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CMS Issues Multiple Skilled Nursing Facility/Nursing Facility Guidance Documents [Ober|Kaler]

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On September 27, 2012, the Centers for Medicare and Medicaid Services (CMS) issued advance copies of four significant survey guidance documents amending the State Operations Manual (SOM) governing the Medicare skilled nursing facility (SNF) and Medicaid nursing facility (NF) survey and certification process. They are being implemented as of November 30, 2012.

The SOM amendments were issued in multiple Survey and Certification (S&C) guidance documents, each of which was accompanied by CMS slides and training materials:

- 12-45-NH: Revisions to Survey Protocol for Long Term Care Facilities and related forms and exhibits;
- 12-46-NH: Feeding Tubes: F-Tag 322
- 12-47-NH: Advance Directives: F-Tag 155; and
- 12-48-NH: Quality of Care: F-Tag 309.

While the documents merit detailed review, following are highlights for particular focus.

Revisions to Survey Protocol (S&C 12-45-NH)

- Surveyors are instructed to devote as much time as possible to observations and conducting formal and informal interviews, while reviews of records and policies and procedures should be performed to obtain specific information or verify or corroborate potential concerns.
- In reviewing facility characteristics and demographic information about the resident population, both statewide and national comparisons will be made.
- The CASPER report will be used to determine if the facility has patterns of deficiencies in particular tags or related tags.
- Complaints should not be reinvestigated, but the issues may point to residents or concerns to be addressed on the current survey.
- The “best” residents to select are often those who have multiple care areas that have been selected as potential concerns.
- As for waivers of staffing or room issues, final approval of any waiver or variance is to be made by the state or CMS regional office and not by the surveyor at the time of the survey. Specific questions about room size, occupancy windows and access will be asked.
- The use of the QM report is highlighted, for example distinguishing between short-stay and long-stay residents for certain purposes, based on whether the resident has been in the facility for 101 or more days.
- *Visitors* have been added to the list of individuals who may be interviewed, which also includes residents, family, etc.
- The admission packet and contract is added to the items that will be requested within an hour or as soon as possible after the entrance conference, as well as a list of all residents who are receiving or have received antipsychotic medications over the past 30 days; a list of residents age 55 and under

and residents who communicate with non-oral devices or sign language, or who speak a language other than the facility's dominant language; and a copy of the current actual daily work schedules for licensed and registered nursing staff for all shifts during the survey period.

- In documenting observations, interviews and “conversations” with staff, residents, family or other individuals, the date, time and names of involved persons must be recorded, along with a description of the information used to survey findings, decisions and deficiencies.
- Surveyors are advised that it is up to them to allow or refuse to allow facility personnel to accompany them during a survey, including not tolerating facility staff who hinder the surveyor, argue about observed problems or otherwise make the survey more difficult.
- Residents receiving dialysis or hospice services are highlighted for consideration in developing samples, among other factors.
- In determining whether a resident is “interviewable” the surveyor is to consider the results of the MDS-Brief Interview for Mental Status. If the result of the BIMS is a score of 8-15, the resident may be identified as interviewable, but at 0-7 or 99 the resident may be identified as a “Family Interview Candidate.”
- In the revised guidance, CMS advises that survey teams should be providing a “daily exit conference” with negative findings since some require observation over time or further investigation.
- Residents, members of their family or guardians have the right to refuse to be interviewed by surveyors. Facility staff are not permitted to participate in such interviews unless requested by the resident, family or guardian. However, residents may only be handled by facility staff. Where a deficiency is disputed and/or appealed the identity of the person providing the information may need to be revealed.

Feeding Tubes: F-Tag 322 (S&C 12-46-NH)

- F-Tag 321 is deleted and its concepts incorporated into F-Tag 322.
- Use of a feeding tube should be based on whether it is unavoidable, i.e., if no other viable alternative to maintaining adequate nutrition and hydration is possible and the use of the feeding tube is consistent with the clinical objective of trying to maintain or improve nutrition and hydration parameters.
- Duration may vary based on the clinical situation.
- CMS outlines what is included in a clinically pertinent rationale for using a feeding tube, along with possible benefits and adverse effects.
- Clinically pertinent documentation for feeding tubes longer than 30 days is expected. CMS notes, in part, that “The extended us of enteral feeding tubes in individuals with advanced dementia remains controversial. The literature regarding enteral feeding of these individual suggests that there is little evidence that enteral feeding improved clinical outcomes (e.g., prevents aspiration or reduces mortality).”
- Guidance is provided on facility obligations when a feeding tube was placed prior to admission or in another setting.
- Technical guidance is offered, as well as a feeding tube investigative protocol.
- Note that there is an expectation that, prior to inserting a feeding tube, “the prescriber” reviews the resident's choices/instructions and goals, as well as advance directive. Contact with the attending physician or facility medical director may occur.
- Scope and severity guidance relating to tube feeding use is included, for the scoring of deficiencies.

Advance Directives: F-Tag 155 (S&C 12-47-NH)

- There is a detailed discussion about expectations for facility policies and procedures to promote and implement resident rights to make health care decisions and advance directives.
- The guidance confirms that residents may not be required to make an advance directive.
- The guidance includes an extensive discussion of advanced care planning with residents, family and others.
- Refusal of treatment may be a ground for discharge only if the regulatory grounds are met. Refusal of treatment may still require other medical care. The example is given that a resident who is refusing food and fluids and who is expected to die is to receive appropriate measures for pressure ulcer prevention.
- Scope and severity guidance relating to advance directives and advanced care planning is included, for the scoring of deficiencies.

Quality of Care: F-Tag 309 (S&C 12-48-NH)

The information in the Quality of Care guidance is relevant, not only to SNFs and NFs, but also to hospices providing services at those locations, whether for terminally ill residents or those needing palliative care.

- The survey guidance anticipates facilities identifying residents who are “approaching the end of life,” leading to interdisciplinary advance care planning, advice about palliative care and hospice care and a period review of the plan of care. The guidance does recognize that it is “difficult to predict exactly when someone will die” but anticipates assessment and reassessment to identify remediable symptoms and identify ways to optimize comfort and relieve suffering. Note that there is a recognition that some interventions may cause discomfort that outweighs benefits, for example, when the risk of skin breakdown and related prevention and treatment measures are infeasible or cause discomfort greater than the benefit.
- The survey guidance includes a helpful discussion of medical treatment in this context, such as when the frequency of monitoring and tests should be greatly reduced or discontinued or less intrusive measures used. Other examples include when palliative use of medications to address terminal restlessness is not considered a form of chemical restraint, or when weight loss and fluid imbalance/dehydration at the end of life are a consequence and not a cause of the dying process and when routine weight measurements should be discontinued.
- The survey guidance addresses how SNFs and NFs make hospice services available either in that facility or by transferring the resident to a facility that has the hospice service that the resident desires.
- The SOM provides guidance on how the facility and the hospice meet their respective obligations under applicable law, and addresses the facility's care obligations after the hospice benefit is elected.
- Investigative protocols are provided, as well as criteria for scoring the scope and severity of deficiencies.