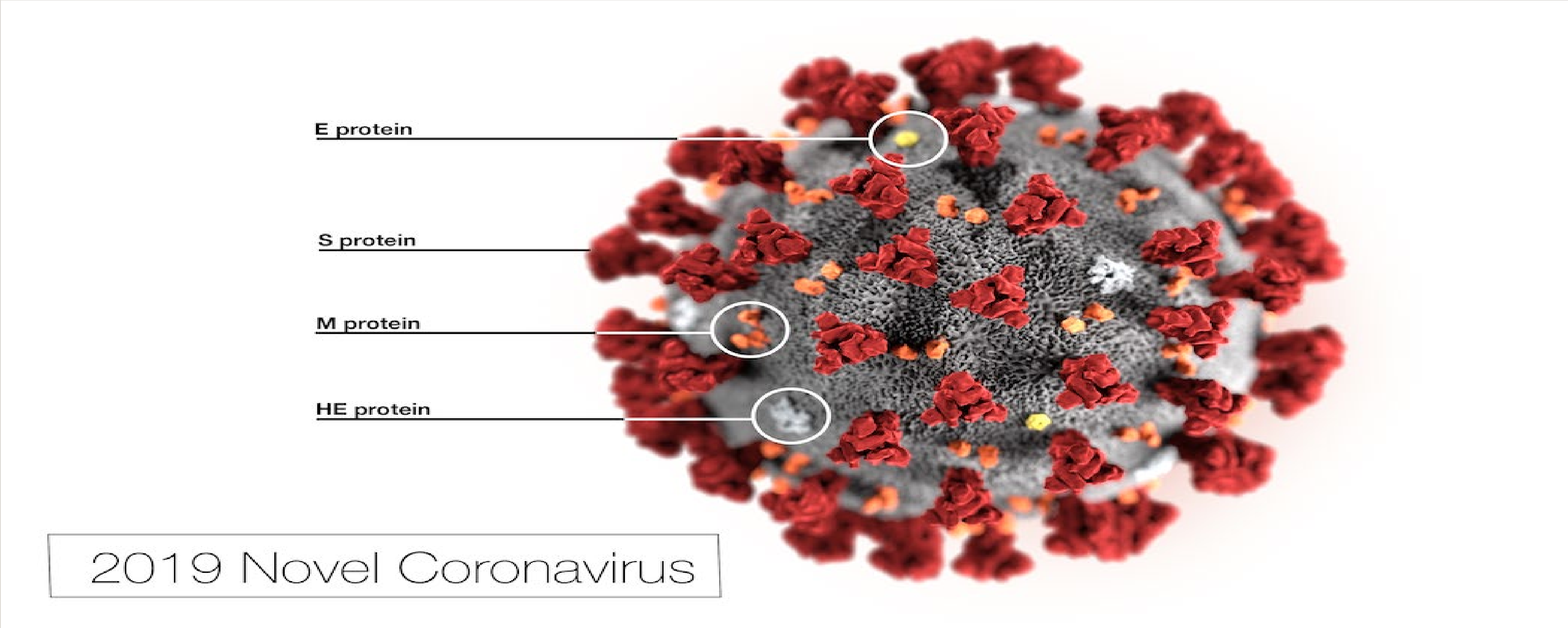
NHCA & LEADING AGE 8/26/2020

CONNIE VOGT RN BSN PROGRAM MANAGER LTC FACILITIES

AGENDA

- New case of COVID
- EP Plans
- CMS FIC Surveys
- CMS QSO 20-35-ALL 8/17/2020
- “Active Screening”
- Communal Dining

I HAVE A COVID19 POSITIVE RESIDENT OR STAFF MEMBER



ICAP/ICAR TOOLKIT

- https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

Actions needed to be taken upon identification of a COVID-19 case at a facility

Notification:

- ☐ Inform Local Health Department of Positive COVID-19 case
- ☐ Inform Licensure (LTC-CMS Survey team)
- ☐ Notify facility leadership and activate Incident Command System if it has not already been activated.
- ☐ Identify a point person (IP, DON, ADON etc.) who will subsequently get in touch with Nebraska ICAP team for reviewing infection control measures on an ongoing basis in coming days.

ICAR/ICAP

- To assist with zoning, training and education
- NOT for staffing – see facility EP plan
- NOT for coordination of transfer to residents to hospitals or other facilities –see facility EP plan

ALF’S 175 NAC 4

- 4-005.04 Compliance Inspections: The Department may, following the initial licensure of an assisted-living facility, conduct an unannounced onsite inspection at any time as it deems necessary to determine compliance with 175 NAC 4-006 and 4-007. The inspection may occur based on random selection or focused selection.
- 4-005.04B Focused Selection: The Department may inspect an assisted-living facility when the Department is informed of one or more of the following:

ALF'S 175 NAC 4

- 8. Outbreaks or recurrent incidents of physical health problems at an assisted-living facility such as dehydration, pressure sores, or other illnesses;

ALF'S 175 NAC 4

- 4-006 STANDARDS OF OPERATION, CARE AND TREATMENT: To provide adequate protection to assisted-living residents and compliance with state statutes, an assisted-living facility must meet the following:
- 4-006.01 Licensee Responsibilities: The licensee of each assisted-living facility must assume the responsibility for the total operation of the facility. The licensee responsibilities include:

ALF'S 175 NAC 4

- 1. Monitoring policies to assure the appropriate administration and management of the assisted-living facility;

ALF'S 175 NAC 4

- 4-006.02 Administration: Each assisted-living facility must have an administrator who is responsible for the overall operation of the facility. The administrator is responsible for planning, organizing, and directing the day to day operation of the assisted-living facility. The administrator must report all matters related to the maintenance, operation, and management of the assisted-living facility and be directly responsible to the licensee or to the person or persons delegated governing authority by the licensee. The administrator must:

ALF'S 175 NAC 4

- 4. Maintain staff with appropriate training and skills and sufficient in number to meet resident needs as defined in resident service agreements;
- 7. Monitor that facility staff identify and review incidents and accidents, resident complaints and concerns, patterns and trends in overall facility operation such as provisions of resident care and service and take action to alleviate problems and prevent recurrence;

ALF'S 175 NAC 4

- 4-006.03 Staff Requirements: The facility must maintain a sufficient number of staff with the required training and skills necessary to meet the resident population's requirements for assistance or provision of personal care, activities of daily living, health maintenance activities, supervision and other supportive services, as defined in Resident Service Agreements.
- 4-006.03C Staffing Resources: The assisted-living facility must ensure that staffing resources and training are sufficient to meet the level of supervision and assistance with activities of daily living, personal care and health maintenance activities that are required by the residents as defined in the resident service agreements.

ALF'S 175 NAC 4

- 4-006.13F Disaster Preparedness and Management: The assisted-living facility must establish and implement disaster preparedness plans and procedures to ensure that resident care, safety, and well-being are provided and maintained during and following instances of natural (tornado, flood, etc.) or *other disasters, disease outbreaks, or other similar situations.* Such plans and procedures must address and delineate:

SNF 175 NAC 12

- 12-005.04B Focused Selection: The Department may inspect a skilled nursing facility, nursing facility, or intermediate care facility when the Department is informed of one or more of the following:
- 8. Outbreaks or recurrent incidents of physical health problems such as dehydration, pressure sores, or other illnesses;

SNF 175 NAC 12

- 12-006 STANDARDS OF OPERATION, CARE, AND TREATMENT: To assure adequate protection and promotion of the health, safety, and well-being of facility residents and compliance with state statutes, skilled nursing facilities, nursing facilities, and intermediate care facilities must meet the following standards except where specified otherwise.

SNF 175 NAC 12

- 12-006.02 Administrator: Every skilled nursing facility, nursing facility, and intermediate care facility must have a Nebraska-licensed administrator who is responsible for the overall management of the facility. Each administrator must be responsible for and oversee the operation of only one licensed facility or one integrated system, except that an administrator may be responsible for and oversee the operations of up to three licensed facilities if approval is granted by the Board of Examiners in Nursing Home Administration and such facilities are located within two hours' travel time of each other, the distance between the two facilities the farthest apart does not exceed 150 miles, and the combined total number of beds in the facilities does not exceed 200. With approval of the Board, an administrator may act in the dual role of administrator and department head but not in the dual role of administrator and director of nursing. The administrator is responsible for:

SNF 175 NAC 12

- 5. Ensuring staffing appropriate in number and qualification to meet the resident needs;
- 7. Ensuring that facility staff identify and review incidents and accidents, resident complaints and concerns, patterns and trends in overall facility operation such as provisions of resident care and service and take action to alleviate problems and prevent recurrence;
- 12-006.04C Nursing Staff Resources and Responsibilities: The facility must provide sufficient nursing staff on a 24-hour basis, with specified qualifications as follows, to provide nursing care to all residents in accordance with resident care plans.

SNF 175 NAC 12

- 12-006.16G3 Written disaster plan;
- 12-006.18F Disaster Preparedness and Management: The facility must establish and implement disaster preparedness plans and procedures to ensure that residents' care and treatment, safety, and well-being are provided and maintained during and following instances of natural (tornado, flood, etc.) and other disasters, disease outbreaks, or other similar situations. Such plans and procedures must address and delineate:

KNOW YOUR BUILDING AND YOUR RESIDENTS

- ***F838***
- ***§483.70(e) Facility assessment.***
- ***The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:***

KNOW YOUR BUILDING AND YOUR RESIDENTS

- ***(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and***

HOW DO WE MANAGE THE OUTBREAK?

- Plan ahead
- Facility Emergency Preparedness Plan
- Work with your local and community resources- Medical Director, Hospitals, other facilities, transportation services,
- Do a facility assessment and ensure it's current (identify special needs- bariatric, oxygen, wandering/elopement, IV's, tube feedings, wound care>
- Do table top preparedness drills

HOW DO WE MANAGE THE OUTBREAK?

- Staffing
- All hands on deck
- Alternative sources
- Cross training

FIC- FOCUSED INFECTION CONTROL SURVEYS

- Based on data submitted to NHSN by the facility
- If a survey team has not been in the building in 12 days a NEW FIC survey must be scheduled.
- CMS sends list on Friday/Saturday- all facilities must be surveyed the next week.
- Each FIC survey is separate- not cumulative
- FIC revisits for Scope and Severity of G and above
- Ensure you submit a) DPOC b) root cause analysis

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-35-ALL

DATE: **August 17, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization

CMS QSO 20-35 ALL

- **CMS is revising guidance on the expansion of survey activities to authorize onsite revisits and other survey types.**
- •**CMS is providing guidance to State Survey Agencies (SAs) on resolving enforcement cases**: CMS is providing guidance on resolving enforcement cases that were previously directed to be held, and providing guidance on Civil Money Penalty (CMP) collection.
- •**Expanded Desk Review Authority:** CMS is temporarily expanding the desk review policy to include review of continuing noncompliance following removal of Immediate Jeopardy (IJ), which would otherwise have required an onsite revisit from March 23, 2020, through May 31, 2020.

I. LONG-TERM CARE GUIDANCE

Expansion of Survey Activities

On June 1, 2020, CMS issued the QSO 20-31-All memorandum that provided survey re-prioritization guidance to transition States to more routine oversight and survey activities. Specifically, once a State has entered Phase 3 of the Nursing Homes Reopening guidance, found in QSO 20-30-NH memorandum, or earlier, at the state's discretion, States were authorized to expand beyond the current survey prioritization (Immediate Jeopardy, Focused Infection Control, and Initial Certification surveys) to perform the following surveys (**for all provider and supplier types**):

- Complaint investigations that are triaged as Non-Immediate Jeopardy-High;

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- Revisit surveys of any facility with removed Immediate Jeopardy (but still out of compliance);
- Special Focus Facility and Special Focus Facility Candidate recertification surveys; and
- Nursing home and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) recertification surveys in facilities where it has been over 15 months since the last standard survey.

CMS QSO 20-35 ALL

- CMS is now **revising** this guidance to authorize additional onsite surveys. In addition to the surveys listed above, States should resume performing the following surveys as soon as they have the resources (e.g., staff and/or Personal Protective Equipment) to do so:

- Onsite revisits as specified in the revisit policy in the State Operations Manual (SOM), Chapter 7, Section 7317.2, for surveys with end dates on, or after June 1, 2020;
- Complaint investigations that are triaged as Non-Immediate Jeopardy Medium; and
- • Annual recertification surveys required to be conducted within 15 months from a provider's last recertification survey.

ENFORCEMENT GUIDANCE

- CMS intends to resolve those enforcement cases that were suspended and provide guidance for closing them out, going forward from the issuance of this memorandum. This process involves four components:
- 1. Expanding the Desk Review policy for Plans of Corrections (POCs);
- 2. Processing enforcement cases that were started **BEFORE March 23, 2020**;
- 3. Processing enforcement cases that were started **ON March 23, 2020, THROUGH May 31, 2020**; and
- 4. Processing enforcement cases that were started **ON OR AFTER June 1, 2020**.

FOR A DESK REVIEW

- CMS is now advising states to follow the guidance below to resolve enforcement cases that were started from March 23, 2020 (QSO-20-20) to May 31, 2020:
- All open surveys with cited deficiency tags must have an acceptable POC and supporting evidence in order for the tags to be corrected (unless a POC is not required such as for isolated deficiencies that CMS or the State determines constitute no actual harm with a potential for minimal harm);
- • If providers have not submitted a POC, the state survey agency (SA) will contact them requesting submission of a POC;

FOR A DESK REVIEW

- **NOTE**: Providers who may have difficulty allocating resources, such as staff, materials, or funding to develop and implement a POC because they are **currently** experiencing an outbreak of COVID-19, as defined in QSO 20-31-All,4 should contact their SA and/or CMS location to request an extension on submitting a POC.

FOR A DESK REVIEW

- SAs must request facilities to submit evidence that supports correction of noncompliance so that a desk review can be performed based on the latest compliance date on the POC. **NOTE: A desk review cannot be completed without supporting evidence from the facility.** This evidence may include documentation containing dates of training, staff in attendance, and evidence that staff were evaluated for skill(s) competency. It may also include monitoring for policy implementation and successful performance by staff.
- SUBMIT DOCUMENTATION TO: DHHS Health Care Facilities DHHS.HealthCareFacilities@nebraska.gov
- Please put survey date and 'supporting evidence" in the subject line

ENFORCEMENT CYCLES

- **CMS Regional Office is working with each State Agency to break 6 month enforcement cycles to help facilities achieve compliance.**
- **Nebraska is conducting outstanding surveys with a citation of scope and severity of G and above FIRST.**
- **Nebraska is conducting these surveys SEPARATELY from the facility annual/recertification survey. (to help break the 6 month enforcement cycle)**

ACTIVELY SCREENING

- Nebraska has reached out to CMS Regional Office for a uniform definition of 'actively screening' for staff.
- From QSO 20-14 NH dated 3/13/20
- *4. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.*

ACTIVELY SCREENING

- DHHS Licensure unit has also received questions regarding software applications for screening residents and has asked for further guidance from CMS.

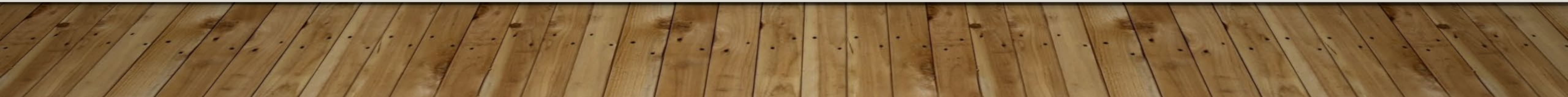
COMMUNAL DINING

- Residents MUST be 6 feet apart
- OR have a barrier in place-
- The barrier MUST be of sufficient height to protect the tallest person
- MUST be disinfected between uses

OTHER REMARKS

- SNF/NF- REVIEW FIC SURVEY TEMPLATE-DO A SELF ASSESSEMENT
- ENSURE NHSN DATA TO AVOID F884 CITATION
- ENSURE NOTIFICATION OF RESIDENTS & RESIDENT REPRESENTATIVES TO AVOID F884 CITATION.
- SUBMIT DPOC AND ROOT CAUSE ANALYSIS WITH EPOC/POC
- ENCOURAGE EPOC ENROLLMENT
- LOCAL/COMMUNITY RESOURCES AND TABLE TOP EXERCISES (MUCH LIKE THE FLOOD)
- Nebraska- revisits G and above BEFORE and SEPARATE from RECERT/ANNUAL Surveys

Any Questions



Thank You!