacking capacity, all individuals are presumed to have capacity for personal decisions
  - Neither advanced age or cognitive impairment in themselves are sufficient to declare incapacity to consent
- No universal set of criteria for sexual consent
- Legal standards & criteria for sexual consent vary across states
  - Most commonly endorsed criteria are:
    1. Knowledge of relevant information, including risks/benefits
    2. Understanding or reasoning which is consistent with individual values
    3. Voluntariness of consent, free from undue influence or coercion

Source: (AMDA, 2016)

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Assessment of Capacity to Consent

- Knowledge of relevant information, including risks/benefits
  - Does individual know:
    - The nature of the sexual activity in which they are engaging?
    - The risks of STDs?
    - How to tell if partner desires the activity?
    - Appropriate times and places for particular sexual activities?
    - With whom they are engaging the activity?
- Understanding or reasoning which is consistent with individual values
  - Does he/she have capacity for the reasoning process inherent to sexual consent including:
    - Understanding of sexual options?
    - Consequences of sexual choices?
    - Consistency with his/her values and preferences?
- Voluntariness of consent, free from undue influence or coercion
  - Is the sexual choice a voluntary choice?

Source: (AMDA, 2016)

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Additional Considerations

- Diagnosis
  - Dementia – diagnosis itself is not necessarily indicative of incapacity
- Cognitive Factors
  - Attention
  - Memory
  - Executive function
- Psychiatric and Emotional Factors
  - Depression
  - Anxiety
  - Fear of abandonment/loneliness
- Personal Values

Source: (AMDA, 2016)

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Assessment of Sexual Consent Capacity

- Resident's awareness of the relationship
  - Is resident aware of who is initiating sexual contact?
  - Does resident believe the other person is a spouse and, thus, acquiesces out of a delusional belief, or is he/she cognizant of the other's identity & intent?
  - Can resident state what level of sexual intimacy he/she would be comfortable with?
- Resident's ability to avoid exploitation
  - Is the behavior consistent with formerly held beliefs/values?
  - Does resident have capacity to say no to uninvited sexual contact?
- Resident's awareness of potential risks:
  - Does resident realize that this relationship my be time limited?
  - Can resident describe how he/she will react when the relationship ends?

Source: (AMDA, 2016)

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Protection

- Monitoring of the alleged victim and other residents at risk, such as conducting unannounced management visits at different times and shifts;
- Evaluation of whether the alleged victim feels safe and if the he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.;
- Immediate assessment of the alleged victim and provision of medical treatment as necessary;
- Immediate notification of the alleged victim's practitioner and the family or responsible party;
- Removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents;
- Notification of the alleged violation to other agencies or law enforcement authorities; and
- Informed and involve administrative staff, including the administrator, as necessary in the investigation

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Corrective Actions

- Must take appropriate corrective action to protect resident
  - Oversee implementation of corrective action
  - Evaluate whether corrective action is effective
  - Determine whether more systemic actions may be necessary to prevent recurrence of situation
  - QAA committee involvement in monitoring the reporting & investigation, including assurances that residents are protected from further occurrences & that corrective actions are implemented as necessary

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Coordination with QAA Committee

- QAA committee tracking & review of abuse allegations
  - Was a thorough investigation conducted?
  - Is the resident protected?
  - Was an analysis conducted as to why the situation occurred?
  - Risk factors that contributed the abuse
- Is there further need for systemic action?
  - Policy & procedure revisions
  - Increased training
  - Resident/Family education about how to report allegations
  - Measures to verify corrective actions implemented
  - Tracking patterns of similar occurrences

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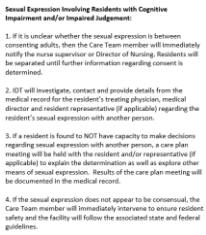
F600 – Facility Best Practice

- Have a policy to address resident
- Sexual Expression
  - A single assessment may not be the best answer



Sexual Expression Involving Residents with Cognitive Impairment and/or Impaired Judgement:

1. If it is unclear whether the sexual expression is between consenting adults, then the Care Team member will immediately notify the nurse supervisor or Director of Nursing. Residents will be separated until further information regarding consent is determined.

2. IDT will investigate, contact and provide details from the medical record for the resident's treating physician, medical director and resident representative (if applicable) regarding the resident's sexual expression with another person.

3. If a resident is found to NOT have capacity to make decisions regarding sexual expression with another person, a care plan meeting will be held with the resident and/or representative (if applicable) to explain the determination as well as explore other means of sexual expression. Results of the care plan meeting will be documented in the medical record.

4. If the sexual expression does not appear to be consensual, the Care Team member will immediately intervene to ensure resident safety and the facility will follow the associated state and federal guidelines.

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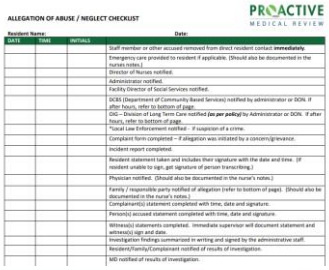
Abuse/Neglect Response Checklist



ALLEGATION OF ABUSE / NEGLECT CHECKLIST

PROACTIVE MEDICAL REVIEW

Resident Name: Date:

DATE	TIME	INITIALS	
			Staff member or other accused removed from direct resident contact **immediately.**
			Emergency care provided to resident if applicable. (Should also be documented in the nurses notes.)
			Director of Nurses notified.
			Administrator notified.
			Facility Director of Social Services notified.
			SCAN (Department of Community Based Services) notified by administrator or DON. If after hours, refer to bottom of page.
			OIG – Division of Long Term Care notified ***(as per policy)*** by Administrator or DON. If after hours, refer to bottom of page.
			*Local Law Enforcement notified - if suspicion of a crime.
			Complaint form completed – if allegation was initiated by a concern/grievance.
			Incident report completed.
			Resident statement taken and includes their signature with the date and time. (If resident unable to sign, get signature of person transcribing.)
			Physician notified. (Should also be documented in the nurse's notes.)
			Family / responsible party notified of allegation (refer to bottom of page). (Should also be documented in the nurse's notes.)
			Complainant(s) statement completed with time, date and signature.
			Person(s) accused statement completed with time, date and signature.
			Witness(s) statements completed. Immediate supervisor will document statement and witness(s) sign and date.
			Investigation findings summarized in writing and signed by the administrative staff.
			Resident/Family/Complainant notified of results of investigation.
			MD notified of results of investigation.

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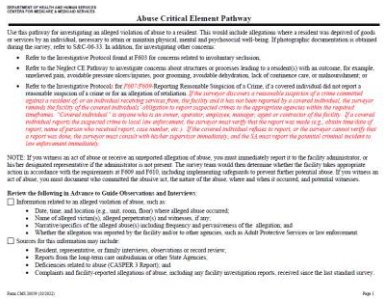

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Abuse Critical Element Pathway

Use this pathway for investigating an alleged violation of abuse to a resident. This would include allegations where a resident was deprived of goods or services by an individual, necessary to attain or maintain physical, mental and psychosocial well-being. If photographic documentation is obtained during the survey, refer to SubC-06-33. In addition, for investigating other concerns:

- Refer to the Investigative Protocol found at F603 for concerns related to involuntary seclusion.
- Refer to the Neglect CE Pathway to investigate concerns about structures or processes leading to a resident(s) with an outcome, for example, unrelieved pain, avoidable pressure ulcers/injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment; or
- Refer to the Investigative Protocols for F607/F609 Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or for an allegation of retaliation. *If the surveyor discovers a reasonable suspicion of a crime committed against a resident of, or an individual receiving services from, the facility and it has not been reported by a covered individual, the surveyor reminds the facility of the covered individuals' obligation to report suspected crimes to the appropriate agencies within the required timeframe. "Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility. If a covered individual reports the suspected crime to local law enforcement, the surveyor must verify that the report was made (e.g., obtain time/date of report, name of person who received report, case number, etc.). If the covered individual refuses to report, or the surveyor cannot verify that a report was done, the surveyor must consult with his/her supervisor immediately, and the SA must report the potential criminal incident to law enforcement immediately.*

NOTE: If you witness an act of abuse or receive an unreported allegation of abuse, you must immediately report it to the facility administrator, or his/her designated representative if the administrator is not present. The survey team would then determine whether the facility takes appropriate action in accordance with the requirements at F609 and F610, including implementing safeguards to prevent further potential abuse. If you witness an act of abuse, you must document who committed the abusive act, the nature of the abuse, where and when it occurred, and potential witnesses.

Review the following in Advance to Guide Observations and Interviews:

☐ Information related to an alleged violation of abuse, such as:
- Date, time, and location (e.g., unit, room, floor) where alleged abuse occurred;
- Name of alleged victim(s), alleged perpetrator(s) and witnesses, if any;
- Narrative/specifics of the alleged abuse(s) including frequency and pervasiveness of the allegations; and
- Whether the allegation was reported by the facility and/or to other agencies, such as Adult Protective Services or law enforcement.

☐ Sources for this information may include:
- Resident, representative, or family interviews, observations or record review;
- Reports from the long-term care ombudsman or other State Agencies;
- Deficiencies related to abuse (CASPER 3 Report); and
- Complaints and facility-reported allegations of abuse, including any facility investigation reports, received since the last standard survey.

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F684 – Quality of Care

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F684 Deficiency Examples – Scope/Severity of J

- 2 SRNAs observed a change of condition for Resident. Staff were not able to obtain the resident's oxygen saturation level due to the resident being drenched in sweat. The resident's fingers were purple almost black in color. The facility had no documented evidence staff conducted a thorough assessment of Resident's physical condition including his/her respiratory status, nor documented evidence of staff's inability to obtain the resident's oxygen saturation level. Resident was transported to the hospital and according to the hospital record he/she required 8 liters of supplemental oxygen per minute to maintain his/her oxygen saturation levels. In addition, Resident was diagnosed with sepsis due to Pneumonia and Acute Respiratory Failure due to lack of adequate oxygenation.

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F684 Deficiency Examples – Scope/Severity of J

- Facility failed to ensure residents received care and treatment in accordance with accepted standards of practice to treat and prevent adverse events related to high blood sugar for 1 resident. Resident's Blood glucose levels were elevated above 400 mg/dl (normal range below 125) on 4 different dates. However, there was no evidence found to indicate that the resident's condition was monitored after the levels were obtained, that staff rechecked the resident's glucose levels, or called the resident's physician to obtain further orders for evaluation and treatment of hypoglycemia.

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F684 – Quality of Care

- § 483.25 Quality of care
- Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

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F684 Quality of Care

- Issues that do not fit in other F tags
- Non-pressure related wounds
  - Arterial
  - Diabetic
  - Venous
- Hospice/End of Life Care
  - Coordination of Care

483.25	Quality of Care
F684	Quality of Care
F685	*Treatment/Devices to Maintain Hearing/Vision
F686	*Treatment/Svcs to Prevent/Heal Pressure Ulcers
F687	*Foot Care
F688	*Increase/Prevent Decrease in ROM/Mobility
F689	*Free of Accident Hazards/Supervision/Devices
F690	*Bowel/Bladder Incontinence, Catheter, UTI
F691	*Colostomy, Urostomy, or Ileostomy Care
F692	*Nutrition/Hydration Status Maintenance
F693	*Tube Feeding Management/Restore Eating Skills
F694	*Parenteral/IV Fluids
F695	*Respiratory/Tracheostomy care and Suctioning
F696	*Prostheses
F697	*Pain Management
F698	*Dialysis
F699	*Trauma Informed Care
F700	*Bedrails

F684 – Best Practices

- INTERACT Program
  - Set and follow parameters for hypo/hyperglycemia
  - Assess for and document resident changes in status
- Weekly wound assessments for all wounds, including measurements if able and wound description
  - Change treatment(s) if no improvement or if there is decline after 2 weeks
  - Documentation of interventions to address underlying cause
    - Diabetes management
    - Circulatory interventions (i.e., compression, medications etc.)
- Coordination of Care and the Care Plan with Hospice

F812 Food Handling, Storage and Preparation

Deficiency Examples – Scope/Severity of F & E

- Observation revealed opened food items in the facility's reach in refrigerator and dry storage area which were not dated.
- Facility failed to maintain professional standards in 2 kitchens. Specifically, the facility failed to remove 5 dented canned food items from 1 kitchen and failed to maintain accurate and complete refrigerator temperature logs in 2 kitchens. These failures had the potential to affect all residents of the facility who received food from the two kitchens.

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F812 Food Handling, Storage and Preparation

- §483.60(i) Food safety requirements.
- The facility must –
- §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
  - (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
  - (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
  - (iii) This provision does not preclude residents from consuming foods not procured by the facility.
- §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

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F812 Facility Best Practices

- Staff education
  - Food handling/food temps
  - Hand hygiene
  - Cleaning schedules
  - Labeling/storage of food
- Monitoring of dietary sanitation Issues (CMS Critical Element Pathway)

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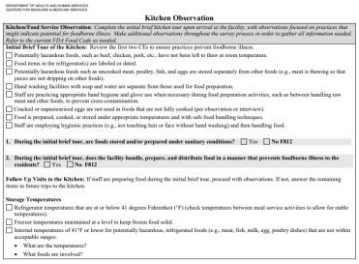

Kitchen Observation

Kitchen/Food Service Observation. *Complete the initial brief kitchen tour upon arrival at the facility, with observations focused on practices that might indicate potential for foodborne illness. Make additional observations throughout the survey process in order to gather all information needed. Refer to the current FDA Food Code as needed.*

Initial Brief Tour of the Kitchen: Review the first two CEs to ensure practices prevent foodborne illness.

- ☐ Potentially hazardous foods, such as beef, chicken, pork, etc., have not been left to thaw at room temperature.
- ☐ Food items in the refrigerator(s) are labeled or dated.
- ☐ Potentially hazardous foods such as uncooked meat, poultry, fish, and eggs are stored separately from other foods (e.g., meat is thawing so that juices are not dripping on other foods).
- ☐ Hand washing facilities with soap and water are separate from those used for food preparation.
- ☐ Staff are practicing appropriate hand hygiene and glove use when necessary during food preparation activities, such as between handling raw meat and other foods, to prevent cross-contamination.
- ☐ Cracked or unpasteurized eggs are not used in foods that are not fully cooked (per observation or interview).
- ☐ Food is prepared, cooked, or stored under appropriate temperatures and with safe food handling techniques.
- ☐ Staff are employing hygienic practices (e.g., not touching hair or face without hand washing) and then handling food.

1. **During the initial brief tour, are foods stored and/or prepared under sanitary conditions?** ☐ Yes ☐ **No F812**

2. **During the initial brief tour, does the facility handle, prepare, and distribute food in a manner that prevents foodborne illness to the resident?** ☐ Yes ☐ **No F812**

Follow Up Visits to the Kitchen: If staff are preparing food during the initial brief tour, proceed with observations. If not, answer the remaining items in future trips to the kitchen.

Storage Temperatures

- ☐ Refrigerator temperatures that are at or below 41 degrees Fahrenheit (°F) (check temperatures between meal service activities to allow for stable temperature)
- ☐ Freezer temperatures maintained at a level to keep frozen food solid.
- ☐ Internal temperatures of 41°F or lower for potentially hazardous, refrigerated foods (e.g., meat, fish, milk, egg, poultry dishes) that are not within acceptable ranges:
  - What are the temperatures?
  - What foods are involved?

F656 Develop/Implement Comprehensive Care Plan

Deficiency Examples – Scope/Severity of J

- Review of Resident's Comprehensive Care Plan revealed an intervention to place the resident near the nurses' station when out of bed. The facility added the intervention to keep the resident near the nurses' station when up in the wheelchair & for the resident to be in the direct view of staff when up in the w/c. However, record review and staff interviews revealed they would be busy and unable to monitor the resident. Staff stated the resident often left the nurse's area and they would find the resident in his/her room on the floor from an unwitnessed fall.

Deficiency Examples – Scope/Severity of J

- Review of the Comprehensive Care Plan for Resident revealed interventions included: assess the skin and report skin breakdown; treatments as ordered; treatment to the Deep Tissue Injury (DTI) to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. However, there was no documented evidence the facility was monitoring the resident's wounds, as there was no Wound Assessment completed from 01/13/2020 until 02/16/2022, after Surveyor intervention. Further, there was no documented evidence treatments were performed as ordered. The resident's pressure ulcers deteriorated and he/she developed osteomyelitis
- Review of the Comprehensive Care Plan for another Resident revealed interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; provide wound care as ordered by the physician; and provide medications and treatments as per orders. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence of physician's orders. There was no initial Wound Assessment until twenty-eight (28) days after admission. Additionally, there was no documented evidence of a Wound Assessment from 12/07/2021, until the surveyor requested to observe a skin assessment on 02/16/2022, seventy-one (71) days later, when the resident's wounds were noted to be larger and unidentified wounds were noted.

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Deficiency Examples – Scope/Severity of J

- Review of the Comprehensive Care Plan for Resident revealed interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence physician's orders for wound care. No documented evidence of a wound assessment from until the surveyor requested to observe skin assessment thirty-six (36) days later, the wound has worsened with a tunneling noted at 6.5 cm.
- Review of the Comprehensive Care Plan for another Resident revealed interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD; treatment to stump per order. Review of Care Plan revealed new treatments for Resident's stage II coccyx and Left AKA was not updated on the care plan until 02/07/2022. No documented evidence of wound assessment for residents left AKA until the surveyor requested to observe skin assessment on 02/16/2022.

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F656 Develop/Implement Comprehensive Care Plan

- §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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F656 – Facility Best Practices

- MDS nurses get copies/notifications of all orders to use for updates
- Assign interventions to "primary" problems and refer to the primary problem instead of repeating the intervention.
- Do "care plan checks" to make sure interventions are in place and being consistently implemented.
- Combine "like" problems/issues (e.g., psychosocial well-being, mood state, behaviors, and psychotropic medications)

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F677 ADL Care Provided for Dependent Residents

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Deficiency Examples – Scope/Severity of D

- Facility failed to provide necessary hygienic care for one resident
  - Observations on 2 dates revealed Resident had long fingernails with jagged, chipped edges. In addition, a dark substance was observed under the resident's nails. The facility assessed Resident as requiring total care with Activities of Daily Living (ADL's), to include personal hygiene and bathing.

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F677 ADL Care Provided for Dependent Residents

- §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene

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F677 Guidance

- The existence of a clinical diagnosis shall not justify a decline in a resident's ability to perform ADLs unless the resident's clinical picture reflects the normal progression of the disease/condition has resulted in an unavoidable decline in the resident's ability to perform ADLs
- Examples of unavoidable declines:
  - Natural progression of a debilitating disease with known functional decline
  - Onset of acute episode causing physical or mental disability while resident is receiving care to restore or maintain functional abilities
  - Refusal of care & treatment to restore or maintain functional abilities after attempts to inform & educate about risks/benefits

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F677 ADL Care Provided for Dependent Residents

- Staff providing ADL assistance in accordance with professional standards of care, the care plan, and resident choices
- Level of assistance identified as needed by the resident on the assessments/MDS matches the care plan
- Appropriate assistive devices in place and utilized?
- Resident encouraged to do as much as they are able?
- Staff explaining care before provision and not "rushing" the resident

CMS Appendix PP

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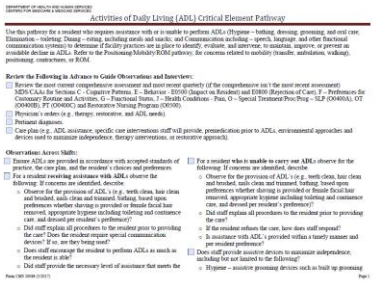

Activities of Daily Living (ADL) Critical Element Pathway

Use this pathway for a resident who requires assistance with or is unable to perform ADLs (Hygiene – bathing, dressing, grooming, and oral care. Elimination – toileting. Dining – eating, including needs and snacks. and Communication including – speech, language, and other functional communication systems) to determine if facility practices are in place to identify, evaluate, and intervene, to maintain, improve, or prevent an avoidable decline in ADLs. Refer to the Positioning/Mobility/ROM pathway, for concerns related to mobility (transfer, ambulation, walking), positioning, contractures, or ROM.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive assessment and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS CAAs for Sections C – Cognitive Patterns, E – Behavior – E0500 (Impact on Resident) and E0800 (Rejection of Care), F – Preferences for Customary Routine and Activities, G – Functional Status, J – Health Conditions – Pain, O – Special Treatment/Proc/Prog – SLP (O0400A), OT (O0400B), PT (O0400C) and Restorative Nursing Program (O0500).
- Physician's orders (e.g., therapy, restorative, and ADL needs).
- Pertinent diagnoses.
- Care plan (e.g., ADL assistance, specific care interventions staff will provide, premedication prior to ADLs, environmental approaches and devices used to maximize independence, therapy interventions, or restorative approach).

Observation: Across Shifts:

- Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the resident's choices and preferences.
- For a resident **receiving assistance with ADLs** observe the following: If concerns are identified, describe
  - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, beard upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
  - Did staff explain all procedures to the resident prior to providing the care? Does the resident require special communication devices? If so, are they being used?
  - Does staff encourage the resident to perform ADLs as much as the resident is able?
  - Did staff provide the necessary level of assistance that meets the
- For a resident **who is unable to carry out ADLs** observe for the following: If concerns are identified, describe
  - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, beard upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
  - Did staff explain all procedures to the resident prior to providing the care?
  - If the resident refuses the care, how does staff respond?
  - Is assistance with ADL's provided within a timely manner and per resident preference?
- Does staff provide assistive devices to maximize independence, including but not limited to the following?
  - Hygiene – assistive grooming devices such as built up grooming

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F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

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Deficiency Examples – Scope/Severity of J

- Facility's Wound Nurse resigned from the facility and although the Administrator became aware that same month the Wound Assessments were not being completed consistently, there was no documented evidence of a skin sweep of all residents in order to identify any new pressure ulcers or identify if pressure ulcers were deteriorating.
- Wound Assessments were left for the staff nurses to complete. However, interview with the staff nurses revealed they were unaware they were to complete the Wound Assessments, had not had training related to measuring and staging of wounds, and were not comfortable completing this type of wound assessment.
- Review of the facility's Skin Care Standard of Practice revealed a skin assessment would be completed weekly by a licensed nurse and staging and measuring would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing. However, record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. As a result, observation of skin assessments performed revealed there was deterioration of residents' wounds and unidentified wounds.

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F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

- §483.25(b) Skin Integrity
- §483.25(b)(1) Pressure ulcers.
- Based on the comprehensive assessment of a resident, the facility must ensure that—
  - (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
  - (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

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F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

- "Avoidable" or "Unavoidable"
- "Unavoidable" means that the resident developed a pressure ulcer/injury even though the facility had:
  - Identified whether the resident is at risk for developing or has a PU/PI upon admission and thereafter;
  - Evaluated resident specific risk factors and changes in the resident's condition that may impact the development and/or healing of a PU/PI;
  - Implemented, monitored and modified interventions to attempt to stabilize, reduce or remove underlying risk factors; and
  - If a PU/PI is present, provided treatment and services to heal it and to prevent infection and the development of additional PU/PIs.

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F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

- When assessing the PU/PI itself, it is important that documentation addresses:
  - The type of injury (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of injury;
  - The PU/PI's stage;
  - A description of the PU/PI's characteristics;
  - The progress toward healing and identification of potential complications;
  - If infection is present;
  - The presence of pain, what was done to address it, and the effectiveness of the intervention; and
  - A description of dressings and treatments.

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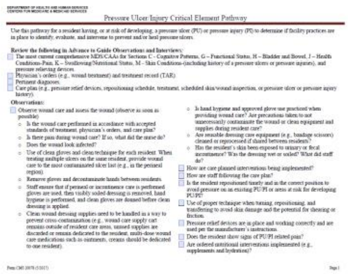

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Pressure Ulcer/Injury Critical Element Pathway

Use this pathway for a resident having, or at risk of developing, a pressure ulcer (PU) or pressure injury (PI) to determine if facility practices are in place to identify, evaluate, and intervene to prevent and/or heal pressure ulcers.

Review the following in Advance to Guide Observations and Interviews:

- ☐ The most current comprehensive MDS/CAAs for Sections C - Cognitive Patterns, G – Functional Status, H – Bladder and Bowel, J – Health Conditions-Pain, K – Swallowing/Nutritional Status, M - Skin Conditions-(including history of a pressure ulcers or pressure injuries), and pressure relieving devices.
- ☐ Physician's orders (e.g., wound treatment) and treatment record (TAR).
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., pressure relief devices, repositioning schedule, treatment, scheduled skin/wound inspection, or pressure ulcer or pressure injury history).

Observations:

- ☐ Observe wound care and assess the wound (observe as soon as possible).
  - Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan?
  - Is there pain during wound care? If so, what did the nurse do?
  - Does the wound look infected?
  - Use of clean gloves and clean technique for each resident. When treating multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (e.g., in the perineal region).
  - Remove gloves and decontaminate hands between residents.
  - Staff ensure that if perineal or incontinence care is performed gloves are used, then visibly soiled dressing is removed, hand hygiene is performed, and clean gloves are donned before clean dressing is applied.
  - Clean wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications such as ointments, creams should be dedicated to one resident).
  - Is hand hygiene and approved glove use practiced when providing wound care? Are precautions taken to not unnecessarily contaminate the wound or clean equipment and supplies during resident care?
  - Are reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?
  - Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing wet or soiled? What did staff do?
- ☐ How are care planned interventions being implemented?
- ☐ How are staff following the care plan?
- ☐ Is the resident repositioned timely and in the correct position to avoid pressure on an existing PU/PI or areas at risk for developing PU/PI?
- ☐ Use of proper technique when turning, repositioning, and transferring to avoid skin damage and the potential for shearing or friction.
- ☐ Pressure relief devices are in place and working correctly and are used per the manufacturer's instructions.
- ☐ Does the resident show signs of PU/PI related pain?
- ☐ Are ordered nutritional interventions implemented (e.g., supplements and hydration)?

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F761 Label/Store Drugs and Biologicals

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KY Deficiency Examples – Scope/Severity of E

- Observation of the Medication Storage Room revealed 3 bags of Normal Saline (NS) that were expired. Further observation revealed multiple medications stored loosely, and in no particular order, in a cabinet above the sink that also contained intravenous (IV) medication administration supplies. The medications included 2 vials of expired IV pain medication, expired IV Vitamin K, and a partially used card of a discontinued medication
- In addition, medications that belonged to deceased residents were also present in the medication storage room.

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F761 – Label/Store Drugs and Biologicals

- §483.45(g) Labeling of Drugs and Biologicals
  - Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
- §483.45(h) Storage of Drugs and Biologicals
  - §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
  - §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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F761 Interpretive Guidance Medication Access & Storage

- Secure all medications in a locked storage area and to limit access to authorized personnel
- Schedule II-V medications must be maintained in separately locked, permanently affixed compartments.
- During medication pass, meds must be under the direct observation of the person administering the meds or locked in the med storage area/cart
- Must have procedures for control & safe storage of meds for those who can self-administer meds
- Have procedures that address & monitor safe storage & handling of meds in accordance with manufacturer specifications
  - Temperature, light, humidity

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F761 Facility Best Practices

- Controlled/scheduled meds kept under double lock
- Stored at proper temperatures
- Multi-dose meds dated when opened and discarded as required
- Different routes stored separately
- Accurate documentation for controlled/scheduled meds
- Disposal methods secure/safe to prevent diversion

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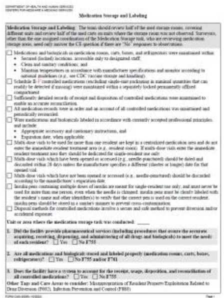
Medication Storage and Labeling

Medication Storage and Labeling: The team should review half of the med storage rooms, covering different units and review half of the med carts on units where the storage room was not observed. Surveyors, other than the one assigned coordination of the Medication Storage task, who are reviewing medication storage areas, need only answer the CE question if there are "No" responses to observations.
☐ Medications and biologicals in medication rooms, carts, boxes, and refrigerators were maintained within: • Secured (locked) locations, accessible only to designated staff; • Clean and sanitary conditions; and • Maintain temperatures in accordance with manufacturer specifications and monitor according to national guidelines (e.g., see CDC vaccine storage and handling). ☐ Schedule II-V controlled medications (excluding single-unit packaging in minimal quantities that can readily be detected if missing) were maintained within a separately locked permanently affixed compartment. ☐ Sufficiently detailed records of receipt and disposition of controlled medications were maintained to enable an accurate reconciliation. ☐ All medication records were in order and an account of all controlled medications was maintained and periodically reconciled. ☐ Were medications and biologicals labeled in accordance with currently accepted professional principles, and include: • Appropriate accessory and cautionary instructions, and • Expiration date, when applicable. ☐ Multi-dose vials to be used for more than one resident are kept in a centralized medication area and do not enter the immediate resident treatment area (e.g., resident room). If multi-dose vials enter the immediate resident treatment area they should be dedicated for single-resident use only. ☐ Multi-dose vials which have been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. ☐ Multi-dose vials which have not been opened or accessed (e.g., needle-punctured) should be discarded according to the manufacturer's expiration date. ☐ Insulin pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person, even when the needle is changed. Insulin pens must be clearly labeled with the resident's name and other identifier(s) to verify that the correct pen is used on the correct resident. Insulin pens should be stored in a sanitary manner to prevent cross-contamination. ☐ Disposal methods for controlled medications involve a secure and safe method to prevent diversion and/or accidental exposure.
Unit or area where the medication storage task was conducted: ____
1. Did the facility provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident? ☐ Yes ☐ No F755
2. Are all medications and biologicals stored and labeled properly (medication rooms, carts, boxes, refrigerators)? ☐ Yes ☐ No F755 and/or F761
3. Does the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications? ☐ Yes ☐ No F755
Other Tags and Care Areas to consider: Misappropriation of Resident Property Exploitation Related to Drug Diversion (F602), Infection Prevention and Control (F880)

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Resources

- State Operations Manual (SOM) Appendix PP
- CMS Nursing Home Website
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes
- QCOR (Quality Certification and Oversight Reports)
- https://qcor.cms.gov/main.jsp
- CMS Survey Resources (Critical Element Pathways)
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes

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Thank You!

KAHCF Quality Summit

Presented By: Shelly Maffia RN, MSN, MBA, LNHA, QCP, CHC, CLNC, CPC
Director of Regulatory Services

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