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Recent Trends in Immediate Jeopardy Citations

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Today's Topics

- IJ Regulations
- Citation trends
- Meeting Compliance
- Education and Tools

Immediate Jeopardy Regulations

- Survey and certification of Long-Term Care Facilities (Skilled Nursing Facility (SNF), Nursing Facility (NF), and/or dually certified SNF/NF) - §488.301 Immediate Jeopardy means 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.*

- Standards for Payments to Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) and Nursing Facility (NF) - §442.2 Immediate Jeopardy means a situation in which immediate corrective action is necessary because the provider's *noncompliance* with one or more requirements of participation or conditions of participation *has caused, or is likely to cause, serious injury, harm, impairment, or death to an individual* receiving care in a facility.

QCOR

Deficiency Count Report

Region	Deficiencies by Scope & Severity											
	B	C	D	E	F	G	H	I	J	K	L	Total
(I) Boston	0	0	0	0	0	0	0	0	12	5	2	19
(II) New York	0	0	0	0	0	0	0	0	4	5	12	21
(III) Philadelphia	0	0	0	0	0	0	0	0	13	12	5	30
(IV) Atlanta	0	0	0	0	0	0	0	0	250	103	31	384
(V) Chicago	0	0	0	0	0	0	0	6	194	78	145	423
(VI) Dallas	0	0	0	0	0	0	0	0	110	117	20	247
(VII) Kansas City	0	0	0	0	0	0	0	0	77	31	19	127
(VIII) Denver	0	0	0	0	0	0	0	0	14	15	19	48
(IX) San Francisco	0	0	0	0	0	0	0	3	19	50	42	114
(X) Seattle	0	0	0	0	0	0	0	6	14	11	34	65
National Total	0	0	0	0	0	0	0	15	707	427	329	1,478

	I	J	K	L	
(VII) Kansas City	77	31	19	3,749	
Iowa	24	12	2	1,115	
Kansas	35	8	14	925	
Missouri	19	10	2	1,209	
Region 1 Nh (1NH)	1	0	1	127	
Region 2 Nh (2NH)	0	0	0	165	
Region 3 Nh (3NH)	4	0	0	173	
Region 4 Nh (4NH)	0	2	1	142	
Region 5 Nh (5NH)	3	2	0	196	
Region 6 Nh (6NH)	1	3	0	115	
Region 7 Nh (7NH)	5	3	0	331	
Nebraska	0	1	1	550	

CITATION TRENDS

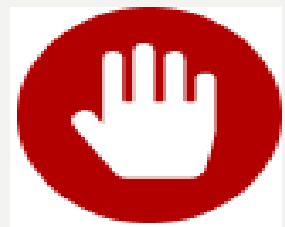
- ABUSE AND NEGLECT
- ACCIDENTS/SUPERVISION
- CPR
- INFECTION CONTROL
- QUALITY OF CARE
- PRESSURE ULCER/INJURY

Top 10 Citations in Missouri

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Missouri Active Providers=521		Total Number of Surveys=2075
F0884	Reporting - National Health Safety Network	288	18.4%	13.9%
F0880	Infection Prevention & Control	99	15.7%	4.8%
F0689	Free of Accident Hazards/Supervision/Devices	45	6.9%	2.2%
F0658	Services Provided Meet Professional Standards	43	6.3%	2.1%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	38	6.9%	1.8%
F0684	Quality of Care	38	6.0%	1.8%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	30	4.4%	1.4%
F0677	ADL Care Provided for Dependent Residents	25	3.8%	1.2%
F0610	Investigate/Prevent/Correct Alleged Violation	24	3.6%	1.2%
F0761	Label/Store Drugs and Biologicals	24	4.6%	1.2%

F 600
Abuse and Neglect

- Facility *failed* to ensure resident was free from physical abuse when staff *failed* to respond appropriately to resident's behavior
- Staff *failed* to be in control of their own behavior striking a resident with a cane and falling to the floor with the resident
- Facility *failed* to report to law enforcement entities a physical assault of one resident by an employee of the facility

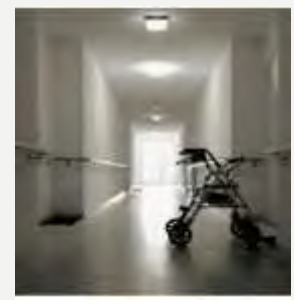


Abuse and Neglect

- Facility *failed* to ensure resident was free from neglect when staff *failed* to appropriately assess and respond to resident with recent heart attack and stents
- Facility staff *failed* to notify the physician and paramedics of the resident's ongoing complaints of chest pain
- Resident with elevated blood pressure and pulse. Transported to hospital

F689 Accidents/Supervision: Falls and Elopement

- Facility *failed* to consistently implement and modify interventions as necessary, in accordance with current standards of practice, to prevent falls for 2 residents
- Facility *failed* to ensure safety interventions in use, including bed alarms, functioned properly
- Facility *failed* to provide adequate supervision to decrease risk of a resident with impaired decision-making skills and impaired judgement from leaving the premises unsupervised
- Facility *failed* to recognize resident missing for over 8 hours



F678 CPR

- Facility *failed* to provide basic life support, including CPR for one resident related to physician orders
- Resident found unresponsive by CNA who reported to nurse
- Nurse *failed* to check the medical record for the resident's code status, initiate CPR or call 911
- The facility *failed* to follow the resident's full code order and wishes

F880 Infection Control

- Facility *failed* to maintain an infection control program during the Covid-19 pandemic to provide a safe environment for residents
- Facility *failed* to prevent cohorting of residents testing positive with residents who tested negative for the Covid virus, resulting in a resident previously testing negative now testing positive

F884 Quality of Care: Medication Error

- Facility *failed* to ensure one resident was free from a significant medication error
- Staff *failed* to update the resident's medical record with a noted medication allergy to an IV antibiotic from the hospital discharge records

Quality of Care: Promote Physical Well-Being

- The facility *failed* to provide services to promote the highest practicable physical well-being for one resident
- The facility *failed* to monitor the resident after a choking incident
- The facility *failed* to properly administer the Heimlich maneuver or call 911 after the resident became unresponsive

F686 Pressure Ulcer/Injury

- The facility *failed* to routinely assess one resident's skin under a specialized hard brace used to stabilize an upper arm fracture causing a Stage 4 pressure ulcer to the upper arm
- Facility staff *failed* to notify the resident's physician for 2 days after the PU was identified to obtain treatment orders
- Facility staff *failed* to keep the resident's air mattress set at the recommended setting, causing the mattress to be too firm
- Facility *failed* to notify the physician when another resident's unstageable coccyx wound deteriorated and obtain a dietary consult
- Facility *failed* to accurately stage and perform complete assessments for multiple PU/PI, *failed* to accurately classify a wound as a PI

Meeting Compliance

RULES AND REGS

POLICIES AND PROCEDURES

These tags include:

- Resident's right to be free from Abuse, Neglect, Misappropriation of Funds, Exploitation, Involuntary Seclusion, Physical/Chemical Restraints
- Hiring guidelines
- Development of Policies
- Reporting
- Investigation/Prevention

§483.12 FREEDOM FROM ABUSE, NEGLECT AND EXPLOITATION

10 F tags under this heading, all have the potential designation of "**Substandard Care**" if a deficiency is cited with a scope/severity of F, H, I, J, K or L.

CMS DEFINITION OF ABUSE AND NEGLECT

- DEFINITIONS §483.12(a)(1) "**Abuse,**" is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the *deprivation* by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

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

- Written policies must include:
- Screening: EDL, Criminal background check, license/certification checks, Resident screening to evaluate facility ability to provide care and services
- Training: new/existing staff, prohibit/prevent, identify/recognize, reporting of abuse, understand behavioral symptoms that may increase risk for abuse
  - Aggressive and/or catastrophic reactions of resident
  - Wandering or elopement-type behaviors
  - Resistance to care
  - Outbursts or yelling out
  - Difficulty in adjusting to new routines or staff

F607 DEVELOP & IMPLEMENT ABUSE, NEGLECT, ETC. POLICIES

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1-4)

- Prohibit and prevent
- Establish policies and procedures to investigate allegations
- Include required training
- Establish coordination with QAPI program

ABUSE WRITTEN POLICIES CONTINUED

- Prevention
  - Establishing a safe environment
  - Identifying, correcting and intervening in situations in which abuse, neglect, etc. may occur
  - Ensuring structure/services in place to care for resident population
  - Identification, assessment, care planning with monitoring and interventions for residents with behaviors and needs which may lead to conflict:
    - Verbally, physically, sexually aggressive behavior
    - Taking, touching, rummaging through other's property
    - Wandering into other's room/space
    - H/O self-injurious behaviors
    - Communication disorders or who speak a different language
    - Require extensive nursing care and/or are totally dependent on staff for the provision of care

Abuse Written Policies continued

- Identification: identifying different types of abuse
  - Suspicious injury
  - Sudden unexplained behaviors-fearful of person or activity
- Protection:
  - Safety of resident(s)
  - Physical exam, if applicable
  - Supervision of resident(s)
  - Prevent retaliation-resident
  - Support of resident, staff, etc.
- Investigation
  - Who to report: charge nurse, supervisor, DON/ADON, Administrator
  - Documentation of investigation

Abuse Written Policies continued

- Reporting/response:
  - Timeframe
  - Law enforcement entities, DHSS, ombudsman
  - Retaliation prevention-reporter (staff, visitor, family, etc.)
  - Reporting to licensing agencies: CNA registry, State Board of Nursing, EDL, Board of Nursing Home Administrators, etc.
  - Analysis of situation
  - Revision of policies and procedures
  - Future staff education

Falls and Elopement

- **F689 Free of Accidents Hazards/Supervision/Devices**
- §483.25(d)(2) Each resident receives adequate supervision and assistive devices to prevent accidents.
- INTENT: §483.25(d) The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
  - Identifying hazard(s) and risk(s);
  - Evaluating and analyzing hazard(s) and risk(s);
  - Implementing interventions to reduce hazard(s) and risk(s); and
  - Monitoring for effectiveness and modifying interventions when necessary.

Systems Approach to Fall Prevention

- Identify and address risks, including the potential for accidents, consideration of the environment, resident's risk factors, and the need for supervision, care, and assistive devices
- Allow for communication of information about observed hazards, identify resident-specific information, develop and implement an individualized care plan based on the Resident Assessment Instrument (RAI) to address each resident's needs and goals, and to monitor the results of the planned interventions.
- The care plan should strive to balance the resident's wishes with the potential impact on other residents.
- Facility systems should include data monitoring of care process that potentially lead to accidents

Monitoring and Modifications

- Monitoring is the process of evaluating the effectiveness of care plan interventions.
- Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.
- Monitoring and modification processes include:
  - Ensuring that interventions are implemented correctly and consistently;
  - Evaluating the effectiveness of interventions;
  - Modifying or replacing interventions as needed and
  - Evaluating the effectiveness of new interventions.

Elopement

- Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.
- A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.
- While wander, door, or building alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision, and require scheduled maintenance and testing to ensure proper functioning.

Elopement

- Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision.
- In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement.
- Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

483.24 Quality of Life

- **F678 Cardio-Pulmonary Resuscitation (CPR)**
- §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
- GUIDANCE §483.24(a)(3)…." facilities must ensure that properly trained personnel (and certified in CPR for Healthcare Providers) are available immediately (24 hours per day) to provide basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring emergency care prior to the arrival of emergency medical personnel, and subject to accepted professional guidelines, the resident's advance directives, and physician orders.

CPR Policies and Procedures

- Facilities must have systems in place supported by policies and procedures to ensure there are an adequate number of staff present at all times who are properly trained and/or certified in CPR for Healthcare Providers to be able to provide CPR until emergency medical services arrives.
- Facility policies should address the provision of basic life support and CPR, including:
  - Directing staff to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and:
  - Who have requested CPR in their advance directives, or
  - Who have not formulated an advance directive or,
  - Who do not have a valid DNR order
  - Ensuring staff receive certification in performance of CPR (CPR for Healthcare Providers)
- Facility policy should also address how resident preferences and physician orders related to CPR and other advance directive issues are communicated throughout the facility so that staff know immediately what action to take or not take when an emergency arises

483.80 Infection Control

- **F880 Infection Prevention & Control**
- The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
- §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
- §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards

483.80 Infection Control

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

Infection Control Policies and Procedures

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

Cohorting of residents

- Cohorting refers to the grouping of individuals with the same condition in the same location (e.g. room, wing or building).
- The term cohorting refers to keeping residents who are COVID-19 positive or are suspected to have COVID-19 in the same space (wing, floor, etc.) that is separate from those who are COVID-19 negative or do not have exposure to COVID-19.
- The goal of cohorting is to minimize interaction of infectious individuals from non-infected individuals as much as possible. Every interaction is a risk because it is how the COVID-19 virus spreads.

F684 Quality of Care: Medication Error

- § 483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
- INTENT: To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

Nursing Assessment

An assessment is required for the planning and provision of quality resident-centered care. A comprehensive **Admission/Readmission assessment** includes:

- resident history: reason for current admission, current illness/injury, relevant past history
- general appearance
- physical examination including a skin assessment
- vital signs, O2 saturation, height and weight
- **allergies and reactions**
- immunizations
- implants: pacemaker/ICD, joint replacement(s), stents
- social and family history

Definition: Well-being

- "Highest practicable physical, mental, and psychosocial well-being" is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident *assessment* and by recognizing and competently and thoroughly *addressing the physical*, mental or psychosocial *needs* of the individual

F686 Treatment/Services to Prevent/Heal Pressure Ulcers/Injury

The facility must ensure that:

- A resident receives care consistent care with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
- A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent ulcers from developing

Systems for Compliance

- Facility systems should include protocols that outline frequency of assessments, daily monitoring and periodic documentation of measurements and terminology. The amount of observation may vary depending on the type of dressing used and the manufacturers' guidelines for replacement.
- When a pressure injury is present, daily monitoring with accompanying documentation and/or when a complication/change is identified should include:
  - An evaluation of the ulcer, if no dressing is present
  - An evaluation of the dressing status, (intact, drainage present if any, is/is not leaking)
  - The status of the surrounding area (peri wound) that can be observed without removing the dressing
  - The presence of possible complications, (signs of increasing ulceration or soft tissue infection: redness, or swelling, increased drainage)
  - Whether pain is adequately controlled, if present

Comprehensive Skin Assessment

- As part of the physical examination a comprehensive skin assessment needs to be completed. This process requires a head to toe examination with viewing and touching of the skin with an emphasis on bony prominences (sacrum, ischial tuberosity, greater trochanters and heels) and skin folds, between fingers and toes and under/around medical devices for skin integrity (G tube site, wound vac, IV lines).
- This assessment should be completed on a regular basis to identify early signs of skin breakdown. It is important to identify the *cause* of the wound, not what is keeping it from healing.
- The goal of the comprehensive skin assessment is to identify those residents at risk for skin issues, develop a plan of care putting in place preventative measures and/or treat those residents with current skin conditions.

Skin Assessment Best Practice

- The skin assessment should be performed as soon as possible with the initial admission assessment. Skin issues can develop quickly and you don't want to take credit for someone else's issue.
- A **Braden** Scale (or similar tool) is used to predict the **level of risk** for the development of skin breakdown.

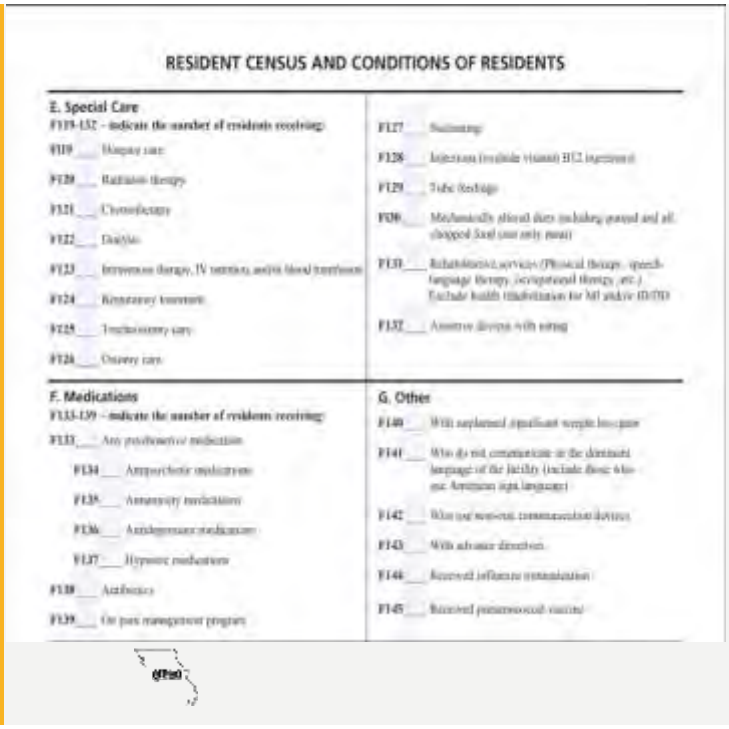
  Current standard of practice is completion upon admission, weekly x 4, quarterly with the MDS assessment and with a significant change in condition. Resident(s) with current skin issues should have a weekly assessment of his/her skin condition by the charge nurse or wound/treatment nurse.
- Any time a resident discharges from your building a skin assessment should be completed: discharge to ED/hospital, another nursing facility or discharge to home.
- Each time the resident is repositioned is an opportunity to perform a brief skin assessment

EDUCATION AND TOOLS

TRAINING
COMPETENCIES
QAPI
TOOLS

TRAINING TOPICS

- Communication – effective communications for direct care staff
- Resident's rights and facility responsibilities – ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents
- **Abuse**, **neglect**, and exploitation – training that at a minimum educates staff on—(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention.
- **Infection control** – a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program
- Culture change (that is, person-centered and person-directed care)
- Care of the cognitively impaired for CNAs
- Identification of **resident changes in condition**, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life



RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 ___ Hospice care

F120 ___ Radiation therapy

F121 ___ Chemotherapy

F122 ___ Dialysis

F123 ___ Intravenous therapy, IV nutrition, and/or blood transfusion

F124 ___ Respiratory treatment

F125 ___ Tracheostomy care

F126 ___ Ostomy care

F127 ___ Suctioning

F128 ___ Injections (excluding vitamin B12 injections)

F129 ___ Tube feedings

F130 ___ Mechanically altered diets (including pureed and all chopped food only meals)

F131 ___ Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health risk evaluation for MI and/or ID/DD

F132 ___ Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 ___ Any psychoactive medication

F134 ___ Antipsychotic medications

F135 ___ Antianxiety medications

F136 ___ Antidepressant medications

F137 ___ Hypnotic medications

F138 ___ Antibiotics

F139 ___ On pain management program

G. Other

F140 ___ With unplanned significant weight loss/gain

F141 ___ Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 ___ Who use non-oral communication devices

F143 ___ With advance directives

F144 ___ Received influenza immunization

F145 ___ Received pneumococcal vaccine

CMS 672
PAGE 2

Review your Facility Assessment Resident Profile and Services and Care or CMS 672 Resident Census and Conditions to assist with identification of training topics

STAFF COMPETENCIES

*Staff competency and care area requirements as identified in the Resident Population Assessment:	
Catheter Care	Intravenous therapy, IV nutrition, medication adminsitration and/or blood transfusion
Incontinence/Toileting Program	Respiratory treatment
End of Life Care	Tracheostomy care
Dementia Care	Behavioral Healthcare (Including PTSD and Trauma History)
Ostomy care	Gastronomy Tube Care/Use
**Restorative Nursing: Dressing, Grooming, and Bathing	Pain Management
Pressure ulcer prevention and treatment	Infection Control
Fall Risk Identification	Communication and interpersonal needs
Technical Skills	Safety and emergency procedures
*Staff competency and care area requirements as identified in the Resident Population Assessment:	
Assessing Nutritional Needs	
Meeting the needs of individuals with MI/ID/DD	

Staff Competencies and Annual Training Requirements

Staff competencies and annual training requirements per regulatory authority and/or facility policy:

Abuse, Neglect, Exploitation, and Misappropriation
Advance Directives
Behavioral Health
Communication
Compliance and Ethics
CPR
Dementia Care Management
Equipment and assistive device training
Infection Control
Other areas identified as areas of weakness during annual performance review/competency evaluation
Promoting resident's independence
Quality Assurance and Performance Improvement
Resident Rights including confidentiality of resident information, right to dignity, privacy, and property.
Safety and emergency procedures, including the Heimlich Maneuver
Job responsibilities and lines of authority
Emergency Preparedness
Facility policies and procedures

Competency Examples

- Disaster planning and procedures - active shooter, **elopement**, fire, flood, power outage, tornado
- **Infection control-** hand hygiene, isolation, standard universal precautions including use of personal protective equipment, MRSA/VRE/CDI precautions, environmental cleaning
- **Medication administration** – injectable, oral, subcutaneous, topical
- Resident assessment and examinations - admission assessment, **skin assessment, pressure injury assessment**, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment
- Specialized care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, trach care/suctioning, ventilator care, tube feedings, **wound care/dressings**, dialysis care
- Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, and implementing non-pharmacological interventions

483.75 Quality Assurance and Performance Improvement

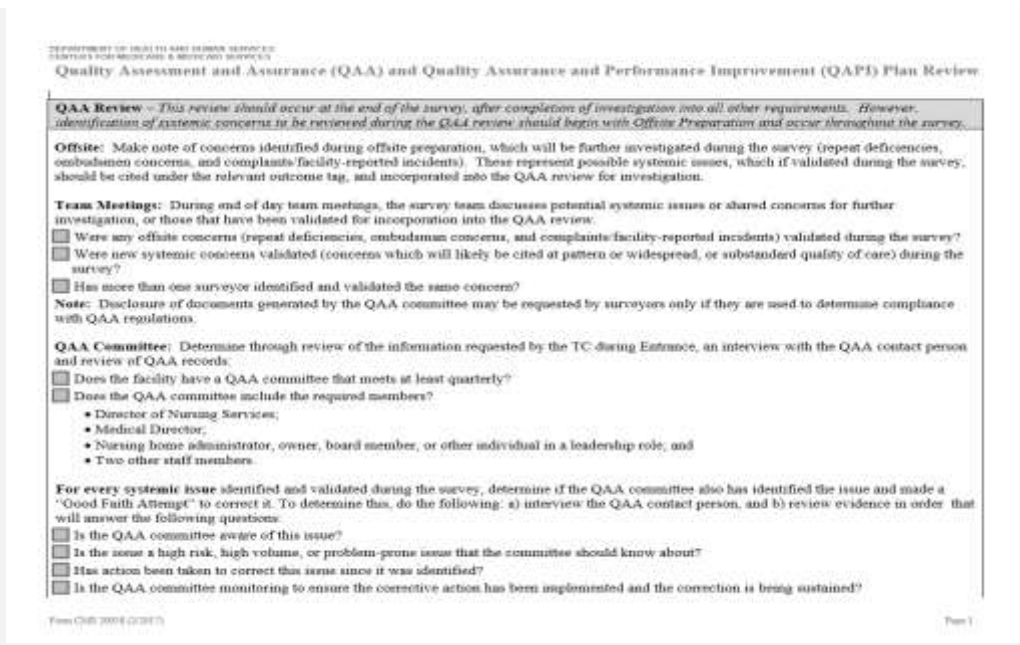
- §483.75(c) QAPI Program feedback, data systems, and monitoring. The policies and procedures must include, at a minimum, the following: … (2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.
-
- §483.75(e) QAPI Program activities …. (3) … The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).

QAPI

- §483.75(e) Program activities (PIP-Element 4).
- The facility must set priorities for its performance improvement activities that focus on *high-risk, high-volume, or problem-prone areas*;
- Performance improvement activities must ***track*** medical errors and adverse resident events, ***analyze*** their causes, and ***implement*** preventive actions and mechanisms that include feedback and learning throughout the facility.
- The facility must conduct distinct ***performance improvement projects (PIP)***. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required. Improvement projects ***must include*** at least annually a project that ***focuses*** on ***high risk*** or ***problem-prone*** areas.

Other Areas QAPI Related

- F607-Abuse
  - §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.
- F801-Food and Nutrition Staff
  - Participating in the quality assurance and performance improvement (QAPI), as described in §483.75, when food and nutrition services are involved
- F944-Training Requirements
  - §483.95(d) Quality assurance and performance improvement.
  - A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.



Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review

QAA Review – *This review should occur at the end of the survey, after completion of investigation into all other requirements. However, identification of systemic concerns to be reviewed during the QAA review should begin with Offsite Preparation and occur throughout the survey.*

Offsite: Make note of concerns identified during offsite preparation, which will be further investigated during the survey (repeat deficiencies, ombudsmen concerns, and complaints/facility-reported incidents). These represent possible systemic issues, which if validated during the survey, should be cited under the relevant outcome tag, and incorporated into the QAA review for investigation.

Team Meetings: During end of day team meetings, the survey team discusses potential systemic issues or shared concerns for further investigation, or those that have been validated for incorporation into the QAA review.

- ☐ Were any offsite concerns (repeat deficiencies, ombudsman concerns, and complaints/facility-reported incidents) validated during the survey?
- ☐ Were new systemic concerns validated (concerns which will likely be cited at pattern or widespread, or substandard quality of care) during the survey?
- ☐ Has more than one surveyor identified and validated the same concern?

Note: Disclosure of documents generated by the QAA committee may be requested by surveyors only if they are used to determine compliance with QAA regulations.

QAA Committee: Determine through review of the information requested by the TC during Entrance, an interview with the QAA contact person and review of QAA records:

- ☐ Does the facility have a QAA committee that meets at least quarterly?
- ☐ Does the QAA committee include the required members?
  - Director of Nursing Services;
  - Medical Director;
  - Nursing home administrator, owner, board member, or other individual in a leadership role; and
  - Two other staff members.

For every systemic issue identified and validated during the survey, determine if the QAA committee also has identified the issue and made a "Good Faith Attempt" to correct it. To determine this, do the following: a) interview the QAA contact person, and b) review evidence in order that will answer the following questions:

- ☐ Is the QAA committee aware of this issue?
- ☐ Is the issue a high risk, high volume, or problem-prone issue that the committee should know about?
- ☐ Has action been taken to correct this issue since it was identified?
- ☐ Is the QAA committee monitoring to ensure the corrective action has been implemented and the correction is being sustained?

Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs)

QAPI

Overview: RCA is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective actions. The RCA process provides you with a way to identify breakdowns in processes and systems that contributed to the event and how to prevent future events. The purpose of an RCA is to find out what happened, why it happened, and determine what changes need to be made. It can be an early step in a PIP, helping to identify what needs to be changed to improve performance. Once you have identified what changes need to be made, the steps you will follow are those you would use in any type of PIP. Note there are a number of tools you can use to perform RCA, described below.

Objectives: Use this guide to walk through a Root Cause Analysis (RCA) to investigate events in your facility (e.g., adverse event, incident, near miss, complaint). Facilities accredited by the Joint Commission or in states with regulations governing completion of RCAs should refer to those requirements to be sure all necessary steps are followed.

Below is a quick overview of the steps a PIP team might use to conduct RCA.

Steps	Explanation
1. Identify the event to be investigated and gather preliminary information	Events and issues can come from many sources (e.g., incident report, risk management referral, resident or family complaint, health department citation). The facility should have a process for selecting events that will undergo an RCA.
2. Charter and select team facilitator and team members	Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. Team members are people with personal knowledge of the processes and systems involved in the event to be investigated.
3. Describe what happened	Collect and organize the facts surrounding the event to understand what happened.
4. Identify the contributing factors	The situations, circumstances or conditions that increased the likelihood of the event are identified.
5. Identify the root causes	A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the event.
6. Design and implement changes to eliminate the root causes	The team determines how best to change processes and systems to reduce the likelihood of another similar event.
7. Measure the success of changes	Like all improvement projects, the success of improvement actions is evaluated.

Steps two through six should be completed as quickly as possible. For facilities accredited by the Joint Commission, these steps must be completed within 45 days of occurrence of the event.

Abuse CEP
CMS 20059

If the **alleged perpetrator was staff**, ask:

- Did the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past (e.g., using derogatory language, rough handling, or ignoring residents while giving care)? If yes, describe.
- Was there a history of resident/family grievances or problems identified with care delivery or services provided? If so, what was the result of the investigation of the concerns, and describe any disciplinary actions and/or training provided related to the complaints/concerns.
- Did annual performance reviews identify issues with the provision of care, treatment, or other concerns? If so, what was provided to address the concerns.
- How is monitoring and supervision provided regarding the delivery of care and services by the alleged perpetrator?

Neglect CEP
CMS 20130

Interviews with Staff Working During the Time the Alleged Neglect

- Why do you think the alleged neglect occurred?
- How did staff respond when the resident requested assistance?
- What do you consider as neglect?
- What do you do if you suspect that a resident is not receiving necessary care and services?

Supervisory Staff Interviews from Relevant Departments Related to

- How do you monitor and provide oversight in order to assure care and services are implemented based upon the care plan and the resident's identified needs, and if there is an acute change of condition?
- How do you monitor staff/resident interactions?
- How do you monitor for the deployment of sufficient numbers of qualified and competent staff across all shifts to meet resident needs?
- How do you determine staffing assignments based on the levels and types of care needed for the resident(s)?

ACCIDENTS CEP CMS 20127

What effective interventions are implemented to prevent falls? Examples may include:

- Responding to the resident's requests timely;
- Placing the resident in a low bed, or providing a fall mat;
- Monitoring resident positioning to prevent sliding/falling;
- Providing proper footwear to prevent slipping;
- Providing PT/OT/restorative care; and/or
- Assuring the resident's room is free from accident hazards (e.g., providing adequate lighting, assuring there are no trip hazards, providing assistive devices).

Does the resident have a position change alarm in place:

- What evidence is there that this device has been effective in preventing falls;
- Is there evidence this device has had the effect of inhibiting or restricting the resident from free movement out of fear of the alarm going off (See Physical Restraints); and
- Is there evidence that the alarm is used to replace staff supervision?

Wandering and Elopement Observations:

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


Post Fall Huddle Guidelines

Date: _____ Time of Fall: _____ Type of Huddle: _____ Room #: _____ SHIFT (circle one) D/PM/NOC

Diagnosis: _____ Pertinent Medical Hx: _____

LOCATION of FALL:

BACKGROUND: Fall risk factors / risk for injury

Information Related to Fall Event | FINDINGS

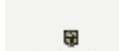
TYPE of FALL | DESCRIPTION

IMMEDIATE OBSERVATION / ASSESSMENT | FINDINGS

ACTION / RECOMMENDATION / PREVENTATIVE MEASURES

Follow – up Plan:

Print and Signature (RN/LVN): _____



OUTSIDE THE HOSPITAL DO-NOT-RESUSCITATE (OHDNR) ORDER

REVOCATION PROVISION

I AUTHORIZE EMERGENCY MEDICAL SERVICES PERSONNEL TO WITHHOLD OR WITHDRAW CARDIOPULMONARY RESUSCITATION FROM THE PATIENT IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST

THIS OHDNR ORDER SHALL REMAIN WITH THE PATIENT WHEN TRANSFERRED OUTSIDE THE HEALTH CARE FACILITY

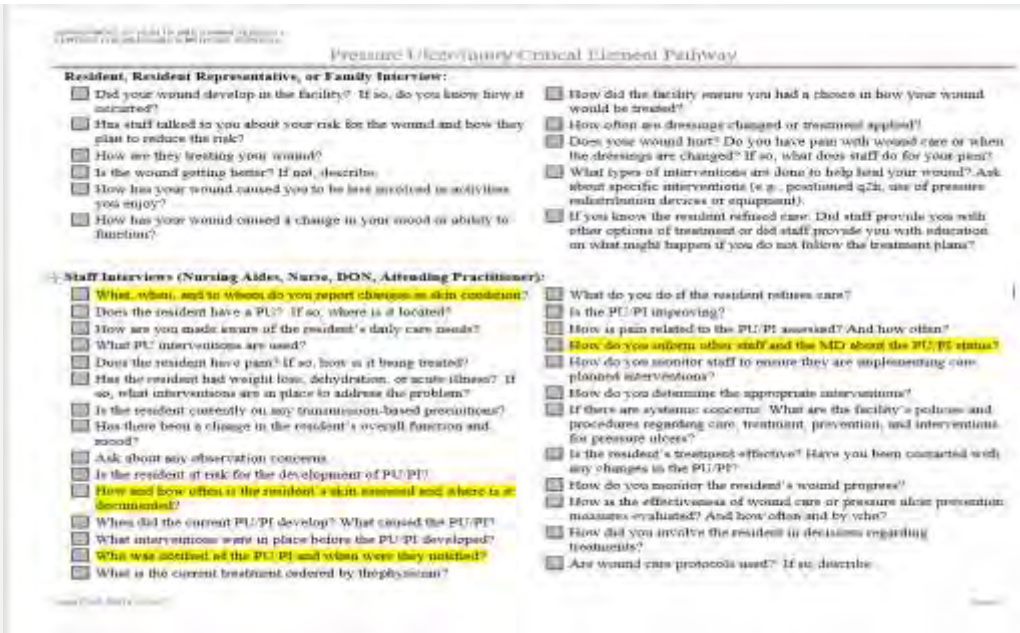
Infection Prevention, Control & Immunizations

Infection Control: This facility task must be used to investigate compliance at F880, F881, F882, F883, F885, and F886. For the purpose of this task, "staff" includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. The infection prevention and control program (IPCP) must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IVs, and oral/IM/respiratory medications.

Entry and screening procedures as well as resident care guidance have varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] COVID-19."

Please Note:
Surveyors conducting a COVID-19 Focused Infection Control (FIC) Survey for Nursing Homes (not associated with a recertification survey), must evaluate the facility's compliance at all critical elements (CE) with the exception of CE#8 and CE#9. The surveyor must also examine the facility's compliance at §483.73(b)(6) or E0024 (at Appendix Z) if the full Emergency Preparedness survey is not being conducted.



Pressure Ulcer/Injury Critical Element Pathway

Resident, Resident Representative, or Family Interview:

- Did your wound develop in the facility? If so, do you know how it occurred?
- Has staff talked to you about your risk for the wound and how they plan to reduce the risk?
- How are they treating your wound?
- Is the wound getting better? If not, describe.
- How has your wound caused you to be less involved in activities you enjoy?
- How has your wound caused a change in your mood or ability to function?
- How did the facility ensure you had a choice in how your wound would be treated?
- How often are dressings changed or treatment applied?
- Does your wound hurt? Do you have pain with wound care or when the dressings are changed? If so, what does staff do for your pain?
- What types of interventions are done to help heal your wound? Ask about specific interventions (e.g., positioned q2h, use of pressure redistribution devices or equipment).
- If you know the resident refused care: Did staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?

Staff Interviews (Nursing Aides, Nurse, DON, Attending Practitioner):

- What, when, and to whom do you report changes in skin condition?
- Does the resident have a PU? If so, where is it located?
- How are you made aware of the resident's daily care needs?
- What PU interventions are used?
- Does the resident have pain? If so, how is it being treated?
- Has the resident had weight loss, dehydration, or acute illness? If so, what interventions are in place to address the problem?
- Is the resident currently on any transmission-based precautions?
- Has there been a change in the resident's overall function and mood?
- Ask about any observation concerns.
- Is the resident at risk for the development of PU/PI?
- How and how often is the resident's skin assessed and where is it documented?
- When did the current PU/PI develop? What caused the PU/PI?
- What interventions were in place before the PU/PI developed?
- Who was notified of the PU/PI and when were they notified?
- What is the current treatment ordered by the physician?
- What do you do if the resident refuses care?
- Is the PU/PI improving?
- How is pain related to the PU/PI assessed? And how often?
- How do you inform other staff and the MD about the PU/PI status?
- How do you monitor staff to ensure they are implementing care planned interventions?
- How do you determine the appropriate interventions?
- If there are systemic concerns: What are the facility's policies and procedures regarding care, treatment, prevention, and interventions for pressure ulcers?
- Is the resident's treatment effective? Have you been concerned with any changes in the PU/PI?
- How do you monitor the resident's wound progress?
- How is the effectiveness of wound care or pressure ulcer prevention measures evaluated? And how often and by who?
- How did you involve the resident in decisions regarding treatments?
- Are wound care protocols used? If so, describe.

HSAG

Facility Acquired Pressure Ulcer Investigation Form

Resident name: _____ Room number: _____

Date pressure ulcer identified: _____ Time/shift identified: _____

Stage of pressure ulcer: _____ Second nurse assessment to verify staging: _____

Investigation

Last Braden Scale number and date: _____

Is this a high-risk resident? ☐ Yes ☐ No

Are daily skin checks being done? ☐ Yes ☐ No

72 hours prior to the pressure ulcer developing, did the resident have:

- ☐ Change in condition
- ☐ Fever
- ☐ Abdominal pain
- ☐ Decreased appetite
- ☐ Illness
- ☐ Fall
- ☐ Confusion
- ☐ Hospitalization
- ☐ Overnight outing
- ☐ Medication change
- ☐ Decreased mobility
- ☐ Other: _____

What prevention strategies were in place when the pressure ulcer was identified:

_____

Five 'Why's' to Uncover the Root Cause

Resident develop a pressure ulcer?

Why? ↓

Why? ↓

Why? ↓

Why? ↓

Root Cause Analysis

Identification/results: _____

Plan of action: _____

Interventions care planned: _____

Nurse: _____

Route copy to: Wound Care Nurse: _____ Director of Nursing: _____

Skin Team Member: _____ Medical Director: _____

Administrator: _____

Resources

- https://qcor.cms.gov
- https://healthapps.dhss.mo.gov/showmeltc/default.aspx
- www.cms.gov CMS State Operations Manual Appendix PP, CMS Critical Element Pathways, QAPI Tools
- www.nursinghomehelp.org Facility Assessment Tool, ICAR Project Announcement
- https://nursinghomehelp.org/educational/infection-preventionist-zip-kit/
- https://nursinghomehelp.org/educational/ltc-infection-prevention-and-control-manual-by-qipmo/
- https://www.hsag.com Facility Acquired Pressure Ulcer Investigation Form
- https://health.mo.gov/safety/ems/pdf/dnrauthorization.pdf OHDNR Form

QAPI Resources

- CMS QAPI Homepage-Wide range of resources available https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html
- QAPI At a Glance https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf
- QAPI Written Plan How-To Guide https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Plan-How-to-Guide.pdf
- Institute for Healthcare Improvement-PDSA http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
- Quality Innovation Network-QIOs (QIN-QIOs) https://qioprogram.org/

QIPMO ICAR Project

- Members of the ICAR Team are available for voluntary, no cost visits (virtual and/or in-person) to any residential care, assisted living, and skilled nursing facility in Missouri. These visits are intended to be consultative and collaborative in nature with a non-regulatory focus to evaluate infection control practices. Visits will consist of:
  - completion of a standardized assessment of infection control processes, focusing on highly transmittable infectious diseases
  - observations of infection control practices
  - preliminary feedback with supplemental educational resources
- Participating facilities will receive a comprehensive feedback report following the visit. Additionally, the QIPMO ICAR team will be available to participating homes for follow-up assistance and education as requested.
- Facilities interested in assessing their infection prevention programs and partnering to enhance patient safety through quality facility assessment, staff education and training can contact the QIPMO ICAR Team at **musonicarproject@missouri.edu or at (573) 882-0241**. You may also contact your QIPMO Nurse or Leadership Coach for more information.

CEUs for Today!

Today's webinar is worth 1 CEU hour for Administrators.

In order to get the credit, you will need to complete the brief survey/evaluation that will pop up at the end of the webinar. An automated email from GoToWebinar will also be sent to all attendees that will include a link to the survey/evaluation.

Please note: the certificate that will be linked in GoToWebinar's automated "thank you for attending" email is ***not your CEU certificate****. Your official certificate will be sent out by QIPMO staff within 1-2 weeks of the webinar.*

Evaluation Link

- https://www.surveymonkey.com/r/QIPMOVirtualSG