



BNHRC REGIONAL QUALITY FORUM Q&A

Division of Quality Assurance / Bureau of Nursing Home Resident Care

P-00452 (12/2012)

Page 1 of 19

This Q&A contains questions submitted at the following BNHRC Regional Quality Forums:

SRO – February 7, 2012
SERO – March 27, 2012
WRO – May 17, 2012
NRO – June 7, 2012
NERO – August 1, 2012

1. ***Does DQA recommend all nursing homes sign on to the Advancing Excellence program? (WRO)***

The Department, the Division, and the Bureau highly support the Advancing Excellence (AE) program nationally and specifically within the state of Wisconsin. We extend our compliments on the current rate of participation for Wisconsin nursing homes being at 71.0% vs. a national average of 54.3%. This has been a positive gain for our state since inception and over the last several years. Overall, there is a correlation between nursing homes that participate in AE and better regulatory outcomes; this may not be due to AE in and of itself, but more reflective of an organization making the efforts and taking strides for improvement in all capacities; AE is a very logical integration into that operational mindset.

AE is a national program with a “state chapter” that supports statewide coalitions of stakeholders called Local Area Networks of Excellence (LANEs). LANE is the central organization within a state to support participating nursing homes in achieving their clinical and organizational goals and to help the Campaign succeed. The LANE is comprised of a wide spectrum of long term care stakeholders including representatives of the nursing home associations, state survey agency, ombudsman office, and quality improvement organization, as well as consumer advocacy organizations. The provider can select any of eight national goals. For more information about the AE Goals, visit their website at http://www.nhqualitycampaign.org/star_index.aspx?controls=welcome.

Goal 1: Staff Turnover: Nursing homes will take steps to minimize staff turnover in order to maintain a stable workforce to care for residents.

Goal 2: Consistent Assignment: Being regularly cared for by the same caregiver is essential to quality of care and quality of life. To maximize quality, as well as resident and staff relationships, the majority of nursing homes will employ “consistent assignment” of CNAs.

Goal 3: Restraints: Nursing home residents are independent to the best of their ability and rarely experience daily physical restraints.

Goal 4: Pressure Ulcers: Nursing home residents receive appropriate care to prevent and appropriately treat pressure ulcers when they develop.

Goal 5: Pain: Nursing home residents will receive appropriate care to prevent and minimize episodes of moderate or severe pain. Objectives for long stay and short stay are slightly different.

Goal 5A: Long stay (longer than 90 days) nursing home residents will receive appropriate care to prevent and minimize episodes of moderate or severe pain.

Goal 5B: People who come from a hospital to a nursing homes for a short stay will receive appropriate care to prevent and minimize episodes of moderate or severe pain.

Goal 6: Advance Care Planning: Following admission and prior to completing or updating the plan of care, all nursing home residents will have the opportunity to discuss their goals for care including their preferences for advance care planning with an appropriate member of the healthcare team. Those preferences should be recorded in their medical record and used in the development of their plan of care.

Goal 7: Resident/Family Satisfaction: Nursing home staff will assess resident and family experience of care and incorporate this information into their quality improvement activities.

Goal 8: Staff Satisfaction: Nursing home administrators will assess staff satisfaction with their work environment at least annually and upon separation and incorporate this information into their quality improvement activities.

Specific resources are available including an easy-to-use web site to provide free, practical, and evidence-based resources to support quality improvement efforts in America's nursing homes. Additional thoughts:

1. BNHRC does not track who does and does not participate in the AE. It is not a regulatory requirement. It is a good program we endorse and support participation.
2. AE is gaining media attention.
 - a. Consumers that research facilities can go to the AE website and see what specific providers are participating in any state.
 - b. The Wisconsin list grows longer daily. The list does not share facility specific performance, simply what phases the facility is participating in.
3. Enrollment is free and you can withdraw at any time.
4. Bottom line, in a business where there is not enough time in the day to get everything done, why not focus efforts on well recognized areas we all want to improve on? Maybe you learn, maybe you share. But, we pay attention to what we measure. What message are you sending being a LTC leader in your building and community?

2. *Wound care certification discounts have been offered to facilities. Will we be looked at differently by surveyors if we have not pursued this certification of an employee, and choose to use an outside wound care consultant to monitor and make recommendations for wound care?* (WRO)

There is no regulatory requirement to employ or have an in-house certified Wound Care Nurse. Facilities are free to utilize outside consultants but the facility is obligated to ensure that the outside service meets professional standards and principles that apply to the professionals providing the service. See F500 for more information. The benefits of having the services of a certified Wound Care Nurse are undeniable and we encourage all facilities to make use of this expertise. However, the primary goal is to prevent pressure ulcers/wounds from occurring in the first place. We are trying to help you gain this service for your facilities by helping to provide the training.

3. *2011 Wisconsin Act 161: Authorizing Physician Assistants to Complete Certain Medically-Related Actions in Nursing Homes and Community Based Residential Facilities --- Does this law change also give PAs the authority to (1) admit persons to a nursing home or (2) conduct the visits (30, 60, and 90 days) required under Medicare?* (WRO)

Act 161 does not give PAs the authority to admit a person to a nursing home.

Both the state and federal nursing home regulations require a physician's order for admission.

Federal regulations require that the resident be seen by a physician at least once every 30 days for the first 90 days* following admission and at least once every 60 days thereafter.

SNF Facilities/Title 18 Medicare Only: In an SNF, the first 30 day visit must be conducted by the physician. After the initial 30 day visit, required visits in an SNF may alternate between personal visits by the physician and visits by a PA, nurse practitioner, or clinical nurse specialist.

NF Facilities/Title 19 Medicaid Only: In an NF, the initial visit and all subsequent visits may be performed by a PA, nurse practitioner, or a clinical nurse specialist **who is not an employee of the facility.**

Dually Certified Facility SNF/NF Title 18/Title 19: In dually certified facilities, the facility follows the SNF standards for Title 18 Medicare residents and the NF standards for Title 19 Medicaid residents.

DHS 132 does not mandate the frequency of physician visits.

FYI: Effective 1/1/11, the Affordable Care Act (ACA) added PAs to the list of practitioners who can perform SNF level of care certifications and recertification of a beneficiary's need for SNF level of care. This is a separate requirement and should not be confused with orders to admit to a nursing home or the mandated physician visits.

Recent minutes of the CMS Long Term Care Consistency Call stated that the ACA allows nurse practitioners to authorize nursing home placement while the nursing home regulations do not. A federal memo is coming. In the meantime surveyors should not cite a nursing home if a nurse practitioner authorizes nursing home placement.

4. *Is there a requirement that a resident arriving at a facility (by ambulance or otherwise) without signed paperwork cannot be allowed to go to their future room until the paperwork arrives? Holding someone in the lobby or other area (even the ambulance) seems overly punitive for something out of the resident's control. (SERO)*

Please view the AMDA Practice Guideline titled, "Transitions of Care in the Long-Term Care Continuum," located at <http://www.amda.com/tools/clinical/TOCCPG/index.html> that notes the following:

- "It is also all too common for adverse events and avoidable complications to occur as a result of poor communication and coordination among caregivers, health care professionals, and the patient during such transitions. Poorly executed care transitions increase hospital readmissions, duplication of services, and waste of resources."
- "Communication between practitioners in different care settings during transitions of care is frequently deficient."
- "Practitioners in different care settings often fail to ensure that the essential elements of the patient's care plan that were developed in one setting are communicated to the next team of clinicians, the necessary steps before and after a patient's transfer are properly and fully executed and that the requisite information about the care the patient received from the sending care team is communicated to the receiving care team."

There are national initiatives occurring around the country related to transitions of care. The situation where a resident arrives via ambulance without the required paperwork should not occur and places both the resident and provider at risk. This is an example of a poor transition of care. This is an example of how the medical director should be immediately involved in this circumstance so that it does not occur in the future. It places healthcare workers (HCWs) in a difficult position.

5. *Can a Physician Assistant or Nurse Practitioner sign the Hospital Discharge Summary and/or the History and Physical for a resident coming from a hospital for admission to a nursing home? (SERO)*

DHS 132.52 Procedures for admission (2) Physicians Orders. No person may be admitted as a resident except upon:

- (a) Order of a physician
- (b) Receipt of information from a physician, before or on the day of admission, about the person's current medical condition and diagnosis and receipt of a physician's initial plan of care and orders from a physician for immediate care of the resident; and
- (c) Receipt of certification in writing from a physician, physician assistant or advanced practice nurse prescriber that the individual has been screened for the presence of clinically apparent communicable disease that could be transmitted to other residents or employees, including screening for tuberculosis within 90 days prior to admission, or a physician, physician assistant or advanced practice nurse prescriber has ordered procedures to treat and limit the spread of any communicable diseases that the individual may be found to have.

6. *What is the current view on personal alarms --- a tool for falls prevention or mental/emotional restraint? (SERO)*

While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms alone do not replace necessary supervision. The 12/8/2006 Reinhart newsletter, written by Linda Dawson, includes a referenced decision by an administrative law judge in Bethel Center vs. CMS that upheld a decision that, pursuant to Medicare participation requirements, a facility is mandated to complete a comprehensive assessment of each resident's needs and write a comprehensive care plan explaining how such resident needs will be met. In this case the facility failed to meet the mandate because it failed to assess a residents' fall risks prior to and after the residents sustained falls, failed to thoroughly assess residents after they sustained falls, and failed to determine what interventions should be implemented to protect the residents and to develop and modify care plans for its residents with individualized fall protection interventions.

Additionally, the ALJ explained that Medicare participation requirements mandate that the facility provide its residents with adequate supervision and assistance devices to prevent accidents. Although the facility regularly used devices such as bed and wheelchair alarms, it nonetheless failed to meet the mandate because it relied on such devices for its fall prone residents instead of intensive personal supervision, despite evidence that such devices manifestly failed to protect residents from falling. The ALJ determined that, although alarms may enhance supervision, they may not substitute for it.

7. *Is it necessary to store large quantities of water on-site or is an emergency water contract sufficient to meet code requirements? (SERO)*

The regulation requires that a facility have a procedure to ensure that water is available when there is a loss of normal water supply. If water is not stored on site, the facility then needs to show that they can get water during an emergency.

8. *What is the process for mandated physician letters after significant negative findings? (NERO)*

The current process that has been in place for more than two years has physician notification letters sent out after all IDR and IIDR timelines and recommendations have been completed and finalized. DQA will not wait for the formal appeal to be completed due to the timeframes of those cases, which can be several years.

As a note to this question, nothing prevents or prohibits a provider from sharing the written results of the IDR process that is sent to all participants. DQA maintains IDR results in our general files and would release them if requested.

9. *Each survey team seems to have a different idea of exact postings required and what those need to contain. What are the survey teams looking for in required postings at the center (Medicare, Medicaid, etc.)? (NERO)*

F156, Notice of Rights and Services 483.10(b)(7). The facility must furnish a written description of legal rights which includes:

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network (Disability Rights Wisconsin), and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

F167, Examination of Survey Results 483.10(g)(1). A resident has the right to:

Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and SEE GUIDANCE UNDER TAG 168.

And lastly, information on whom to contact for application for Medicaid services and whom to contact for Medicare services and questions:

Dinh Tran is our trainer on this subject. His direct line is 608-266-6646.

10. *In a Person Directed Environment focused upon providing choices and creating a household model of care, how do we meet the interpretation of the DQA for F323 while remaining true to the openness of this model, and provide an environment promoting self-determination of elders residing in the facility? While the interpretive guidelines state their support of a person centered model and guidance directs surveyors to balance, we are asked in practice to remain institutional in our approach. As an example, when residents and their guests are visiting we provide snacks and beverages for them to access without asking, a practice found in many long term care buildings. The question of resident safety was raised by a surveyor despite there not having been any negative incidents or safety issues in the past or present related to having these areas available on open neighborhoods. Our Elders and their guests appreciate the availability of these items. Through DQA questioning and actions toward team members it is clear that residents are not*

encouraged to be independent and make their own choices despite having no signs of being unable to do so. (NERO)

We support person directed care (PDC). Supervision and assistance to prevent accidents is the rule. A provider must evaluate the type of resident and the risk factors that can be present. If, for example, you have a memory care unit with residents whom the facility has assessed as having limited safety awareness, then having unsupervised liquids at 144 F for ease of access is counterintuitive. Burns have occurred to residents across the state who have had access to scalding water. There have been outcomes. To not address similar risk factors, such as unsupervised access to scalding coffee, after a facility has had a similar incident in the same unsupervised room; we would be negligent not to address it. What may be safe for some residents of your facility may not be safe for all residents of your facility. That may mean different set ups on different units, depending on whom you have admitted and the needs that you are addressing.

We have witnessed some wonderfully creative problem solving by the provider community to be able to balance safety and access.

11. *We've noted an increasing focus on "culture change" issues in recent surveys. Though most providers are on board with the concept, it's being adopted in ways that seem most appropriate for each facility, and there is little in the regs that is specifically prescriptive. What kinds of "culture change" issues are being cited in surveys, and what documentation do we need to have on hand to document resident preferences in order to avoid such a cite? (SERO)*

S&C memo 09-31 dated 4/10/09 addressed the revisions at the quality of life and environment tags; changes in the interpretative guidelines encourage providers to make changes in the environment to go from an institutional setting to one that is more homelike for the Resident. Examples of citations related to this have been cited at F241, F252, and F253.

F241 Dignity: Citations have included use of trays in the dining room and differences in equipment offered to a set of residents in one dining room vs. another dining room. Citations have been issued in regards to staff responding to residents in an argumentative manner; resident at common dining room wearing brief and with lap blanket on bottom; resident eating in room with commode next to tray table; staff talking about their dissatisfaction with work schedules in the dining room with residents present; Foley catheter not covered; references to "Depends" as diapers; staff not knocking; the use of Styrofoam dishware; no eating utensils.

F242 Self-determination: Citations involving staff getting resident half-dressed and put back to bed at 4:00 a.m.

F252 Environment: Citations have included overhead paging; institutional, closed off nurses' stations, and institutional signage pertaining to resident care.

F253 Environment: Citations have looked at the overall cleanliness and maintenance of resident care equipment.

CMS and the Pioneer Network continue to collaborate on resident centered care, with the MDS 3.0 reflective of increased resident centered care focus.

12. *Does the May 4, 2012 DQA Memo 12-005 prohibit the use of electric hairdryers for persons on O2? (WRO)*

DQA Memo 12-005 is an advisory memo related to the use of electric hair dryers with Residents using oxygen. This is a dangerous situation that potentially puts the Resident at risk of significant harm. The final determination as to how extensive the advisory memo is followed rests with the individual provider. The memo outlines the hazard, recommends following manufacturer guidance, offers an alternative, and then lists resources for individual providers to make an assessment and subsequent informed choice. Note: this memo is in response to a LTC industry request.

13. *Is anyone aware of battery operated hairdryers that last longer than 10 minutes to avoid citations for oxygen with hairdryers? (NERO)*

BNHRC is not aware of a source of battery operated hair dryers. This question seems to stem from the informational memo ("informational" emphasized) regarding the potential risk factors that can be associated with the use of oxygen around (1) a heat source and (2) properly functioning hair dryers. It was not meant to be a prohibition to the use of hair dryers. To date, there has not been a citation in NERO or the state regarding the use of hair dryers.

Can we still use regular hair dryers if the residents signs off on the “risks” of doing?

You can still use regular hair dryers in good repair without running oxygen. Whether or not a provider chooses to have a release is an operational decision to be made by the provider.

- 14. *Where are we going with mental health issues in the nursing home? Recently, the police department and hospitals will not place residents on 72 hour hold unless there is a psych diagnosis, which means all dementia residents with no psych diagnosis won't be accepted. This will make nursing homes reluctant to take dementia with behaviors knowing that, if they can't keep other residents safe, they have no way to have them sent out. (NERO)***

This question refers to the recent Wisconsin Supreme Court Decision regarding Helen E.F. and Chapter 51, Emergency Detention and Chapter 55. In that decision the judicial branch of government encouraged the legislative branch of government to codify and coordinate these two chapters for the good of the people of Wisconsin.

We are not in a position to clarify the Department's position on mental health issues in nursing homes at this time.

The submitter raises a very important point; the point of control for who is admitted to your facility now has even greater importance and that an accurate evaluation is made prior to admission to ensure the care required is within the capacity of the facility.

North Central Health Care is a good example of a provider that has creatively addressed this issue for the consumers they serve and has demonstrated willingness to share lessons they have learned.

- 15. *Can family, guardians, etc. refuse to have a psychotropic medication reduction? (NRO)***

First, they should never get to this issue. When a psychotropic is started, it is the expectation that dose reductions should be planned and discussed with families/legal decision makers. When this plan is discussed **and** consented to prior to the medication being administered, a refusal for reduction should never arise.

However, sometimes the medication is not started in the facility and/or the planning is not done. The concerns of the family as to why they do not want a dose reduction are valid and part of the facility's consideration. However, just like physical restraints, a family cannot say the resident must be given a drug at a specific dose. If the physician and care team have decided that the drug is causing problems or it is uncertain if it is still needed, and a dose reduction is indicated and recommended, the family cannot refuse.

- 16. *There are some facilities that do and have been surveyed that preset medications without receiving citations? As long as all the Medication Rights are being followed, is this an issue? (NRO)***

Presetting in general is not prohibited by the regulations. However, presetting creates the potential for many errors and would be a practice that is not typically accepted. There are different kinds of presetting scenarios. However, there are standards of practice which make some scenarios problematic. For example, standards support that the person who presets the medication is the one who should administer the medications.

- 17. *Do psychotropic drug consents need to be done each time a dosage is changed on a psychotropic medication? Do consents need to be done annually? (SRO)***

When a consent form is completed, a discussion of the treatment plan occurs for that medication. That treatment plan may involve a range of dosages that may be used. The person completing the consent form should indicate that range on the form. When the form has a range, then a new consent form for each dose increase or decrease would not be needed. However, discussing outcomes and progress with the resident and the guardian or power of attorney for healthcare would be normal practice.

Informed consent forms are valid for 15 months.

- 18. *Are anti-depressants viewed/treated in the same way as anti-psychotics with regards to reductions? (SRO)***

Both of the medications require two attempts at reduction within the first year with those attempts occurring in two different quarters separated by one month (annually after the first year). The difference for these medications comes in the clinically contraindicated part. "Clinically contraindicated" means those situations where a dose reduction can

be avoided. Clinically contraindicated usually means there is evidence the medication is working and standards of practice support continued use.

So, for example, take someone with documented major depression receiving an antidepressant. If the medication is working and side effects are tolerable, a dosage reduction in the first year may not make sense as standards of practice support longer term use of antidepressants for major depression.

However, if the antidepressant was for a behavior not related to depression, there are no standards of practice to support long term use and there should be an attempt at a dosage reduction within that first 9 months of use.

Once again, the general requirement for dosage reduction is the same. The difference is that the clinical contraindication will be different depending on the use of the medication.

19. *What is the status of pain regulations; what is the acceptable level of pain? How determined? (NRO)*

In 2010, CMS revised the guidance at F309 to specifically address pain management. There have been no changes to the regulation since that time. An acceptable pain level is what the RESIDENT says it is --- or, in cognitively impaired residents, when they display comfort.

There are a number of pain scales that can be used. Some residents are able to verbalize a 0 – 10 numerical rating; others may verbalize none, mild, moderate, severe. Nonverbal residents may be able to use the Wong-Baker faces scales. For those residents who have cognitive impairments, the nurses would assess for non-verbal indicators of pain. The scale to use is determined as part of the assessment process. Once a pain scale is established, staff should ensure consistent use of the same scale in order to successfully manage the resident's pain.

If you go to the Wisconsin Clinical Resource website, there are standards of practice.

20. *What is the status of utilizing the QIS survey process in Wisconsin? (NRO)*

The QIS process is on hold for an indefinite period. CMS identified issues with the process that need to be addressed before role out can continue.

21. *When can we expect QIS survey in Wisconsin? (SRO)*

Wisconsin surveyors need to go through training to implement QIS. At this time, no date has been identified when Wisconsin surveyors will receive QIS training.

22. *When do you anticipate Wisconsin formally changing over to the QIS process? Have you had any indication from CMS as to what this year's survey "focus" areas will be? (SERO)*

CMS does not direct "focus" areas for us to concentrate on when doing surveys.

23. *Will the new survey process be stream-lined as far as the many questions that will be asked of residents? (NERO)*

By "new survey process" we believe that this question is aimed at the Quality Indicator Survey commonly referred to as QIS. The State of Wisconsin has not been trained on the QIS process and, at this point in time, CMS has placed expansion of the program on indefinite hold.

This is a good question and we encourage that it be asked of CMS. If you require assistance with finding contact information for this response, please feel free to contact the DQA and we shall get that to you.

24. *Is there such a thing as a level of care for reimbursement purposes anymore? If so, how does it impact rates? (NRO)*

No, there are no more levels of care for nursing home residents. The levels are determined solely from the MDS assessments.

25. If a surveyor observes a staff treatment error that has potential for harm, is he or she required to intervene to prevent or rectify the error (e.g., hand washing, med pass, use of gait belts)? (NRO)

This is a question that all of us struggle with at times. The direction that we have received from CMS, as well as from DQA trainers, is that surveyors would intervene only if there is a reasonable degree of certainty that actual harm would occur or if the practice would place the resident in immediate jeopardy. Examples of times when we would intervene would be:

1. Resident is going to receive too much insulin.
2. Staff are going to reuse a lancet or needle.
3. Staff have feces contaminated gloves and are going to provide oral care/assist with placement of dentures.

Surveyors are trained to intervene at the last possible moment to allow the staff person the opportunity to catch their error. At the time of the intervention, the surveyor will ask the staff person to step out of the room and conduct an interview with the staff person confirming what the staff person was going to do.

26. Could the DQA consider offering Webinars on compliance as it relates to trending of citations? (SRO)

SRO participates in the DON meeting every two months and gives trending/compliance information at that meeting. All of the regions are participating in Regional Quality Focus where the question of compliance or citing trends can be discussed.

27. What is the status of abbreviated surveys for facilities with a history of good performance? Will we get a decision tree tool similar to res-to-res altercations for reporting requirements? (SRO)

CMS has no immediate plans for altering the survey process --- or the tasks that must be completed during survey --- based on a facility's past compliance history.

There are no immediate plans to develop a decision tree for reporting requirements. Training on the reporting requirements will be offered during the summer at the University of Oshkosh.

28. What considerations are being discussed to prevent withholding re-hospitalizations due to negative incentives and accountability for negative outcomes? How are surveyors instructed to follow the intent of a regulation vs. strict adherence? (SRO)

The Department has an initiative underway that is looking at re-hospitalizations.

For the second question, surveyors review any hospitalization for the care and treatment that the resident received leading up to the hospitalization to determine if the nursing home met their care and treatment needs.

29. What can you tell us that would help prepare for the April 2012 QI/QM system revision deadline approaching? (SRO)

Continue to complete MDS 3.0's following the RAI manual; you need consistent, accurate data that matches the resident.

30. 5-Star Quality System: Are we expecting more changes to this system other than the QI/QM component? If so, are there any that you can discuss? (SRO)

CMS continues to use three factors when rating facilities in its 5-star rating system. These are (1) the facility's past compliance record, (2) the facility's quality indicator measures, and (3) the facility's staffing level.

31. What are the major areas of concern that the DQA are looking at during surveys right now? When can we expect the switch to QIS to occur? How does the DQA feel their relationships are with us (nursing homes)? (WRO)

Major areas of concern that are looked at during a survey include unplanned weight loss, hydration, pressure ulcers, restraints, infection control, and falls. DHS has two performance objectives --- dealing with preventing and reducing facility-acquired pressure ulcers and fall prevention. CMS continues to maintain a focus on restraints and pressure ulcer reduction.

QIS is on hold indefinitely.

The DQA relationship with most providers is one of mutual respect and collaboration. DQA has prescribed tasks that must be completed during a survey and this is understood by all. DQA does not operate on a quota basis. It is recognized that we are all working towards quality care for vulnerable citizens of Wisconsin.

32. *I have a theory why IJ's are so much higher in our state than others. A surveyor doesn't have to prove harm, only potential, much easier. (SERO)*

Stats. page 10, Appendix Q of the SOM, Guidelines for Determining Immediate Jeopardy, was revised in May 2004. The guidelines apply to all certified Medicare/Medicaid facilities in all states. CMS defines Immediate Jeopardy as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident." Serious harm, injury, impairment, or death does not have to occur before considering Immediate Jeopardy. The high potential for serious harm to occur in the very near future also constitutes Immediate Jeopardy. The CMS expectation is that, when making a deficiency determination, we start with Level 4 and work down. All IJ cites go through a statewide IJ call and not all IJ calls result in an IJ cite.

33. *What is the purpose of citing one situation under several F-tags? For instance, B&B assessment not completed to the surveyor's satisfaction. No negative outcome. Facility cited for F-272, 279, and 315. This seems excessive, if not punitive. (SERO)*

S&C Memo 05-20, 3/10/05, regarding Independent but Associated Deficiency Citations:

It is CMS's expectation that, if a deficient practice creates noncompliance with more than one regulation, noncompliance with each requirement should be cited. Refer to examples in the S&C Memo. The S&C memo states that CMS is aware that some providers feel that more than one deficiency for a single type of negative outcome represents piling on. CMS goes on to state that the regulations do not support this view. Quality of care tags define the outcomes of care that are expected. Root causes for not meeting these outcomes may be because of deficient practices in assessment and/or care planning, or in failing to implement the care plan. In such cases, CMS has directed that we cite all associated tags. Additionally, in tags that have had revised guidance (F314, F315, etc.), the section titled "Determination of Compliance,"(Task 6, Appendix P) directs surveyors to look at potential tags for additional investigation when noncompliance is identified as part of the deficiency determination.

34. *Clarification regarding access to computers in care locations, especially when the staff is using these computers for daily "real time" documentation of resident care --- Is it appropriate to set a room aside for the surveyors with computer access and, when the staff is not on the computers in the care areas, allow the surveyor to change computers if they wish? (SERO)*

S&C Memo 09-53, 8/14/09, Surveying Facilities that Use Electronic Health Records:

Providers are allowed to use whatever system of medical records best suits their needs. This includes paper and/or electronic systems. However, a provider must grant access to any medical record, including access to EHRs, when requested by the surveyor. If access to an EHR is requested by the surveyor, the facility will (a) provide the surveyor with a tutorial on how to use its particular electronic system and (b) designate an individual who will, when requested by the surveyor, access the system, respond to any questions, or assist the surveyor as needed in accessing electronic information in a timely fashion. Each surveyor will determine the EHR access method that best meets the need for that survey. During the entrance conference in a facility using EHRs, the survey team must request that the facility provide a terminal(s) where the surveyors may access records.

35. *Please provide clarification on the requirement to provide copies of all complaints and investigations during the annual survey that were not submitted to DQA under the abuse, neglect, misappropriations, and injury of unknown source and how that relates to the same incidents and investigations that have been submitted and reviewed by the QA committee that are deemed to be protected documents. (NRO)*

Surveyors request to see written evidence to determine that each facility has adequate procedures for investigating, reporting, protecting, and ensuring similar incidents do not occur in the future. This directive is found in the State Operations Manual. In the past, we asked for the last 30. Now, due to the more stringent reporting guidelines, there should be very few issues not reported. Therefore, surveyors will be asking for all investigations not reported to DQA back to the last recertification survey.

In 2006, DQA, Wisconsin Health Care Association, and Leading Age produced a collaborative training session on Quality Assurance Privilege. As part of that training the document, "Quality Assurance Committee Information and Its Privileged Status," was developed for providers and surveyors to outline what is and is not covered under QA Privilege. Page 2 of that document covers general rules which include:

"Any document that is specifically required to be produced or completed by state or federal law will not receive privilege status by being produced, completed or reviewed during the quality improvement process."

This means that investigations, which are required by state and federal regulations, are not covered under the QA Privilege.

The document and the webcast are still available out on the DHS website and can be found under DQA Provider Training.

36. *Please clarify Otis Wood's letter regarding surveyors not requesting the 30 most recent incidents.* (SRO)

The surveyors will ask for the allegations reviewed since the last recertification survey (or complaint that reviewed this information) so that task 5G can be done. The letter reads, in part, "nursing homes may have unreported incidents on file and DQA surveyors will continue to review any unreported incident reports that the facility has on file." This letter was just to clarify that "30" were not required; i.e., some facilities would take years to get to 30 and DQA would only review from recert to recert.

37. *Please clarify the change of not asking for the last 30 incidents ... but still wanting to see proof of how the facility handles grievances.* (WRO)

CMS still requires us to ensure that Providers have a mechanism in place to address Resident grievances and that grievances that are reported are dealt with in a timely fashion. Not everything that is grieved rises to the level of a mandatory reporting event. Those events or incidents that are not reported and that you deal with should be preserved in a file or in some location so that, during a survey, we can see the evidence that you do have a mechanism in place to address Resident grievances. Before the current mandatory reporting requirements were put into place, we used to ask for the last 30 grievances, complaints, or incidents to ensure compliance with the Resident grievance requirements. Now, with the new reporting requirements in place, there are fewer and fewer grievances. In recognition of these, we have started to ask for files/folders/logs of grievances or other evidence to show that you have a system in place and that it is and has been operational.

38. *Please clarify expectations with the crime reporting regulation.* (WRO)

DQA has no expectation other than, if there is a reasonable suspicion that a crime has been committed, that incident must be reported to law enforcement. We encourage providers to work with local law enforcement agencies to clarify who and what to report.

39. *Review documentation requirements for investigations.* (SERO)

Reference DQA Memo 11-032, dated December 5, 2011, *Guidance for Investigating and Reporting Alleged Violations in Nursing Homes.*

40. *Any data on the new law Reporting Reasonable Suspicion of a Crime in a LTC Facility?* (SERO)

There is no data on the law related to reporting reasonable suspicion of a crime.

41. *When reporting a suspicion of a crime to the DQA, do you complete the online abuse, neglect, injury, etc. report or call the complaint line, or both. If an employee also needs to report, where would I document that the employee wishes to jointly report with the facility and/or jointly report to the law enforcement agency?* (SERO)

The facility should follow the normal process to report; i.e., the immediate online alleged mistreatment report followed by the full incident report within 5 days. They can simply note in the online report that they are reporting it as an alleged incident and possible crime. They can include the names of staff who are reporting via the incident report.

42. *If a suspicion of a crime is reported by a covered individual and the occurrence also meets the requirements for incident reporting, must the facility report the incident using the usual incident reporting mechanisms? (SERO)*

Current regulation requires a facility to report incidents --- §483.13(c)(2). The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency). This requirement has not changed and the mechanics of complying with this regulation are the same as they have been. Reporting the suspicion of a crime is the responsibility of "covered individuals." There may be instances where an occurrence will require both the facility to report the alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and "covered individuals" must report the suspicion of a crime to the state survey agency and to local law enforcement.

43. *Is it acceptable for a facility in its compliance policy to state that covered individuals may either (a) report reasonable suspicion of crime directly to the state survey agency and law enforcement or (b) report reasonable suspicion of crime to the facility administrator who will then coordinate timely reporting to the state survey agency and law enforcement on behalf of all covered individuals who made the report to the administrator? (SERO)*

Yes, covered individuals may (a) report reasonable suspicion of crime directly to the state survey agency and law enforcement and/or (b) report reasonable suspicion of crime to the facility administrator who will then coordinate timely reporting to the state survey agency and law enforcement on behalf of all covered individuals who made the report to the administrator. Reporting to the administrator would suffice if an individual has clear assurance that the administrator is reporting it. Reports should be documented and the administrator should keep a record of the documentation. Everyone who saw a possible crime has the obligation to report it. The administrator could coordinate the reports submitted, but each person has to report. In addition, facilities cannot prohibit or circumscribe reporting directly to law enforcement even if they have a coordinated internal system.

Employees may be instructed to report any reasonable suspicion of a crime committed against a resident of a facility to DQA via:

- Online complaint survey: <http://www.dhs.wisconsin.gov/bqaconsumer/HealthCareComplaints.htm>
- Telephone: 1-800-642-6552
- **And**, by contacting the local city, township, village, or county law enforcement agency.

(§ 939.12, Wis. Stats., defines a crime as "conduct which is prohibited by state law and punishable by fine or imprisonment or both." (See Chapters 940-961, Wis. Stats.)

44. *When a resident who has a history of falls does so unwitnessed and suffers a fracture of some kind, must this be reported to the DQA? (SERO)*

Yes, if the fall was not witnessed. It's an injury of unknown source that needs to be investigated. (For example, was the resident pushed?)

45. *Say something is missing in a facility, like money, and you can't find it but you replace the money --- do you need to report? (NERO)*

Replacement is not the key to this response. The key is, "Was the item reported as stolen or missing?" If the complainant states that the money is missing and it is not located within a short period of time, then yes, it is reportable.

46. *We were cited in a recent survey for not reporting a CNA who inadvertently did not use a gait belt to transfer a resident and, during transfer, the resident's knees became weak and the CNA lowered the resident to floor. No injury occurred. Though the CNA was disciplined and all staff were reminded of the policy, we did not believe it to be abuse or neglect. Surveyor indicated that not using a gait belt would always be a reportable incident. We subsequently reported two other instances of a similar nature. Both incidents were not deemed to rise to the level of abuse by the State. We feel we are capable of determining what is neglect or abuse and (respectfully) should not be second-guessed after the fact. We know our staff, their history, etc.*

We are a very trustworthy facility and would not hesitate to report anything we remotely considered to be abuse. The State definitions in the Caregiver Policy are very clear to us and helpful; why can we not continue to use that logic in our decision-making? (NERO)

Based on instruction and expectations of CMS on the subject matter, such latitude has not been granted to state survey agencies or the industry we regulate. This subject matter has been discussed in great detail with CMS. Please be aware that the federal definition of "neglect" is the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Failure to use a care-planned gait belt would meet the definition of "failure to provide goods and services necessary to avoid physical harm...."

- 47. With the requirement for the self-reporting of ALL instances of abuse, neglect, and misappropriation, the staff time that this requirement has consumed is totally counterproductive to direct resident care. The constant employee "suspensions pending investigation" for "perceived or phantom" instances of neglect which, by and large, are usually performance issues takes valuable staff away from cares. The constant resident interview process as a component of the "thorough" investigation requirement only serves to heighten resident anxieties. Isn't there some COMMON SENSE approach which can be taken in these matters? While the intent of F225/F226 is appropriate, the ongoing implementation is totally counter-productive. (NERO)***

NERO staff conducts this standard the same as the other four regions in the state. It is clearly a frustration for the industry and multiple DQA memorandums and updates have been provided to assist in compliance with the federal expectation.

You are encouraged to continue to work with CMS, Department executives, and industry associations for any modifications to the current federal practice.

- 48. Why do we continue to receive memos regarding reporting of abuse, neglect, mistreatment, and misappropriation? Has the focus changed? Are providers missing something? (SRO)***

DQA and CMS have worked closely together to ensure that Wisconsin ensures that all NHs report **all** allegations of abuse, neglect, misappropriation, and mistreatment to DQA. The additional memos were sent to ensure clarity and consistency across the state.

- 49. How is the crime reporting going? Have there been any problems with it? Are providers performing it correctly? (SRO)***

We do not collect data on issues related to the implementation of the crime reporting requirements. We have not had to deal with a situation where the commission of a reasonable crime was not reported. It appears that everyone is complying with this requirement appropriately.

- 50. While many DQA surveyors are professional and courteous to our staff, some are not. These surveyors create a poisonous environment due to their accusatory comments, eye-rolling, and intimidation tactics. What steps can DQA and the providers take to stop the few from destroying careers and driving good, mission-driven people out of this caring profession? (WRO)***

During the entrance conference, the Team Coordinator should discuss and provide you with a copy of our shared expectations. It should be clear who to contact if you have a concern regarding the behavior or demeanor of a surveyor. We are also going to identify who we should contact to raise similar concerns if a member of your staff is exhibiting obstructive behavior. You can go a long way to ease any anxiety your staff may have when we enter by reinforcing that we are not there to trick anyone or get anyone. We will follow up on all identified areas of concern. If a surveyor is reviewing three falls or more, they will ask similar questions about each fall to evaluate whether staff members were complying with regulatory requirements for each fall. This is part of our job of protecting residents and correctly determining whether a deficient practice has occurred.

- 51. There seems to continue to be inconsistency in citing practices and in the levels of deficiencies cited. Example: Elderly resident eloped 15 minutes on a sunny, warm afternoon in one region and the facility is cited IJ. In another region, in a very similar situation, no IJ is cited. (WRO)***

In an attempt to reduce inconsistencies, we conduct an IJ call. This call is convened and Bureau supervisors, as well as appropriate subject matter experts, discuss the surveyor findings in order to make a determination of Immediate Jeopardy. No determination of IJ is made independently or alone by any region or surveyor. It is possible that in the region where IJ was cited, the Resident suffered a significant injury or may have died in the 15 minutes they were outside. Or, the resident may not have suffered harm at all but was at high risk for serious harm occurring because of the resident's lack of safety awareness or the hazards in the area where the resident could have walked. In the region where IJ was not cited, the Resident may have been found in the company of a staff member, family member, or another visitor; may have had a high degree of safety awareness; or, may not have been in an area where serious hazards existed. The circumstances may be similar on the surface; however, the facts and evidence may be different. We apply the principles of IJ to each individual case and make a decision based on the facts and evidence we have for each situation. It is also possible that we could not identify a deficient practice in the case where there was no citation (facility hadn't done anything wrong) or that the facility had immediately identified the deficient practice and corrected it, so there was past non-compliance.

52. *Why does Wisconsin issue a deficiency when a CNA is abusive and the facility reacts properly and timely by reporting, firing, and testifying in court to obtain a conviction? Similar events in Minnesota do not result in deficiencies. (WRO)*

There are many possible reasons why a situation sometimes results in a citation and why a seemingly similar situation does not. We participate in monthly LTC consistency calls with the other states and CMS in Region 5. The goal is to ensure that not only are we consistent within our state, but that there is also interstate consistency. Without more detailed information I can only guess that a deficiency was cited because the surveyor identified a practice that was not consistent with regulatory requirements and that an adequate plan to prevent further occurrences had not been implemented. CMS has regulatory requirements that are both outcome codes and procedural codes that they expect to be cited when appropriate. The deficient practice may have been procedural.

53. *Although surveyors view some deficiencies given as minor and, perhaps, may be meeting a quota or preserving their job value, do they fully realize the impact this can have on the facilities' insurance rates and insurance contracts, as well as the perception the public can develop at a time when they need to feel comfortable with the care their loved ones receive. Our newspapers summarize our surveys annually and all of the small cites appear as felonies! Is this productive or would a system that was similar to the correction order process be practical? (WRO)*

There is no quota for deficiency citing under which we operate and cite a deficiency or which will ensure job preservation. We must follow the CMS mandated survey process as objectively as we can. In order to cite a deficient practice, we must have evidence to show that the deficient practice occurred. You are encouraged to contact your newspapers and work with them when reporting a deficiency at harm level one or two. We do not have the authority to change the survey process; we must follow the steps required by CMS.

54. *With an ever increasing focus on cost containment and balancing the Wisconsin State Budget, why are 4-7 surveyors deployed on a fairly straightforward, simple complaint? I have worked in a different state and complaint visits typically involve only 1-2 surveyors and the scope is limited to the complaint without an entire sample being pulled. I appreciate the check and balance system we have in place for consumers to have a third-party conduct a complaint visit, but the existing practice seems to be an inefficient use of resources. The results of these complaints have either been unsubstantiated or minor deficiency issued. What is the CMS expectation for a complaint visit and is the NERO going above and beyond with the existing complaint survey practices? (NERO)*

NERO has experienced turnover of survey staff and leadership. The probationary and training period for a new surveyor lasts 12-18 months and concludes with the passing of an exam called the Surveyor Minimum Qualifications Test or SMQT. The observations, interviews, and record reviews must be co-signed by a SMQT'd surveyor to count. DQA is not allowed to directly charge CMS for facility survey tasks until the new staff passes the SMQT. Trainers at times, will accompany new staff. CMS staff also accompany state survey staff as part of our review/inspection process and evaluate if we are following CMS procedures. Ombudsman has also conducted cooperative complaint investigations; we have included observers (NHA student from UWEC in SRO) and, of course, a member of Central Office staff or regional supervision can be present at any given time. It sounds like one or a combination of those factors occurred for the provider.

In terms of meeting CMS expectations for complaint process, the answer is "sometimes." We are reviewed on a regular and ongoing basis for compliance with CMS expectations for the survey process; this includes the reporting of hours for each survey, as well as off-site preparation, problem identification, appropriate sample size, evidence collection (investigatory technique), and deficient practices identified. The largest non-compliance with CMS standards in the last federal fiscal year involved a NERO complaint survey that CMS wanted DQA to cite at an Immediate Jeopardy level and we did not; thus, we received a lower rating for the severity level of the identified deficient practice. That case, in terms of our dialogue with CMS and final measures expected in December, has not been resolved to date. DQA served the SOD at a level below Immediate Jeopardy.

55. How does DQA explain the high number of deficiency-free surveys in the Southeast region as compared to the near non-existence in this region? (NERO)

Surveyors are trained in a consistent manner on the survey process. We also have internal QA practices to ensure that the regulatory process is followed consistently across the state. There are a number of possible explanations why one region has more deficiency free surveys than another region. We plan to look into this to find out why this difference exists and to determine if we need to take corrective action.

56. A statement was made during a survey by one of the surveyors that "there is no such thing as a deficiency-free survey." I do know there are facilities that are issued deficient free surveys and my concern is that there may be different standards on this subject in the different regions. Or, perhaps it was simply incorrect information. (SRO)

There are cite-free surveys; SRO has had two (health team surveys) in the last year or so. It is possible there was a misunderstanding of terminology being used.

57. The relationship between certain DQA staff can be trying at times. With some of the surveyors (not all), it seems as if, no matter what documentation you provide, it is not enough; they conclude that you should have done more or should have known a negative outcome will occur; they pick out an "incident" and they are going to cite it no matter what documentation or explanation you provide. Another issue is the documentation; if it is not documented, then they conclude that it was not done. I believe the standard for citing is that there has to be some type of proof that the care wasn't provided or wasn't provided appropriately, rather than the facility having to prove that the care was delivered appropriately. Is my interpretation correct or incorrect? (NRO)

When an issue is identified by the surveyors, they will routinely ask for any and all documentation related to an incident. If they are still looking for other specific information, such as a physician's order or an updated care plan, they will ask for that as well. If there are concerns with a surveyors' conduct, the Shared Expectations memo, which is provided at the time of entrance, provides you with supervisor contact information.

The expectation of the CMS, the Division, and the Bureau is that surveyors corroborate information that is being gathered through all sources. For instance, a surveyor identifies that a treatment is not documented. Interviews are conducted with the resident, family, and staff who worked those shifts to determine if the treatment had been done or not. The lack of documentation may be cited on its own (complete and accurate medical record, updating the care plan, etc.).

58. Another area that we have concerns about is the use of staff and resident quotes in the Statement of Deficiencies; the staff statements are most generally incorrect and modified to support the deficiency being cited. I believe there are survey guidelines related to using quotations in the SOD; can you tell me exactly what those guidelines are and how do we address that issue when quotations show up in the SOD when the guidelines are not followed? (NRO)

Surveyors document an interview in the Surveyor Notes Worksheets. If the words or phrases are noted exactly as spoken, the surveyor indicates it as such and it is marked as a direct quote in the SOD. The Surveyor Notes Worksheets are considered a legal document. If a quote comes into question with either the regional office, MPRO, or at a hearing, the person receiving the concern will refer to the Surveyor Notes Worksheet to determine how the information is documented and if the quote supports a deficient practice. CMS expects us to include the quote in the SOD.

59. *What is being done in the state to standardize the survey process, to prevent or minimize variation among regions? Same issues in different facilities are not surveyed the same; what oversight is provided to increase consistency? (SERO)*

DQA has a training program that is recognized nationally for its quality. CMS federal monitoring surveys, federal oversight surveys, grid calls, surveyors from different regions have conducted surveys outside of their assigned regions, combined regional survey teams. Supervisors and consultants are on-site during surveys. When a supervisor or consultant identifies something that might be an inconsistency, it has triggered training to be conducted. Consultants and supervisors routinely review survey packets.

Differences can occur during a survey based on where information obtained during a survey leads the surveyor to further investigate. Additionally, what may appear to be similar situations from one facility to another may actually have different conditions (e.g., resident feedback may be different from facility to facility).

60. *If a facility makes a very specific complaint against a surveyor for certain demeaning or accusatory behavior, is it reasonable for the facility to request that the surveyor in question not be assigned to survey that facility in the near future? How should a facility best handle these situations during the survey? (SERO)*

If there are concerns regarding surveyor demeanor, this should be brought to the attention of the surveyor's supervisor. Please reference DQA publication P-00098, *Provider Relationships During the Nursing Home Survey Process* (Rev. 01/2012). Decisions regarding this would be made between the Bureau Director and the RFOD.

61. *There are a few providers in the SE region that give all providers a bad name and, yet, they continue to be open because surveyors often tell us, "Where else will the residents go?" And, your surveyors put excellent homes thru the ringer because "they expect more out of us." Is this fair and equitable treatment? (SERO)*

The survey process is the same for all facilities and it doesn't allow you to expect more or hold certain facilities to a higher standard than others. The survey process is applied to all facilities equally, regardless of their survey history.

62. *David Beyer mentioned that there is a new ventilation code coming for fans above ovens. Any word on what this entails? (SERO)*

Discuss the issue with the surveyor, since the surveyor is familiar with the equipment or specific arrangement.

Assuming this is an oven that is used for cooking applications, most kitchens have the proper ventilation in place. Some facilities have kitchenettes set up around the facility that are used periodically for cooking. Routine cooking without an exhaust fan is most likely what David Beyer is alluding to. Many facilities have these fans, like the ones you'd typically find in your home; the air circulates, yet does not exhaust out through a duct to the building exterior. Two options are to (1) install the exhaust system or (2) change the cooking operations to a location that does have the proper ventilation.

S&C Memo 12-21, just released by CMS, addresses some of the relief being afforded, yet a waiver would be required to allow these configurations.

63. *Does DQA "embrace the use of household kitchens" and a relaxation of the LSC requirements necessary to make this a true home-like experience? (SERO)*

S&C Memo 12-21-LSC, dated 3/9/12. CMS says, if you are cooking for 30 or less and you are cooking grease laden food (bacon, some types of meat), you can get a waiver for these household kitchens and you don't have to prove hardship. DQA does support household kitchens.

64. *Are humidifiers acceptable in a sub-acute rehab facility? If yes, are there special cleaning precautions that are needed? (SERO)*

If you are using humidifiers in resident's rooms, you have to make sure that you have the proper electrical grounding, that you aren't using extension cords (e.g., no trip hazard, not blocking exit door). As far as cleaning, you need to follow the manufacturer's requirements; there is no LSC to cover testing or cleaning of humidifiers.

- 65. On March 9, CMS announced it would provide waivers for certain components of current LSC (furniture in corridors, open kitchens, fireplaces, combustible decorations that are at odds with the 2012 edition). Can someone address the process and substance of these waiver requests? The issue is how do we get plans approved if it needs to be cited as a prerequisite for submitting waiver? It is a big financial risk to invest in new building only to be cited and then have waiver rejected. (WRO)**

CMS, at the request of the LTC industry (PDC, Pioneer, Sage, etc.), was asked to consider and provide physical environment acknowledgement of “culture change” initiatives with the LSC. Current CFR regulations adopt the 2000 edition. CMS S&C Memo 12-21 allows four (4) specific requirements of the 2012 edition of the LSC to be petitioned on a case-by-case basis to permit some culture change initiatives sought after by the LTC industry.

LTC providers are **not** required to use these 2012 LSC provisions; it is purely **optional**. LTC providers can find all of the details regarding the specific 2012 LSC provisions at www.nfpa.org.

Waivers and how they are processed should follow CMS “standard” operating procedures established in the SOM.

DHS understands that a proactive approach to request a waiver during the planning stages is beneficial to all parties involved. DHS asked this question during the CMS RO State Agency call on March 21, 2012. CMS informed DHS that they will not be processing any waiver requests outside of the standard survey recertification process.

DHS can offer, during the state level plan review process, that the issue will be evaluated and a waiver request can be processed. Disclaimer: DHS cannot process this waiver request through CMS channels. Facility will have to wait until sometime in the near future, be cited during their regularly scheduled recertification survey, request a waiver, and process through the standard methods of CMS as identified in the SOM. CMS holds final adjudication and DHS can make no claims or guarantees of approvability by CMS.

CMS is highly aware that a large number of facilities are not fully sprinkler protected at this time. This is a major concern, due to the extensive amount of time to budget, design, plan review, test, and inspect a system. CMS five (5) year window for compliance ends August 13, 2013. CMS denial rate for waivers has increased significantly in the last 12 months and shows no sign of changing in its restrictive nature.

A brief presentation on CMS Memo 12-21 and the four specific provisions is available on the May 24 Wisconsin Healthcare Engineering Association spring conference (Wisconsin Dells) website, for those that might be interested. Information is available at <http://www.whea.com/wheassociation>.

INFECTION CONTROL Q&A

- 1. Related to Quarantines of Nursing Units: If two employees who are not currently working call in with flu symptoms, is it required that the nursing unit be quarantined although no residents present any signs or symptoms of the flu? If the answer is yes, what is the logic for this stance? (SERO)**

According to Public Health, if no residents are ill there is no need for quarantine. Should residents become ill (an outbreak), the quarantine protocol is recommended (restrict admissions etc.) until a week after the onset of the last case.

- 2. Provide status on mandating of flu shots in health care setting. Will this ever be mandated as an industry? (SERO)**

Immunization of healthcare workers has been and continues to be a primary prevention strategy in preventing influenza. Numerous healthcare and professional organizations recommend mandatory influenza immunization of healthcare workers. They include but are not limited to:

- American Academy of Family Physicians (AAFP)
- American College of Physicians (ACP)
- American Hospital Association (AHA)
- American Medical Directors Association (AMDA)

American Pharmacists Association (APhA)
 American Public Health Association (APHA)
 Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)
 Aurora Healthcare
 Infectious Disease Society of America (IDSA)
 National Foundation for Infectious Disease (NFID)
 National Patient Safety Foundation (NPSF)
 Pharmacy Society of Wisconsin
 Society for Healthcare Epidemiology of America (SHEA)
 Wisconsin Medical Directors Association (WAMD)

- 3. Can you provide clarification with regards to the trend with citing F441 related to antimicrobial stewardship and infection criteria? We can monitor all we want and inform the MD that the symptoms do not meet criteria, but are consistently unsuccessful in impacting prescribing patterns of antibiotics and, yet, we are still cited. Is there a document you can share from the AMDA or similar that provides guidance to physicians? Our medical director is reluctant to tell other physicians not to prescribe antibiotics because of the frail nature of the patients we serve, and multiple co-morbidities, an infection can quickly become septic and that is certainly an outcome we'd all like to avoid. (SERO)**

Antimicrobial Stewardship is an essential part of any infection prevention and control program. Facilities should have policies and procedures to guide appropriate use of antimicrobials.

- See the article titled, "Pharmacist-Led Model of Antibiotic Stewardship in a Long-Term Care Facility," in the October 2012 issue of "Annals of Long-Term Care," Volume 20 – Issue 10, located at <http://www.annalsoflongtermcare.com/print/1440>.
- See DQA publication P-00319, "Antimicrobial Stewardship Resource Chart," located at <http://www.dhs.wisconsin.gov/publications/p0/p00319.pdf>. This document articulates the position of numerous professional organizations regarding appropriate use of antibiotics.
- See document titled, "Joint Statement on Antibiotic Resistance from 25 National Health Organizations and the Centers for Disease Control and Prevention," located at http://cddep.org/sites/cddep.org/files/etc_consensus_statement.pdf.
- See the CDC website "Get Smart for Healthcare: Antibiotic Use in Long-term Care Facilities," located at <http://www.cdc.gov/getsmart/healthcare/learn-from-others/factsheets/longterm-care.html>.

- 4. What is viewed as "best practice" by DQA regarding use of antimicrobials and blood glucose monitoring? (SERO)**

The DQA expects providers to select and adopt current standards of practice related to services they provide. Please see the answer to the previous question related to "best practice" for information on current standards of practice.

The CDC recommends the use of individual glucose meters for residents. In the event that glucose meters are shared between residents, they **must** be cleaned and disinfected.

The Wisconsin Healthcare-Associated Infections (HAI) in Long-Term Care Coalition recommends the use of individual glucometers. The Coalition is in the final stages of development of a provider toolkit for individual use of glucose meters.

- 5. If your organization is unable to increase employee influenza vaccination rates to 90% voluntarily, what recommended steps would you suggest be taken? Please speak to the legality of mandating staff. (SERO)**

Many Wisconsin nursing homes have already changed their policies to mandate influenza immunization of their staff. These nursing homes have achieved influenza vaccination rates close to 100% since changing their policy. Nursing homes that don't have mandatory immunization policies are mandating that staff wear a surgical mask while working.

6. *What are the requirements for SNFs for administering the shingles and Tdap vaccines? Is it mandatory that these vaccines are administered or is the SNF only required to provide education to the patient and their family about these vaccines?* (SERO)

There is no regulation that requires nursing homes to administer the shingles and Tdap vaccines. However, the federal infection control regulation requires that a provider's infection prevention and control program be in accordance with current standards of practice.

Each year, the CDC Advisory Committee on Immunization Practices (ACIP) develops recommendations for immunizing adults. These recommendations may be found at the ACIP website located at <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.

Each nursing home's infection preventionist and medical director should review these recommendations and current infection prevention and control standards of practices, be familiar with diseases circulating in their community (Influenza, Pertussis, etc.), and develop facility immunization standards. Residents should be educated regarding ACIP immunization standards, as well as facility immunization standards and where residents may obtain immunizations desired by residents but not offered by the facility.

7. *We have received direction regarding care of residents with Foley catheters; however, we have not received direction on how to care for residents who wish to change between a leg bag (during the day) and a regular bag (at night) every day. How often should we be using a new bag and how often should we be changing their catheters?* (WRO)

DQA is not aware of any evidence-based standard that addresses the care of a leg bag and how often it should be changed.

8. *What is the final ruling on catheter changes? If the doctor orders every 30 days, does he need a reason?* (NERO)

The facility is required by regulation to provide care and treatment consistent with current standards of practice. There is no evidence-based standard that supports routine catheter changes. See "CDC Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009)" that notes:

"Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indicators such as infection, obstruction, or when closed system is compromised."

9. *Do we need a pertussis protocol for staff and residents?* (NRO)

Nursing homes need to be aware of what diseases are circulating in their communities and their infection prevention and control program should follow current standards of practice related to prevention, identification, and control of these diseases. With this being said, Wisconsin has experienced a widespread bout of pertussis. The CDC ACIP recommendations include Td/Tdap immunization for adults.

See "Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis (Tdap) Vaccine in Adults Aged 65 Years and Older," from the Advisory Committee on Immunization Practices (ACIP), 2012.

See the DHS "Pertussis Report, Wisconsin" located at <http://www.dhs.wisconsin.gov/immunization/pdf/pertreport.pdf>.

- 10. During a recent survey while the surveyors were investigating antimicrobial stewardship, a surveyor made the comment that, whether or not the physician provided rationale for treating with an antibiotic without appropriate indications, the facility would still be cited because they were not meeting the standard. We have always been told that if a physician makes a decision to treat based on his/her clinical judgment, it is acceptable as long as rationale is provided. Please clarify. (NRO)**

Nursing homes are required to provide services consistent with current standards of practice. If a treatment is not consistent with current standards of practice, surveyors will look for information that addresses this issue. Surveyors often find the use of antibiotics to treat urinary tract infections in the absence of bacteria. Antibiotics are medications used to treat bacterial infections. In the absence of bacteria, there is not an adequate indication for the use of the antibiotic. The provider's medical director would be expected by regulation to address issues concerning medications being ordered without adequate indication for their use. See DQA publication P-00316, *UTI Resource Chart*.

- 11. If a resident has significant heightened behaviors and, in the past, it was typically a UTI and is the only symptom, what are the alternatives? (SERO)**

Each resident should be comprehensively assessed at the time of the behaviors to determine the cause of the behaviors. Automatically defaulting to a diagnosis of UTI based on one symptom without localizing symptoms would not be appropriate. Providers in collaboration with their medical director and infection preventionist should develop policy and procedures for defining a symptomatic UTI and appropriate treatment of it.

- 12. We need some help with issues related to not changing Foley catheters on a monthly basis. Our residents with Foleys all have them for appropriate reasons and all have a urologist. All the urologists in our community insist on changes each month, despite what regulatory bodies are telling us. We feel that at times we border on getting into medical practice issues. (SERO)**

Institutional policies to routinely change catheters are not appropriate based on current standards of practice. Each resident should be assessed to include input from their physician(s) regarding the necessity of needing a routine catheter change. Facility policies should be consistent with current standards of practice.