POLARIS PULSE®

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New, Revised and Draft Guidance to Surveyors

June 1, 2006 Implementation

1. **Revised Survey Tags F 520 / 521 QAA**
2. **Revised Survey Tags F 248 / 249—Activities**
3. **New Psychosocial Outcomes Guide for Surveyors**

Following the format established by the 2004 Pressure Ulcer F 314 update, the revised F Tags address Intent, Definitions, Overview, Assessment, Care Planning and Interventions along with adding an Investigative Protocol, Determination of Compliance and Deficiency Categorization.

Quality Assurance and Assessment Tags F520 and 521

The revisions condense F 520 and 521 into one tag, clarify QAA committee functions, composition and frequency of meetings, identification of quality deficiencies, development of action plans, implementation of action plans and correction of identified quality deficiencies.

By statute, the surveyor may not review committee meeting records unless the facility chooses to provide the records to the surveyor. HOWEVER, this does not mean that certain information or reports are precluded from being reviewed by surveyors during the course of the survey.

The documents the committee used to determine quality deficiencies are subject to review by the surveyors, including:

- Open and closed record audits
- Facility logs and tracking forms
- Incident reports
- Consultant reports
- Other reports as part of the QAA committee function

If the facility's QAA committee has not identified concerns, especially if related to repeat deficiencies, this may be an indication that the committee is not performing the functions required by the regulation.

In order to fulfill the regulatory mandate at F 520, the facility's QAA committee must work toward identifying the root causes that led to quality deficiencies and must develop appropriate corrective plans of action.

Action plans may include, but are not limited to:

- Development / revision of clinical protocols
- Revisions of policies and procedures
- Development of training for staff
- Plans to purchase or repair equipment / improve physical plant
- Development of standards for evaluating staff performance

The Investigative Protocol guides the surveyors in determining that the QAA committee:

- Meets at least quarterly, more often if necessary
- Identifies quality deficiencies
- Develops and implements appropriate plans of actions to address identified quality deficiencies and
- Monitors the effect of plans of actions and makes needed revisions

If investigation reveals that the QAA committee is making good faith efforts to identify quality deficiencies and to develop action plans to correct quality deficiencies, F 520 should not be cited. **If the survey team has independently identified noncompliance in the same areas as those that have been selected by the QAA committee, the surveyors are expected to cite the noncompliance at the other requirements.**

Examples of noncompliance at Tag 520 include:

- The action plan to correct a quality deficiency regarding food temperature was not being followed by staff in the dietary department, and

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food is not being served at proper temperatures

- An action plan was developed to correct a problem with inadequate assessment of root cause of falls. Staff did not implement the plan and residents are still having serious falls.

The Long Anticipated Revision to F Tag 248—Activities

This regulation mandates that the facility consider each resident's varying interests. The mere development of a program is **not** sufficient for compliance. A facility cannot merely place residents into any available activity. Instead, the facility **must** individualize activities according to each resident's interests, in order to enhance well-being. The interpretive guidelines also clarify areas such as assessment, care planning, interventions, and activity approaches for residents with behavioral symptoms.

Definitions in the revised guidelines include:

- "Activities" - refer to any endeavor, other than routine ADLs, in which a resident participates that is intended to enhance her/his sense of well being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence.
  - ⇒ Although routine ADLs are excluded from activities, many facilities provide special enhancements to certain aspects of bathing and grooming, including spa services, and beauty shop services that can be considered a part of activity programs.
- "One to One Programming" refers to programming provided to residents who will not, or cannot, effectively plan their own activity pursuits, or residents needing specialized or extended programs to enhance their overall daily routine and activity pursuits.
  - ⇒ Some residents who need this type of intervention may be unable to participate in group activities.
- "Person appropriate" refers to the idea that each resident has a personal identity and history that includes much more than just their medical illnesses or functional impairments, and that activities should be relevant—as much as possible to the specific needs, interests, culture, background, etc. of the individual for whom they are developed.
  - ⇒ This term has been endorsed by the Alzheimer's Association as a replacement for "age appropriate" since it is desirable to consider individual preferences instead of having blanket policies prohibiting such things as a resident carrying a doll.
- "Program of activities" includes a combination of large and small group, one to one, and self-directed activities; and a system that supports the development, implementation, and evaluation of the activities provided to the residents in the facility.

The Guideline Overview contains a section, "Resident's Views on Activities" that provides information from a Centers for Medicare and Medicaid Services (CMS) research effort that interviewed 160 residents and conducted observations of non interviewable residents.

The residents listed activities as an important component of dignity, specifically mentioning choice of activities and having activities that amount to something, such as those that produce or teach something; activities using skills from residents' former work; religious activities; and activities that contribute to the nursing home.

Residents in the study wanted activities to be "not childish", to use their minds, include something for men, relate to past work, get out of the facility, allow for socializing with people from outside the facility; and be " active" (such as exercise class).

The guidance includes websites for accessing information about what facilities are doing to advance culture change and to have activities that are more like home.

Deficiencies at F248 are most likely to have psychosocial outcomes. The survey team will compare their findings to the various levels of severity on the Psychosocial Outcome Severity Guide.

Psychosocial Outcome Severity Guide

The purpose of the Psychosocial Outcome Severity Guide is to help surveyors determine the severity of psychosocial outcomes resulting from identified noncompliance at a specific F tag. The Guide is used to determine the severity of a deficiency in any regulatory grouping (e.g., Quality of Care, Quality of Life) that resulted in a negative psychosocial outcome.

This Guide is not intended to replace the current scope and severity grid. Psychosocial outcomes (i.e., mood and behavior) may result from a facility's

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noncompliance with any regulatory requirement. Although a resident may experience either a negative physical outcome or a negative psychosocial outcome, some may experience or have the potential to experience both types of negative outcomes. Psychosocial outcomes and physical outcomes are equally important in determining the severity of noncompliance, and both need to be considered before assigning a severity level. The severity level assigned should reflect the most significant negative outcome or highest level of harm/potential harm.

Psychosocial outcomes of interest to surveyors are those caused by the facility's noncompliance with any regulation. This also includes psychosocial outcomes resulting from facility failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, which led to continuation or worsening of the condition.

Draft F Tag 334
Influenza and Pneumococcal Immunizations

CMS published a final rule October 7, 2005 that requires Medicare & Medicaid participating nursing homes to provide residents with the opportunity to be immunized against influenza and pneumonia. Currently in draft form, CMS expects to issue the advance copy of F 334 within the next few weeks.

In June 2006, CMS' Office of Clinical Standards and Quality is expected to release a new Immunization Quality Measure that will be incorporated into the survey guidance for this requirement.

Prior to the release of the new guidance, surveyors will continue to survey for immunization according to the current survey process. Interpretive guidance for infection control concerns may be found at Tag F 441.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: Is a discharge return not anticipated tracking form required if a resident was discharged with return anticipated, but will not be returning due to death in the hospital?

A: The RAI Version 2.0 Manual states a second discharge tracking form is not necessary unless required by the state. The state RAI Coordinator should be contacted for state specific requirements. Texas does require the completion of a return not anticipated form if the resident will not return to the facility.

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Polaris Group is pleased to present the following ***CEU approved*** teleconference trainings

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Topic	Date
F-Tag Review	5/2
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Sections K, P, T	5/9
Master ADL Coding	5/11
Understanding Therapy Part B Caps	5/16
Medicare Utilization	5/18
Medicare Basics	5/23
SNF Denial Notice Requirement	5/25
Case Management for 53 RUGs	6/1

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