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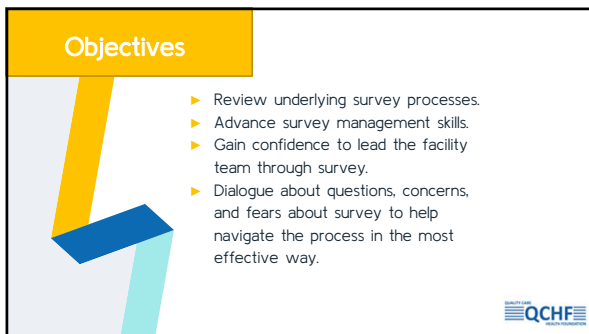
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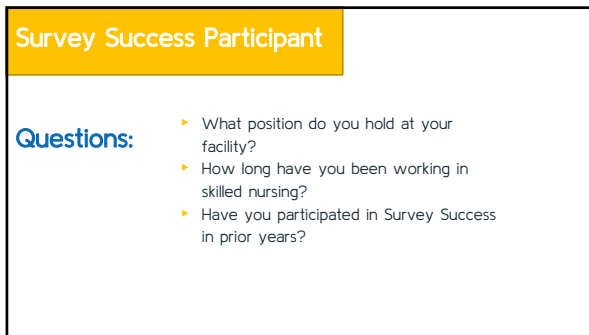
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**CMS Requirement of Participation (RoP)**



In October 2016, the Centers for Medicare and Medicaid Services (CMS) [published](#) a final rule revising the Medicare and Medicaid Requirements of Participation (RoP) for nursing centers. This represents the first comprehensive revision to the regulations since 1991.



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**CMS/CDPH Waivers**

Unprecedented global waivers from CMS and CDPH during 2020 in wake of the COVID-19 Pandemic.



Global waivers are now expiring or are being reduced in scope. A slow return with increased focus and scrutiny.

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**One Year of IP Focus Surveys**

**COVID-19 Focus Survey for Nursing Homes**

**General Standard Precautions**

Are staff performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use)?

**Hand Hygiene**

Are staff performing hand hygiene when indicated?

If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?

If there are shortages of ABHR, are staff performing hand hygiene using soap and water instead?

Are staff washing hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids)?

Do staff perform hand hygiene (even if gloves are used) in the following situations:

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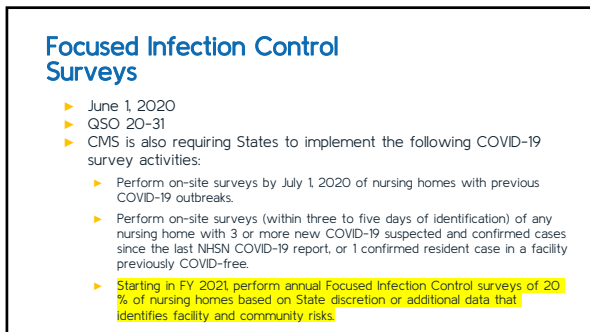
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### Focused Infection Control Survey

- ▶ Perform on-site FIC surveys (start within three to five days of identification) of any nursing home with 3 or more new COVID-19 confirmed cases since the last National Healthcare Safety Network (NHSN) COVID-19 report, or 1 confirmed resident case in a facility that was previously COVID-free, and other factors that may place residents' health and safety at risk. These factors include:
    - ▶ Multiple weeks with new COVID-19 cases.
    - ▶ Low staffing.
    - ▶ Selection as a Special Focus Facility per Section 1819(f)(8)(B) of the Social Security Act.
    - ▶ Concerns related to conducting outbreak testing per CMS requirements; or
    - ▶ Allegations or complaints which pose a risk for harm or Immediate Jeopardy to the health or safety of residents which are related to certain areas, such as abuse or quality of care (e.g. pressure ulcers, weight loss, depression, decline in functioning).
- CMS will work with State Survey Agencies to identify facilities that meet the above criteria.

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### New Infection Control Penalties

In addition to the mandatory remedies of Temporary Manager or Termination, imposition of Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, and 15-30 days to demonstrate compliance with Infection Control deficiencies. Enforcement imposed by CMS will dictate CMP imposed at highest amount option within the appropriate (IJ) range in the CMP analytic tool.

<https://skillednursingnews.com/wp-content/uploads/sites/4/2020/06/6.12020COVID-CAREs20Survey20and20Enforcement20Memo-FINAL20pdf.pdf>

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### Non-compliance Penalties

- ▶ Non-compliance for an Infection Control deficiency when none have been cited in the last year (or on the last standard survey) 5K.
- ▶ Non-compliance for Infection Control Deficiencies cited once in the last year (or last standard survey) 15K.
- ▶ Non-compliance that has been cited for Infection Control Deficiencies twice or more in the last two years (or twice since second to last standard survey) 20K.
- ▶ Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Harm Level (Level G, H, I), regardless of past history.\*
- ▶ Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Immediate Jeopardy Level (Level J, K, L) regardless of past history.\*

■ \*highest allowed

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**Participant Questions**

- ▶ How many COVID-19 Infection Control Surveys did you experience?
- ▶ Were they deficiency free?



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**CMS Survey Priorities**

States should prioritize providers based on a history of noncompliance, or allegations of noncompliance, with the below items:

- ▶ Abuse or neglect
- ▶ Infection control
- ▶ Violations of transfer or discharge requirements
- ▶ Insufficient staffing or competency
- ▶ Other quality of care issues (e.g. falls, pressure ulcers, etc.)

<https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf>



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**Public Health Emergency Outcomes**

- ▶ CMS also noted that when conducting the focused infection control surveys, long-term care facility surveyors "should be alert to, and investigate any concerns related to residents who have had a **significant decline** in their condition (e.g. weight loss, mobility) during the public health emergency."



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**CDPH Survey Priorities**

- ▶ Intending to survey by September 30, 2021:
  - ▶ Facilities with more IP Focus Surveys
  - ▶ Facilities with more complaints
- ▶ Call L&C for complaints lodged
- ▶ Intending to survey all SNF by December 31, 2021



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**Survey Success**

The tools and resources provided in Survey Success, CAHF/QCHF trainings conferences and your passion and dedication, will provide you with what you need.



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**Team Preparation**

- ▶ Preparation Plan
- ▶ Mock Survey



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**In the Window Review...**

- ▶ CASPER Reports
- ▶ Grievances
- ▶ Resident Council
- ▶ Entity Reported Events (ERI)/Abuse Allegations



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**What is your top priority in being survey ready?**



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**Daily Actions - Guardian / Angel Rounds**

Observation, follow-up, assignments, dining, and staff:

- ▶ Consistent
- ▶ Thorough
- ▶ Caring/Encouraging
- ▶ Ethical



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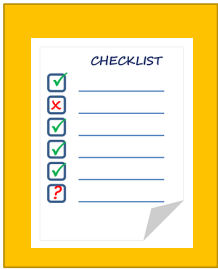
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**Rounds**

- ▶ Rounds Checklist
  - ▶ Who?
  - ▶ Then what?
- ▶ Personal hygiene items (labels)
- ▶ General cleanliness/clutter
- ▶ Home-like/personal
- ▶ Infection prevention



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**Infection Preventionist Rounds**

- ▶ Surveillance
- ▶ PPE
  - ▶ Donning/doffing, signage
- ▶ Hand Hygiene
- ▶ Cleaning/disinfecting
- ▶ Competencies



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**Medication**

- ▶ Observation
- ▶ Medication Room
- ▶ Medication Cart
- ▶ Narcotic Management
- ▶ Destruction
- ▶ Glucometers



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**Culture of Preparedness – Psychological Safety**

- ▶ "Psychological safety isn't about being nice. It's about giving candid feedback, openly admitting mistakes, and learning from each other." - Amy Edmondson
- ▶ Three activities that you have to just keep doing often:
  - ▶ Set the stage
  - ▶ Invite engagement
  - ▶ Respond productively



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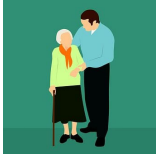
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**Employee Engagement**

- ▶ Educate self and leadership of facility
- ▶ Who does survey rely on?
- ▶ Retention and expanding skills
- ▶ Prep of new staff



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**Developing Survey Relationships**

- ▶ Team meeting at District Office.
- ▶ CAHF Chapter meetings for trends.
- ▶ District Office RAP Sessions.
- ▶ Set the tone of surveyor interactions.



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**Participant Questions**

- ▶ What CDPH relationship building do you participate in?
- ▶ What CDPH relationship building does the facility participate in?



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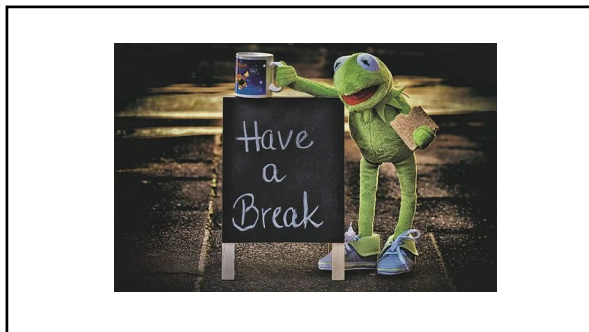
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**Survey Binder**

- ▶ Why?
- ▶ What's in there?
- ▶ Who?
- ▶ Where?
- ▶ Updates?
- ▶ Additional-CMS listed items



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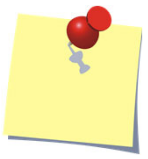
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### Required Postings

- ▶ Consumer board
  - ▶ Federal Requirements
  - ▶ State Requirements



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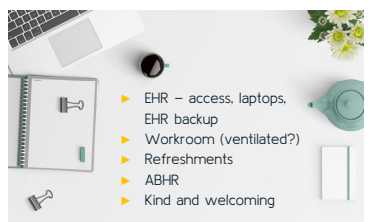
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### Surveyor Care

- ▶ EHR – access, laptops, EHR backup
- ▶ Workroom (ventilated?)
- ▶ Refreshments
- ▶ ABHR
- ▶ Kind and welcoming



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### Facility Assessment

- ▶ Review at least annually.
- ▶ Or when the facility admits residents that require substantially different care.
- ▶ Or whenever any actual or planned for change/triggering event would require substantial modification to any part of the assessment.
  - ▶ **Look at what you said you needed!**
- ▶ What good is the Facility Assessment?



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**Facility Assessment Survey Questions**

- ▶ How did the facility assess the resident population? Does this reflect the population observed?
- ▶ How did the facility determine the acuity of the resident population?
- ▶ How did the facility determine staffing levels?
- ▶ How did the facility determine what skills and competencies would be required by those providing care?



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**Facility Assessment Questions, continued**

- ▶ Who was involved in conducting the facility assessment?
- ▶ How did the facility determine what equipment, supplies, and physical environment would be required to meet resident needs?
- ▶ How did the facility develop its emergency plan?
- ▶ If a deficient practice is systemic and it is observed at another tag, was this related to an incomplete facility assessment?



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**Exercise**

- ▶ Interpret Facility Assessment
  - ▶ What does it inform you for competencies?
  - ▶ What impact on staffing?
  - ▶ What effect on other departments?



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### Sample Facility Assessment

Assistance with Activities of Daily Living	Indicate number/average or range at each level of independence/dependence				
	Independent	Supervision	Assist of 1 staff	Assist of 2 staff	Dependent
Dressing	8%	12%	10%	17%	55%
Personal hygiene	12%	20%	14%	20%	34%
Bathing	10%	20%	21%	18%	30%
Mobility: Ambulation	10%	20%	20%	25%	25%
Mobility: Wheelchair use	3%	5%	17%	43%	32%
Bed Mobility	17%	20%	13%	22%	28%
Transfer	3%	4%	23%	20%	50%
Eating	10%	20%	20%	25%	25%
Toileting	13%	10%	10%	13%	64%
Dentures	11%	10%	11%	20%	48%
Hearing Aid	0%	11%	14%	15%	60%

Other Activity Info: List i.e., complex procedure # of resident with Behavior Support

Of the # 17, of residents with Pressure Ulcers -

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### Facility Assessment Exercise Questions

- ▶ What does it inform you for competencies?
- ▶ What impact on staffing?
- ▶ What effect on other departments?




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### Sample Facility Assessment

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Of the # 17, of residents with Pressure Ulcers -

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**Facility Assessment – New Inquiry**

A new inquiry you are considering has diagnosis:

- ▶ Fracture hip
- ▶ Mild dementia
- ▶ COPD
- ▶ Nephrostomy tube



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**Facility Assessment Question**

▶ What steps do you take to meet the new resident's needs?



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**Quality Impacts**

- ▶ Customer Satisfaction
- ▶ Reputation
- ▶ Payment
- ▶ Contracts
- ▶ Insurance/Liability



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**Quality Measurement**



- ▶ What is Quality?
- ▶ How do you measure Quality?
- ▶ Process measure vs. Outcome measure

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**What is Quality Assurance and Process Improvement? (483.75)**



- ▶ Develop, implement, and maintain an **effective comprehensive** data-driven QAPI program that **focuses** on systems of care, outcomes of care and quality of life.
- ▶ Maintain documentation & demonstrate ongoing program:
  - ▶ Address full range of care & services provided.
  - ▶ **All systems of care & management practices.**
  - ▶ Include clinical care, quality of life, and patient choice.
  - ▶ Use best evidence to define & measure goals that reflect predictive processes of care to achieve expected outcomes.
  - ▶ Reflect the complexities, unique care, and services that the center provides.



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**Quality Assurance & Performance Improvement F-867**



- ▶ Evidence of QAPI meetings
- ▶ Identification and implement plan for areas identified
- ▶ Trends in focus areas
- ▶ Review QAPI Plan



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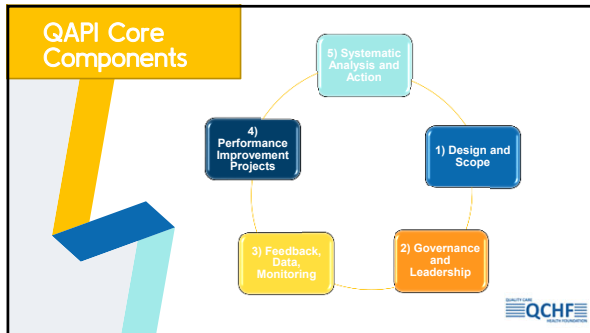
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**What is QAPI Really?**

It's about doing something...

- ▶ Data Gathering
- ▶ Review
- ▶ Trending
- ▶ Comparison
- ▶ Identification
- ▶ Action
- ▶ Evaluation

...Improving something.

**QAPI is NOT paper compliance!**

QCHF

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**Data Gathering: Resources...where do you find them?**

**Internal:**

- ▶ Financial Reports
- ▶ HR Reports
- ▶ Internal Program Success

**External:**

- ▶ [AHCA/NCAL LTC Trend Tracker](#)
- ▶ CASPER
- ▶ Customer/Staff Satisfaction Survey Vendors
- ▶ [Nursing Home Compare](#)
- ▶ [OSHPD](#)

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Data Review



- ▶ When – frequency and timing
- ▶ Who – multidisciplinary
- ▶ What – integration and importance



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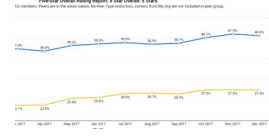
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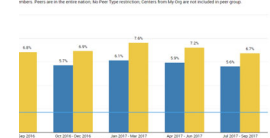
Trending...

- ▶ What is a trend?
- ▶ What data should be trended?

**Five Star Overall Rating Report 5 Star Overall 3 Stars**



**Quality Measure (M) Report LS Weight Loss - 1 Quarter View**



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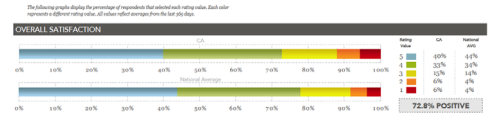
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- ▶ Where to find comparisons?
- ▶ What makes a good comparison?
- ▶ Where does benchmarking fit in?
- ▶ Why do I care about comparisons?

**CALIFORNIA**

OVERALL SATISFACTION



72.8% POSITIVE

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### Identification of Quality Improvement

- ▶ What is satisfactory?
- ▶ When do you intervene?

Measure Description	CMS ID	Data
BR ModSevere Pain (B)	N011.01	2.9%
BR ModSevere Pain (L)	N014.02	4.1%
BPMedPainMed(L)	N016.01	8.6%
NewSevere Pain User (S)	N000.02	1.6%
PhysRestMeds (L)	N027.01	0.0%
Falls (L)	N032.01	0.1%
DRUG (Med) (L)	N013.01	0.0%
Antipsych Med (B)	N011.01	0.0%
Antipsych Med (L)	N011.02	0.0%
Antianxiety/Hypnotic (L)	N033.01	0.0%
Diabet (Diabetic) (Diabetic (S))	N024.01	0.0%
Depress Dx (L)	N030.01	0.0%
UTI (L)	N024.01	0.0%



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### Action!

- ▶ Creating an action plan
  - ▶ Strong/Intermediate/Weak
- ▶ Creating a Process Improvement Project (PIP)
- ▶ Implementation/Deployment
- ▶ Get buy in

Overall Goal: We want to improve: With a change in DCRs in the last year, we have had more change in the licensed nursing staff than usual, and we think there has been an increase in the hospital readmissions. The goal is to reduce the readmission rate from 15.9% to ~14%.

SDIC DELIVERABLES: What needs to be done to accomplish our goal?	CRITICAL LINKAGES: Who needs to be involved and how are we connected?	PERSON RESPONSIBLE: Who will be ensuring this deliverable is completed?	ACTION STRAT: What specific steps need to be taken? List for each deliverable.	PLAN FOR MONITORING: How will we monitor? How will we measure?	TARGET: Complete by when? For what outcome?
Reduce readmission rate to 14% by fall 2024	Admin, RNOR & COO	Admin	Full list of all readmissions who were re-admitted to Acute Hospital within 30 days of discharge to O&A. Use data analysis on each readmission to determine if the readmission was preventable. Find trends by departments.	Admin & COO will monitor by reviewing case studies for trends.	12/20/21
Services Received across all readmissions, number and location of those for readmission	COO & COO	Admin	Do the right thing, working with licensed nurses to ensure the right thing is done monthly training. Schedule on 10th of each month.	COO, Admin & COO will do the right thing training. Admin will do the group training.	12/31/21
Monitor CNA's and the head NPs & Nurses	COO & COO	Admin	COO will do on the right training on the right way to do the right thing and the importance of getting COO in a timely manner and a feedback on monthly readmission.	COO & COO will do the right thing training. COO will do the monthly training.	12/31/21



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### Evaluation

- ▶ Did we do what we said we were going to do?
- ▶ Did the right staff have input into the action plan?
- ▶ Did the right staff know about the action plan?
- ▶ What worked?
- ▶ What could have been done better?
- ▶ What changes to the action plan should be made to change the outcome?



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**Exercise: Quality Care Nursing Home**

- ▶ QI/QMs Report to QAPI Committee by Nursing Department
- ▶ Pick one area you want to create a PIP based on these results.
  - ▶ Who would you have on your PIP team?
  - ▶ What do you look at for action planning?

Post Acute Care	1.2%	1.0%	0.0%	1.1%	My Centers
SS Antipsychotic Medication	1.7%	1.7%	1.8%	1.8%	My Peers
SS Pain	13.7%	12.2%	9.4%	9.7%	My Centers
	12.0%	12.7%	13.1%	14.1%	My Peers
SS Pressure Ulcers New or Worsened	0.4%	0.3%	0.3%	0.6%	My Centers
	0.7%	0.7%	0.8%	0.9%	My Peers
SS Influenza Vaccination	88.9%	88.9%	88.9%	80.0%	My Centers
	82.0%	82.2%	82.3%	80.5%	My Peers
SS Pneumococcal Vaccination	96.3%	94.9%	94.2%	94.7%	My Centers
	83.1%	84.9%	84.6%	82.4%	My Peers
SS Improvement in Function	71.0%	72.7%	71.3%	70.2%	My Centers
	68.2%	68.0%	67.4%	66.4%	My Peers

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**Participant Question**

- ▶ What clinical measure would you choose as top priority based on the QI/QM report?

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**Participant Question**

- ▶ Who would you put on the PIP team?
- ▶ Choose all that apply.

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**Compliance**

**Critical Element Pathway**  
for QAPI from CMS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL

**Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI)**

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

**Office:** Make note of concerns identified during office preparation, which will be further investigated during the survey (reportable incidents, concerns, and complaints facility reported incidents). These represent possible systemic issues, which if validated during the survey, should be noted under the relevant subcategory, and incorporated into the QAA review for investigation.

**Team Meetings:** During mid- and 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 office concerns (reportable deficiencies, complaints, concerns, and complaints facility reported incidents) validated during the survey?

Were any systemic concerns (validated concerns which will likely be cited in pattern or widespread, or substandard quality of care surveys)?

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 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

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**Quality Assurance**

**Data**

- ▶ Sources
- ▶ Accuracy
- ▶ Trending
- ▶ Importance and relevance
- ▶ Team involvement

QCHF

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**Process Improvement**

- ▶ Prioritize
- ▶ Action Plan
- ▶ Process Improvement Project (PIP)
- ▶ Team involvement

QCHF

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**QAPI leads to Excellence, not just Compliance**

Resources:

- ▶ [CMS – QAPI](#)
- ▶ [AHCA/NCAL ED \(Catalog\)](#)
- ▶ [AHCA/NCAL – QAPI](#)
- ▶ [HSAG – QAPI Electronic Resource Library](#)
- ▶ [CAHF Clinical & Quality Tools](#)
- ▶ [Process Tool Framework](#)

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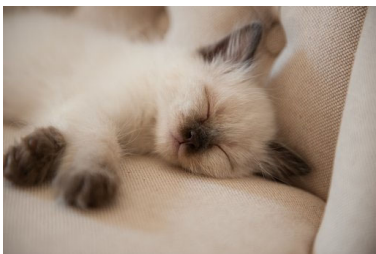
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**Take a break**



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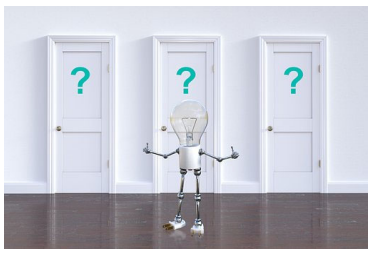
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**Questions and Answers**



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- ▶ Investigation of care issues and resident experiences
- ▶ Surveyor guidelines for:
  - ▶ Observations
  - ▶ Interview Questions of Residents, Family, Staff
  - ▶ Investigation Guidelines
  - ▶ Facility Tasks
- ▶ 41 total Pathways

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**Critical Element Pathways**

- Beneficiary Notice
- Communication & Sensory
- Dining
- Behavioral-Emotional
- Infection Prevention Control & Immunization
- Activities of Daily Living
- Kitchen
- Activities
- Resident Council
- Sufficient & Competent Staff
- Med Administration
- Environment
- QAA and QAPI
- Abuse
- Urinary Catheter or UTI

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**Critical Element Pathways**

- Bowel & Bladder Incontinence
- Positioning, Mobilization, ROM
- Hospice & End of Life
- Unnecessary Medications
- Pain Management
- Extended Survey
- Physical Restraints
- PASARR
- Pressure Ulcer
- Medication Storage
- Rehab and Restorative
- Respiratory Care
- Hydration

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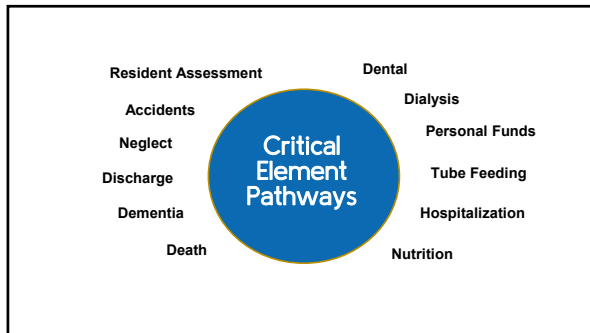
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### Quality Indicators/ Quality Measures



- ▶ Data to make informed decisions to improve quality.
- ▶ Data is only as good as the information being input.
- ▶ Consistent time frame.



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### QI/QM Definitions

- ▶ **CDIF** – Cumulative Days in Facility.
  - ▶ One or more stays.
- ▶ **Target period** – Span of time that defines QM reporting period.
- ▶ **Short-Stay:**
  - ▶ CDIF is less than or equal to 100 days at the end of the target period.
- ▶ **Long-Stay:**
  - ▶ CDIF is greater than or equal to 101 days at the end of the target period.



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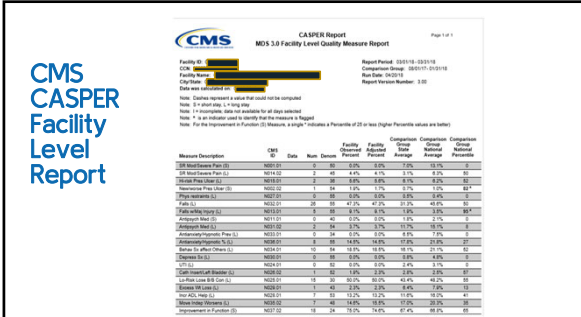
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**CMS CASPER Facility Level Report**

**CASPER Report**  
MDS 3.0 Facility Level Quality Measure Report

Report Period: 03/01/20 - 03/31/20  
Comparison Group: 03/01/20-03/31/20  
Facility Name: [REDACTED]  
City/State: [REDACTED]  
Report Version Number: 3.00

Measure Description	CMS ID	Date	Num. Denom.	Percent	Facility Percent	Comparison Group	
						Group Average	Group Percent
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### Competencies

- ▶ What are competencies?
- ▶ How to identify what competencies your team need.
- ▶ How will staff competencies impact survey.



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### Nurse Competency



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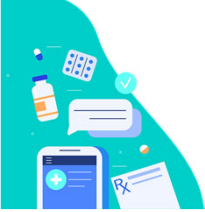
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### Nursing Staff Competency



**"Competency"** is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

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**Nursing Staff Competency**

- ▶ The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
- ▶ Providing care includes, but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

**Proficiency of nurse aides**

- ▶ The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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**Nursing Staff Competency**



- ▶ The facility's assessment must address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population.
- ▶ Additionally, staff are expected to demonstrate competency, such as preventing and reporting abuse, neglect, exploitation, dementia management, and infection control.
- ▶ Also, nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program.

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**Nursing Staff Competency**

Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as:



- ▶ Resident Rights
- ▶ Person centered care
- ▶ Communication
- ▶ Basic nursing skills
- ▶ Basic restorative services
- ▶ Skin and wound care
- ▶ Medication management
- ▶ Pain management
- ▶ Infection control
- ▶ Identification of changes in condition
- ▶ Cultural competency

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**Nursing Staff Competency**  
Demonstration of Competency



Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Examples for evaluating competencies may include, but are not limited to:

- ▶ Lecture with return demonstration for physical activities.
- ▶ A pre- and post-test for documentation issues.
- ▶ Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents.
- ▶ Reviewing adverse events that occurred as an indication of gaps in competency.
- ▶ Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

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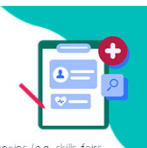
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**Nursing Staff Competency**



A competency-based program might include the following elements:

- ▶ Evaluates current staff training programming to ensure nursing competencies (e.g. skills fairs, training topics, return demonstration).
- ▶ Identifies gaps in education that is contributing to poor outcomes (e.g. potentially preventable re-hospitalization) and recommends educational programming to address these gaps.
- ▶ Outlines what education is needed based on the resident population (e.g. geriatric assessment, mental health needs) with delineation of licensed nursing staff verses non-licensed nursing and other staff member of the facility.

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**Nursing Staff Competency**



- ▶ Delineates what specific training is needed based on the facility assessment (e.g. ventilator, IV's, trachs).
- ▶ Details the tracking system or mechanism in place to ensure that the competency-based staffing model is assessing, planning, implementing, and evaluating effectiveness of training.
- ▶ Ensures that competency-based training is not limited to online computer based, but should also test for critical thinking skills as well as the ability to manage care in complex environments with multiple interruptions.

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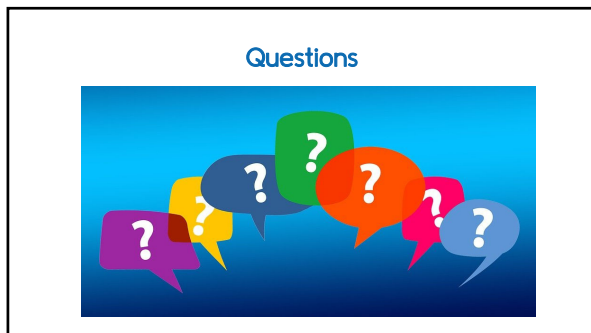
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