There is a New Sheriff in Town and He is Called The LTC Survey Process.

This new way of surveying is going to replace the one that we are all used to here in Missouri and the QIS survey that other states have been using. So everyone all across America will be using the same LTC Survey Process.

CMS has taken the best components out of each type of survey and combined certain features to come up with the new process. The surveyors will now be using computer-based software to complete surveys; each surveyor will now be carrying a tablet. The process includes the Critical Element Pathways, and they will answer yes or no to the questions which will then direct the surveyor as to whether they should investigate further or if the process he or she is looking at is working and the system that you and your facility have in place is good. This type of survey is to make all surveys more uniform and consistent across Missouri and the nation.

The New Survey Process is meant to be more resident-centered. Surveyors will be interviewing your residents independently, but also in a Resident Council Meeting to see how things are going for your residents. Questions like: Do you know how to file a grievance? Have staff made you feel afraid, humiliated, or degraded? Do you receive snacks at bedtime or when you request them?

Check out the Critical Element Pathway on Resident Council Meetings; if you are not currently having a monthly Resident Council Meeting – why not? This would be a great QAPI Project! If you need help with Resident Council or QAPI just give us a call. We are glad to help.

For the CMS Pathways and other very helpful tools go to - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
There has been a lot of confusion swirling around in regards to discharges from nursing homes and when do we notify the Ombudsmen Office. I am hoping we can set the record straight with assistance I received from Shelley Williamson, Administrator, Section for Long-Term Care Regulation, Department of Health and Senior Services.

On May 12, 2017, CMS sent out a Survey and Cert Notice: 17-27-NY. It can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-27.pdf. The notice included Implantation Issues, Long-Term Care Regulatory Changes: Substandard Quality of care (SQC) and Clarification of Notice before Transfer or Discharge. The following speaks to the Notice of Transfer or Discharge.

**Notice of Transfer or Discharge**

The regulation at 42 CFR 483.15(c)(3)(i) requires, in part, that before a facility transfers or discharges a resident, the facility must “notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand….” The facility must also “…send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.” Sending a copy of the notice to a representative of the Office of the State Long-Term Care (LTC) Ombudsman provides added protection to residents and ensures the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. Specific requirements for transfers and discharges are outlined below:

**A. Facility-Initiated Transfers and Discharges**

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the ombudsman only needed to occur as soon as practicable as described below.

*continued on page 3*
For any other types of facility-initiated discharges, the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the Office of the State LTC Ombudsman at least 30 days prior to the discharge or as soon as possible. The copy of the notice to the ombudsman must be sent at the same time notice is provided to the resident and resident representative.

**Emergency Transfers**

When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.

**B. Resident-Initiated Transfers and Discharges**

A resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. The medical record must contain documentation or evidence of the resident’s or resident representative’s verbal or written notice of intent to leave the facility. A resident’s expression of a general desire or goal to return home or to the community or elopement of a resident who is cognitively impaired should not be taken as notice of intent to leave the facility. For resident-initiated transfers or discharges, sending a copy of the notice to the ombudsman is not required.

Additional information can be found at the CMS website: [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html)
For a nurse, I've never liked medicine. I've given enough of it and while it does have a place in medical therapy, I prefer the short-term kind. I'm not putting anyone down who truly needs pharmacological assistance. I just feel there's something to be said for the mind-body connection subscribed in Eastern medicine. I also like Florence Nightingale’s philosophies - good hygiene, cleanliness, healthy diet, sanitary water, exercise, kindness, and sunshine. My friend and fellow nurse, Hattie, also feels this way and told me she used to promote it tirelessly! Imagine my shock the other day when Hattie, who had been a community nurse in Cairo, IL for many years, recalled a story about a patient she had (we'll call him Bill), who despite clean water, hard physical labor on the river, and plenty of ☀ sunshine, absolutely could not live without his Viagra!

In the early 1990s, Hattie followed her physician from town to town, serving multiple small clinics in southern IL, when a new drug was brought onto the market. Originally developed by Pfizer to relieve CHEST PAIN, it was shown in the clinical trials of several English gentleman to reduce chest pain by dilating the blood vessels near the heart, but as a side effect, it was also dilating blood vessels in other parts of the body! I can only imagine being a nurse on that floor! Thus, rather than introducing another blood pressure pill onto an already saturated market, the wise ad executives at Pfizer opted to create Viagra. Thus, the little blue pill was born! No longer would strapping, testosterone-waning men suffer the embarrassment of erectile dysfunction right at that inopportune moment. Instead, they could simply pop a Viagra and P O Q F! Their manhood was instantly restored!

According to Hattie, Bill was a regular at the clinic, always coming by for some little thing or another. However, she began noticing that every time Bill left, he was prescribed medicine or given samples from the doctor that didn’t really match up to his supposed ailment. Dr. Brown, while honest and thorough, still believed in discretion, and did not mention this side issue to his nurse. But one day, Hattie asked, “What is wrong with him that he has to see you every time we’re in town?” And Dr. Brown, being in his late 60s, appreciative of his good nurse, and a little embarrassed, blushed and explained the situation. Hattie had a good laugh but she told me that it got her thinking. As far as she knew, Bill had never married and with his clean overalls, shy shuffles, and patient manners, she didn’t see him paying for the privileges of the number of companions it would take to go through that much Viagra.

This situation went on for some time with Bill coming in for a cough or a tummy ache and leaving with his supply and no one pretending the be the wiser. Until one day, while overwhelmed with sick patients, Bill shuffled to door and asked if he could see Dr. Brown about an infected toe he had festering. Dr. Brown looked at Bill and asked him which toe it was. Bill replied, “Uh, it’s my right toe!” and promptly stuck out his left foot, smiling ear to ear. Dr. Brown grinned and Hattie met Bill around back.

They say it’s always the quiet ones that fool you, Hattie recounted, but I imagine there were quite a few men in Cairo that summer who had a good time without ever saying a word! I thought about checking the census but maybe Florence Nightingale had it right...

**MAYBE I SHOULD JUST CHECK THE WEATHER INSTEAD!!**
### Medication Management System: Are YOU Ready?

**Katy Nguyen, MSN, RN ♦ QIPMO Clinical Educator**

Regulation 483.45 for pharmacy services addresses safe medication management for the long-term care industry. According to the new revision of appendix PP of State Operations Manual (SOM) that will be effected on November 28th, 2017, there are many components of the medication system that are required for to be **compliant** for survey. Below is summary for the regulatory requirements and to help in an audit system to address the pharmacy system. An audit system includes the staff performance from observation and the policies and procedures that meet the best practices and clinical standardization.

*References: Advanced-Appendix PP (phase 2), CMS: CE pathway, 2017*

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
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<tr>
<td><strong>F755</strong> Pharmacy System/Procedures/Pharmacist/Records</td>
<td>The facility must provide routine and emergency drugs and biologicals to its residents and have a licensed pharmacist. The policies and procedures to assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals. Establishes a system of records of receipt and disposition of all controlled drugs that is maintained and periodically reconciled. Demonstrates use of written protocols or resources to guide antibiotic use.</td>
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<td><strong>F756</strong> Drug Regimen Review, Report Irregular, Act On</td>
<td>A licensed pharmacist must review Drug Regimen Review at least once a month (and PRN) and report any irregularities to the attending physician. The facility must develop and maintain policies and procedures for the monthly drug regimen review.</td>
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<td><strong>F757</strong> Drug Regimen is Free From Unnecessary Drugs</td>
<td>Policy and procedure for adequate monitoring for excessive dose; excessive duration; indications for its use; adverse consequences; reduced or discontinued and any combinations of the reasons. Did the facility ensure that each resident's medication regimen was free from unnecessary medications? (Note: If the unnecessary medication is a psychotropic medication).</td>
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| **F758** Free From Unnecessary Psychotropic Meds/PRN Use | For **Psychotropic Medications**, did the facility ensure that:  
- they are used only to treat a specific, diagnosed, and documented condition;  
- a gradual dose reductions (GDR) was attempted, unless clinically contraindicated, and non-pharmacological approaches to care were implemented;  
- PRN use is only if necessary to treat a specific, diagnosed, and documented condition;  
- PRN orders for psychotropic medications which are not for antipsychotic medications are limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication;  
- PRN orders which are for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner did not renew the order without first evaluating the resident? |
| **F759** Free of Medication Error Rates of 5% or More | Observation and calculation for Significant and Non-Significant Medication Errors:  
*Medication Error Rate = Number of Errors Observed divided by the Oppotunities for Errors (doses given plus doses ordered but not given) X 100.* |
| **F760** Residents Are Free of Significant Med Errors | Medication Errors: Examples:  
- Omissions, Unauthorized Medication, Wrong Dose, Wrong Route of Administration, Wrong Dosage Form, Wrong Medication, Wrong Time; Failure to “Shake Well” or Mix a Suspension, Crushing Medications (manufacturer instructs to “do not crush”), wrong techniques for eye drop, ear drop, inhaler; wrong Medication Preparation |
| **F761** Label/Store Drugs and Biologicals | System for Access to medications, Storage of Drugs and Biologicals; drug label and expiration dates; Store all drugs and biologicals in locked compartments (schedule II-V medications); Store medications at proper temperatures |
When a new resident is admitted to a home, staff complete an interim care plan, immediate plan of care, or admission care plan. CMS has “termed” these types of plan of cares as **Baseline Care Plans**.

Regulation §483.21 Baseline Care Plans involves several areas to be covered in the baseline care plan: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendation, if applicable. The baseline care plan must contain minimum healthcare information necessary to properly care for each resident and must meet professional standards of quality care.

Regulations do not give details of what is to be contained in the orders and services. However, the homes may consider some of the following areas to be included in the Baseline Care Plan:

- Resident’s initial goals: long or short-term placement, D/C plan
- Resident’s most important personal preference
- Basic and special needs such as IV, TF, wounds, trach, oxygen, peg tube, ostomies, pacemaker
- High-risk medications such as insulin, psychotropic/antipsychotics, or anticoagulants
- Social service areas such as cognitive/communication ability, behavior/psycho-social concerns
- Code status
- Dietary services such as diet and consistency
- PT/OT/SLP, respiratory therapy, hospice, dialysis
- Risks for falls, skin, elopement, infection
- Functional status-ADL’s
- Significant labs, blood sugar, PT/INR
- Significant Disease/Illness Management

Emphases of the Baseline Care Plan is to provide effective, **PERSON-CENTERED CARE** of the resident and preserve resident rights.

Regulation §483.21 Baseline Care Plans does allow the home to use a comprehensive care plan in place of the baseline care plan if they chose to do so. For instance, using the comprehensive care plan (that was already completed) on a resident that returns from the hospital with only minor changes. However, this does not override the RAI process. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable. This must be in a **LANGUAGE** that the resident and/or representative understands.

The Baseline Care Plan Summary must be provided to the resident and their representative (if applicable). This **summary** includes the initial goals of the resident, a summary of the resident’s medications and dietary instructions, and services and treatments to be administered by the facility (or personnel acting on behalf of the facility). Include any updated information based on the details of the comprehensive care plan, as necessary.

The Baseline care plan summary must be in a language that the resident and/or representative can understand. The format and location of the summary is at the facility's discretion. The medical record must contain evidence that the summary was given to the resident and/or representative. If the comprehensive care plan identifies a **CHANGE** in the resident’s goal, physical, mental or psychosocial functioning, which were not identified in the baseline care plan, the resident and/or representative, must be given an updated summary. Once the comprehensive care plan has been developed and implemented, the expectation is that the resident and/or representative would be actively involved in the care planning process.

*SOM Appendix PP for Phase 2, F-Tags Revisions, and Related Issues. F655 §483.21(a) Comprehensive Person-Centered Care Planning information pages 201-205*
The resident has the right to request treatment; however, the home and staff are not required to provide the medical treatment if the requested treatment or services are medically unnecessary or inappropriate. On the other hand, resident have the right to refuse any treatment or services, but this does not release the home from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. The home is still expected to provide appropriate measures for pressure injury prevention, even if a resident has refused food and fluids and is nearing death.

If a resident (directly or through an advance directive) declines treatment (such as refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his or her wishes. If a resident is unable to make a health care decision, a decision by the resident’s legal representative to forego treatment may, subject to State requirements, be equally binding on the home. A home may not transfer a resident for refusing treatment unless all other criteria for transfer or discharge are met.

The home’s staff need to attempt to determine the reason for the refusal of care, including a resident who is unable to verbalize their needs and address the concern, if possible. Any services that are used in good quality of care and that are being refused need to be put in the comprehensive care plan. See F656, Comprehensive Care Plans, for further guidance.

GUIDANCE §483.10(c)(6), (c)(8), (g)(12)
Sleep Deprivation: the number one risk elders face in traditional Long-Term Care.

PROJECT TITLE: Restorative Sleep Vitality Program (RSVP)

Missouri Coalition Celebrating Care Continuum Change (MC5) in partnership with Missouri Department of Health and Senior Services and Empira are looking for 30 LTC Communities to participate in a restorative sleep project.

PROJECT GOAL: Support resident health and well-being by:
- Helping elders have a more restful and refreshing sleep throughout the night
- Providing more active engagement during the day to promote better sleep.

Requirements for participation:
- Remain active in the RSVP program from 2018 through 2019
- Licensed Skilled Nursing Home in Missouri and in good standing with DHSS
- Develop and track 5 interventions to reduce sleep disturbances at night
- Develop and track 3 interventions to keep residents awake and engaged during the day
- Participate in at least 3 full-day educational sessions at an off-site location
- Assign a RSVP team leader who will:
  - Provide Monthly Facility Level Casper Reports
  - Establish a QAPI program with RSVP as a PIP
  - Utilize the PDSA method with QI techniques
  - Provide turnover rates within the QAPI team monthly
  - Provide the number and quality of PDSA cycles completed or attempted goals monthly
  - Provide any change in Administrator or Director of Nursing.
  - Submit all requested data or reports to support efforts timely.
  - Report any barriers, problems, or concerns to the Collaborative Coach.

(Participation is voluntary and there is no compensation.)

Collaborative Project Coach- Dave Walker  Collaborative Project Coordinator- Alexis Roam

Application deadline is January 15, 2018

Applications can be found at www.momc5.com or contact Dave Walker at walkerdavi@missouri.edu

APPLY NOW  APPLY NOW  APPLY NOW