Training Session Handouts

Use Appeals to Overturn Elder-Care Surveyor Infection Control Citations

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Skilled Nursing Facilities: Infection Control Surveys and Administrative Dispute Resolution

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What We Will Cover

- Current Developments
- Survey Issues
- Response
- Appeals

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Headlines

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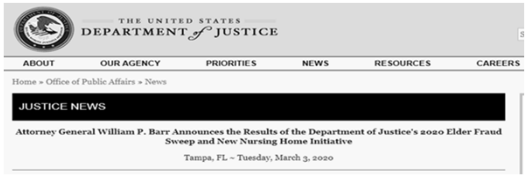
THE UNITED STATES DEPARTMENT of JUSTICE

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JUSTICE NEWS

Attorney General William P. Barr Announces the Results of the Department of Justice's 2020 Elder Fraud Sweep and New Nursing Home Initiative

Tampa, FL ~ Tuesday, March 3, 2020

- Launched National Nursing Home Initiative with HHS.
- "We will use every available tool to pursue nursing homes that provide grossly-substandard care to their residents. In fact, we have initiated investigations into approximately 30 individual nursing facilities in nine states."
- "Mark my words: The Initiative will bring to justice those owners and operators who put profits before patients, and it will help to ensure that the residents receive the care to which they are entitled."

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LOCAL

Local nursing home disputes state health department's findings following COVID-19 survey

Barrett Lawlis Lancaster Eagle-Gazette

Published 4:02 a.m. ET Jan. 31, 2021

View Comments

LANCASTER - A local senior care facility is disputing a claim from the state health department regarding the treatment of residents at the facility after they were diagnosed with COVID-19.

- In Virginia, 77% of nursing homes recently had infection control problems. Then came the coronavirus.

Despite COVID, some Pennsylvania nursing homes struggle with infection control procedures

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CMS Infection Control

- Immediate Jeopardy
- CMS Aug 14, 2020:
  - On March 4, 2020, CMS prioritized its inspection protocols to allow inspectors to focus on the most serious health and safety threats like infectious diseases and abuse.
  - These surveys have resulted in more than 180 immediate jeopardy level findings for infection control, which is triple the rate of such deficiencies found in 2019.

Press release

Trump Administration Has Issued More Than $15 Million in Fines to Nursing Homes During COVID-19 Pandemic

Aug 14, 2020 | Leadership, Nursing facilities

Share

CMS Enforcement Action Against Nursing Homes Triples compared to last year

Under the leadership of President Trump, the Centers for Medicare & Medicaid Services (CMS) today announced that the agency has imposed more than $15 million in civil money penalties (CMPs) to more than 3,400 nursing homes during the public health emergency for noncompliance with infection control requirements and the failure to report coronavirus disease 2019 (COVID-19) data. This is part of the Trump Administration's commitment to safeguarding nursing home residents from the ongoing threat of COVID-19 and holding nursing homes accountable for the health and safety of the residents they serve.

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Survey Changes - COVID

- March 4, 2020 QSO-20-12 – Surveys suspended unless IJ
- March 20, 2020 QSO-20-20 – CMS Prioritized surveys
- April 13, 2020 QSO-20-25 – Guidance on Transfer Scenarios (addressing 1135 waiver)
- April 24, 2020 QSO-20-28 – Suspension of 5 Star Program

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Survey Changes - COVID

- May 6, 2020 QSO-20-29 - New Regulation - 483.80(g)
  - Report required data to CDC-NHSN weekly (New tag - F884)
  - Inform residents/families by 5 p.m. next calendar day of new confirmed COVID case (staff or resident) or 3 new onset respiratory symptoms (New tag – F885)
  - Issued revised survey protocol/tool to include new tags

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Survey Changes - COVID

- June 1, 2020 QSO-20-31
  - States required to complete Focused Infection Control Survey on 100% of nursing homes by July 31,2020.
  - Mandated Focused Infection Control surveys for any outbreaks
  - FY 2021 – annual Focused Infection Control surveys on 20% of nursing homes in the state

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Surveys Resume - COVID

- June 1, 2020 – QSO 20-31 – Surveys expanded
- August 26, 2020 - QSO-20-28 - New Regulation COVID Testing 483.80(h)
- December 4, 2020 - QSO 21-06 – 5 Star Scores Updated (January 27, 2021)
- January 4, 2021 - QSO-20-31 Revised

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Enforcement- COVID

- March 20, 2020 QSO-20-20 – Initial suspension
- May 8, 2020 QSO 20-29 – Reporting rule & Enforcement
- June 1, 2020 QSO-20-31 – Enhanced Enforcement for F880
- August 17, 2020 QSO-20-35 - Issued CMP and Denial of payment for new admissions (DPNA) parameters for open cycles and delayed enforcement

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Surveys - COVID

- Around 115,000 total health surveys in 2020
  - includes Focused Infection Control surveys
- About 40,000 more total surveys than in prior two years
- Over 61,000 Focused Infection Control surveys in 2020 nationwide

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Enforcement- COVID

- More F880 citations
- 2020: 11,300 in 2020
- 2018 about 7,500 and 2019 about 7,500
- Scope and severity changes
- More IJs (7% in 2020 compared to 1)
- Most F880 deficiencies were Level 2
- More E and F than in prior years

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Enforcement – COVID in 2020

- F880
- Citations 11,295 in 2020.
- 43% of providers, 9.9% of surveys

- F884 (NEW)
- Citations 3,947 in 2020.
- 11.8% of providers, 3.5% of surveys

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Overview of Survey Citations

- GAO Report: Infection Control in SNFs Prior to COVID-19: May 20, 2020
  - 2013 – 2017 period of review
  - 82% out of 13,299 surveyed SNFs cited for infection control
  - 48% repeat infection control citations
  - 19% multiple repeat citations

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Post-Acute Areas for 2021

- COVID issues that are permanent issues.
  - Reporting and testing – **Top 10 deficiencies**.
- States Restart SNF Surveys.
  - COVID focused questions.

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ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE

		Top Citations 2021
1	F0884	Reporting - National Health Safety Network
2	F0880	Infection Prevention & Control
3	F0886	COVID-19 Testing-Residents & Staff
4	F0689	Free of Accident Hazards/Supervision/Devices
5	F0684	Quality of Care
6	F0580	Notify of Changes (Injury/Decline/Room, etc.)
7	F0883	Influenza and Pneumococcal Immunizations
8	F0885	Reporting-Residents, Representatives & Families

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Enforcement Going Forward

- Increase in Denial of payment for new admissions (DPNAs) going into effect
- Increase in Civil Money Penalties
  - F884 cites
  - Mandatory fines for level 2 F880
  - Increase in Immediate Jeopardy for F880
- Loss of Nurse Aide Training Program due to Denial of payment for new admissions (DPNA) and fines

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CMS Infection Control - FY 2021

- Starting in FY 2021, perform annual Focused Infection Control surveys of 20 percent of nursing homes based on State discretion or additional data that identifies facility and community risks.
- To count toward the required 20 percent, these FIC surveys must be stand-alone surveys not associated with a recertification survey.
- States that fail to perform these survey activities timely and completely could forfeit up to 5% of their CARES Act Allocation, annually.

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OIG Initiatives

U.S. Department of Health and Human Services
Office of Inspector General

- OIG Audit of Infection Control Program
  - Issued in May, 2020 update to OIG Work Plan
  - Will audit infection control program deficiencies
  - Audits ongoing and study will be issued in 2021
  - Selective (not random) audit of SNFs
  - Assess compliance with infection control RoP and emergency preparedness
  - Why is audit being completed?
    - ❖ SNFs cited for infection control deficiencies

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OIG Initiatives

- Action Items for SNFs
  - Revisit all infection control efforts
  - Make sure these efforts are documented
  - Follow and update policies and procedures as needed
  - Document all COVID-19 education and training
  - Create tracking procedure for use of COVID-19 CARES Act funds
  - Be prepared to explain all actions taken

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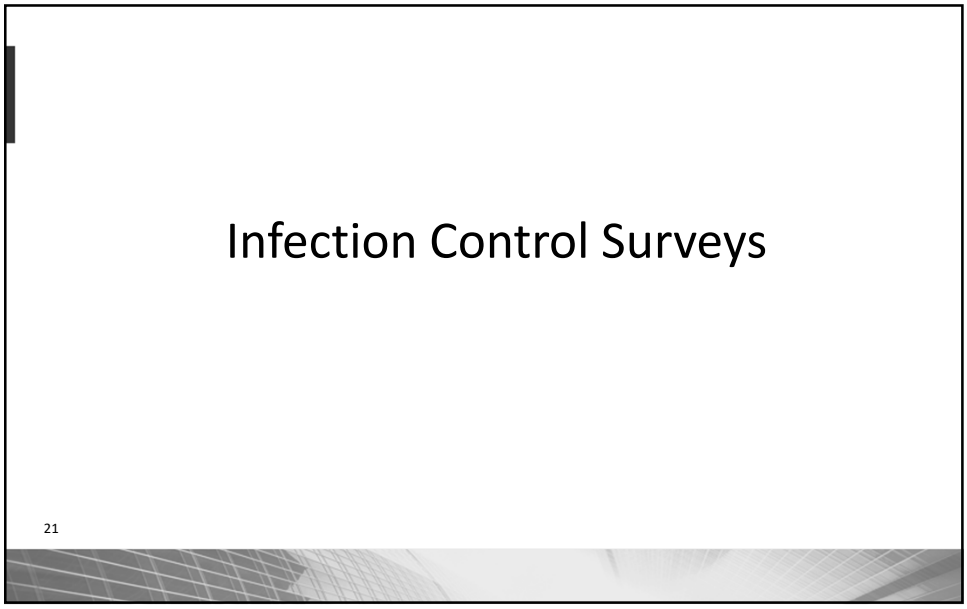

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CMS Infection Control Surveys

- SNFs reminded to have a system of surveillance to identify infections in accordance with RoP on infection control
- Elements of focused infection control surveys for SNFs
  - Offsite vs. Onsite Activity
  - Visitor entry and screening procedures
  - General standard precautions
  - Hand hygiene
  - PPE
  - Transmission-Based precautions
  - Resident care

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CMS Infection Control Surveys

- Elements of focused infection control surveys for SNFs
  - ❖ Infection surveillance
  - ❖ Visitor entry
  - ❖ Education monitoring and screening of staff
  - ❖ Emergency preparedness

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- 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).

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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.

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- Coordination

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Infection Prevention, Control & Immunizations

Coordination:

☐ Each surveyor is responsible for assessing the facility for breaks in infection control throughout the survey and is to answer CEs of concern (e.g., standard and transmission based precautions, source control).

☐ One surveyor performs or coordinates (e.g., immunization review) the facility task to review for:

- Standard and transmission-based precautions
- Resident care for COVID-19
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Visitor entry
- Education, monitoring, and screening of staff
- Staff and resident COVID-19 testing
- Suspected or confirmed COVID-19 reporting to residents, representatives, and families
- Laundry services
- Antibiotic stewardship program
- Infection Preventionist
- Influenza and pneumococcal immunizations

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- Sample residents and staff

☐ Sample residents/staff as follows:

- Sample three staff, include at least one staff member who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if this has occurred in the facility), for purposes of determining compliance with infection prevention and control national standards such as exclusion from work, as well as screening, testing, and reporting.
- Sample three residents for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions, as well as resident care, screening, testing, and reporting.
  - Include at least one resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if any).
  - Include at least one resident on transmission-based precautions (if any), for any reason other than COVID-19.
- Sample five residents for influenza and pneumococcal immunizations.

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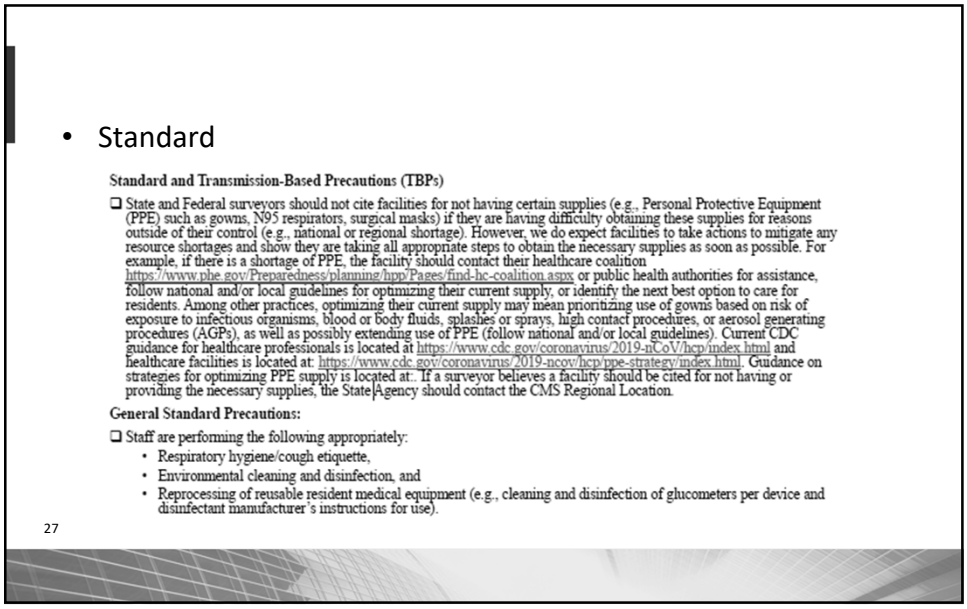
• Standard
Standard and Transmission-Based Precautions (TBPs)
❑ State and Federal surveyors should not cite facilities for not having certain supplies (e.g., Personal Protective Equipment (PPE) such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control (e.g., national or regional shortage). However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE, the facility should contact their healthcare coalition https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx or public health authorities for assistance, follow national and/or local guidelines for optimizing their current supply, or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Guidance on strategies for optimizing PPE supply is located at:. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.
General Standard Precautions:
❑ Staff are 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).
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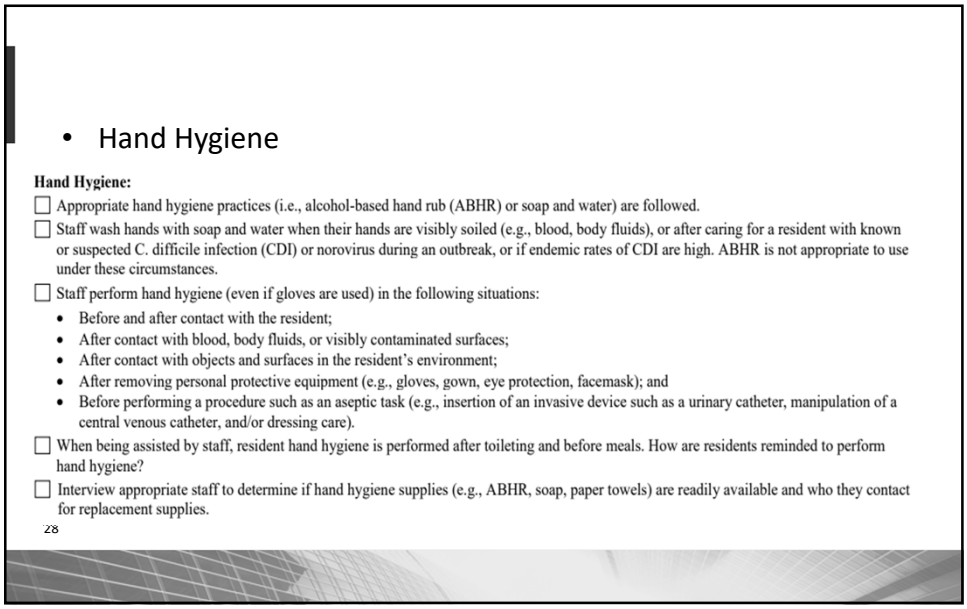
• Hand Hygiene
Hand Hygiene:
☐ Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR) or soap and water) are followed.
☐ Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.
☐ Staff perform hand hygiene (even if gloves are used) in the following situations:
• Before and after contact with the resident;
• After contact with blood, body fluids, or visibly contaminated surfaces;
• After contact with objects and surfaces in the resident's environment;
• After removing personal protective equipment (e.g., gloves, gown, eye protection, facemask); and
• Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).
☐ When being assisted by staff, resident hand hygiene is performed after toileting and before meals. How are residents reminded to perform hand hygiene?
☐ Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.
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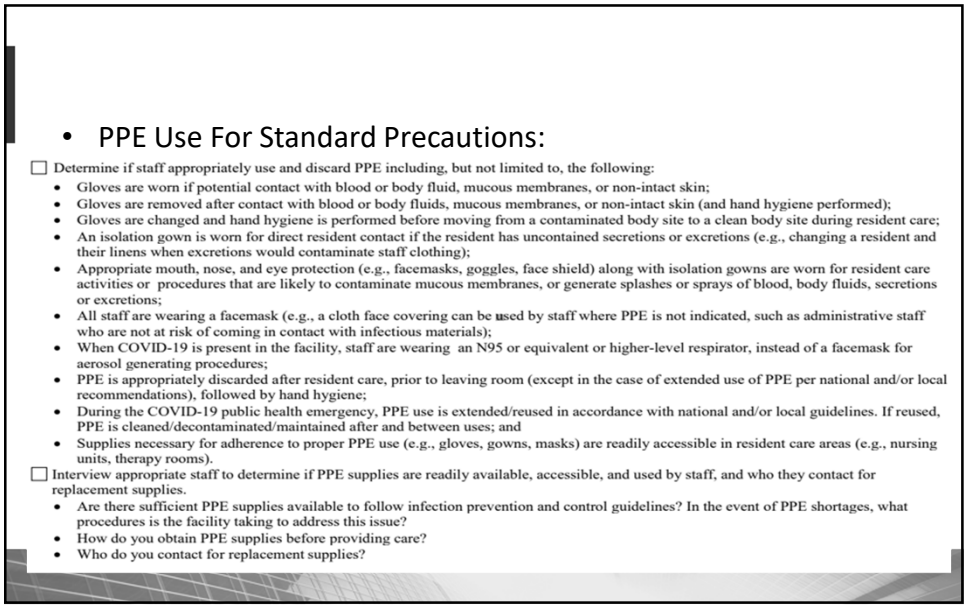
• PPE Use For Standard Precautions:
☐ Determine if staff appropriately use and discard PPE including, but not limited to, the following:
• Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
• Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin (and hand hygiene performed);
• Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
• An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing);
• Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions;
• All staff are wearing a facemask (e.g., a cloth face covering can be used by staff where PPE is not indicated, such as administrative staff who are not at risk of coming in contact with infectious materials);
• When COVID-19 is present in the facility, staff are wearing an N95 or equivalent or higher-level respirator, instead of a facemask for aerosol generating procedures;
• PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene;
• During the COVID-19 public health emergency, PPE use is extended/reused in accordance with national and/or local guidelines. If reused, PPE is cleaned/decontaminated/maintained after and between uses; and
• Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).
☐ Interview appropriate staff to determine if PPE supplies are readily available, accessible, and used by staff, and who they contact for replacement supplies.
• Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
• How do you obtain PPE supplies before providing care?
• Who do you contact for replacement supplies?

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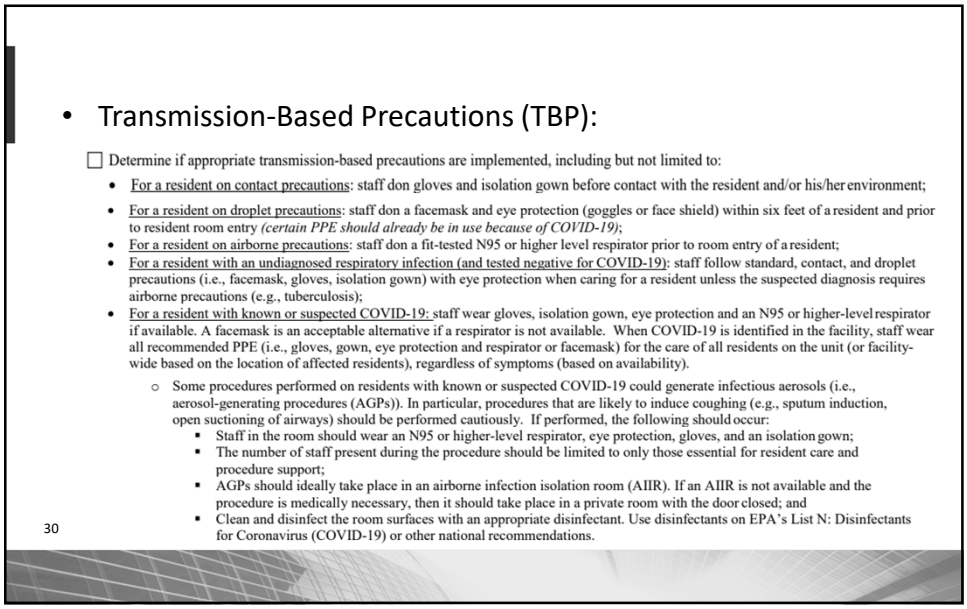
• Transmission-Based Precautions (TBP):
☐ Determine if appropriate transmission-based precautions are implemented, including but not limited to:
• For a resident on contact precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
• For a resident on droplet precautions: staff don a facemask and eye protection (goggles or face shield) within six feet of a resident and prior to resident room entry *(certain PPE should already be in use because of COVID-19)*;
• For a resident on airborne precautions: staff don a fit-tested N95 or higher level respirator prior to room entry of a resident;
• For a resident with an undiagnosed respiratory infection (and tested negative for COVID-19): staff follow standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis);
• For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).
o Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (i.e., aerosol-generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
▪ Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown;
▪ The number of staff present during the procedure should be limited to only those essential for resident care and procedure support;
▪ AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed; and
▪ Clean and disinfect the room surfaces with an appropriate disinfectant. Use disinfectants on EPA's List N: Disinfectants for Coronavirus (COVID-19) or other national recommendations.
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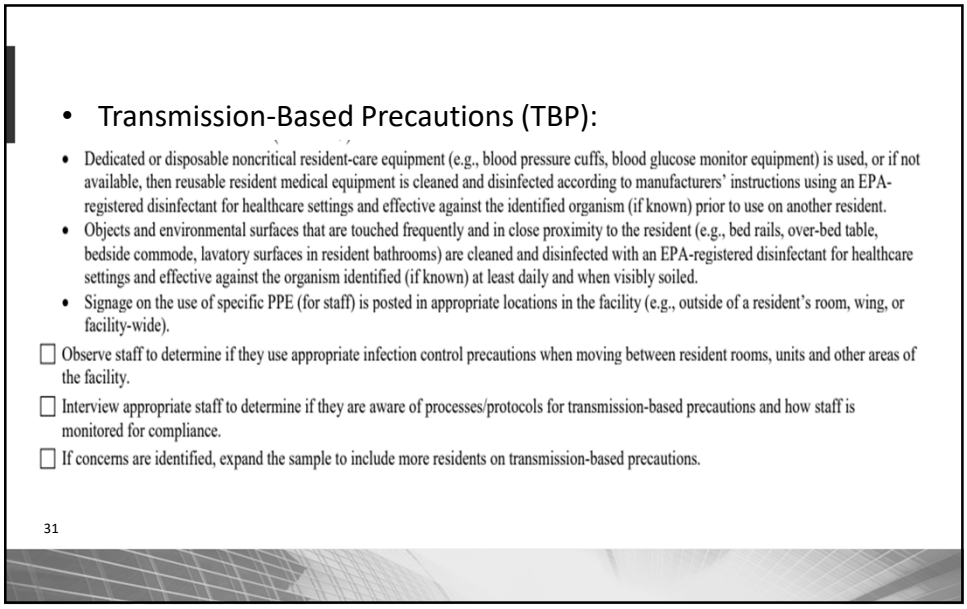
• Transmission-Based Precautions (TBP):
• Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then reusable resident medical equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare settings and effective against the identified organism (if known) prior to use on another resident.
• Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare settings and effective against the organism identified (if known) at least daily and when visibly soiled.
• Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide).
☐ Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units and other areas of the facility.
☐ Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.
☐ If concerns are identified, expand the sample to include more residents on transmission-based precautions.
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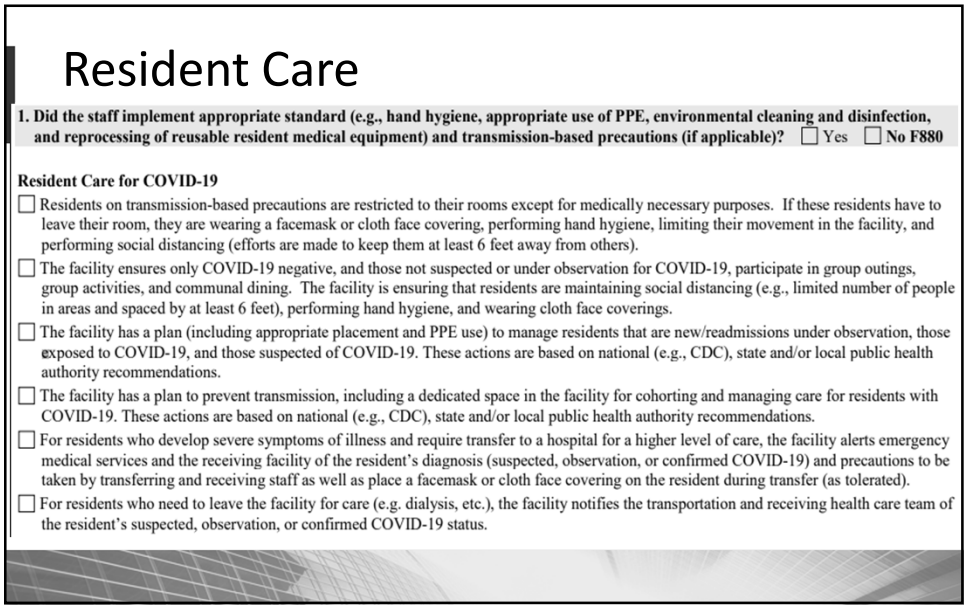
Resident Care
1. Did the staff implement appropriate standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and transmission-based precautions (if applicable)? ☐ Yes ☐ No F880
Resident Care for COVID-19
☐ Residents on transmission-based precautions are restricted to their rooms except for medically necessary purposes. If these residents have to leave their room, they are wearing a facemask or cloth face covering, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others).
☐ The facility ensures only COVID-19 negative, and those not suspected or under observation for COVID-19, participate in group outings, group activities, and communal dining. The facility is ensuring that residents are maintaining social distancing (e.g., limited number of people in areas and spaced by at least 6 feet), performing hand hygiene, and wearing cloth face coverings.
☐ The facility has a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions under observation, those exposed to COVID-19, and those suspected of COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.
☐ The facility has a plan to prevent transmission, including a dedicated space in the facility for cohorting and managing care for residents with COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.
☐ For residents who develop severe symptoms of illness and require transfer to a hospital for a higher level of care, the facility alerts emergency medical services and the receiving facility of the resident's diagnosis (suspected, observation, or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask or cloth face covering on the resident during transfer (as tolerated).
☐ For residents who need to leave the facility for care (e.g. dialysis, etc.), the facility notifies the transportation and receiving health care team of the resident's suspected, observation, or confirmed COVID-19 status.

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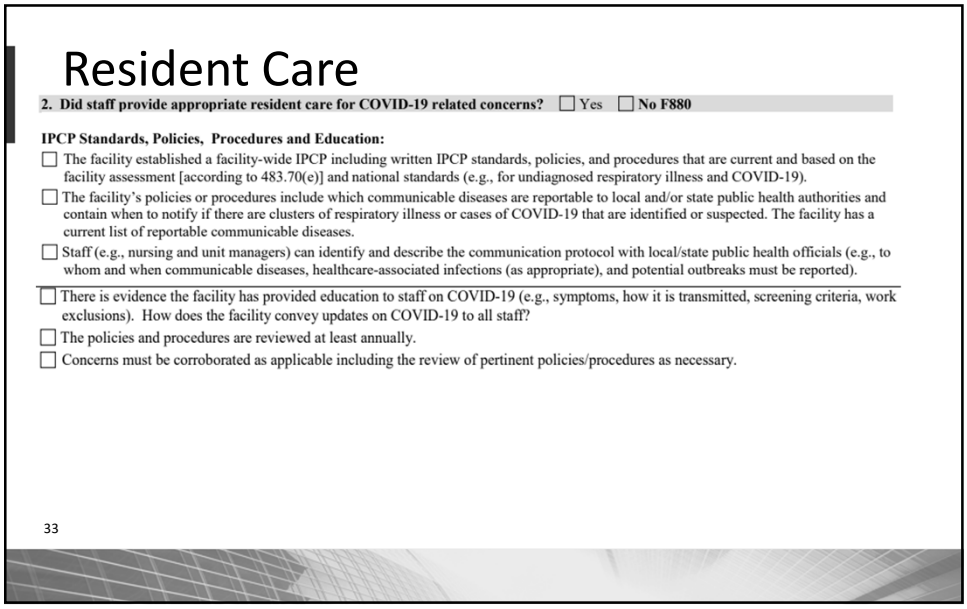
Resident Care
2. Did staff provide appropriate resident care for COVID-19 related concerns? ☐ Yes ☐ No F880
IPCP Standards, Policies, Procedures and Education:
☐ The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on the facility assessment [according to 483.70(e)] and national standards (e.g., for undiagnosed respiratory illness and COVID-19).
☐ The facility's policies or procedures include which communicable diseases are reportable to local and/or state public health authorities and contain when to notify if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected. The facility has a current list of reportable communicable diseases.
☐ Staff (e.g., nursing and unit managers) can identify and describe the communication protocol with local/state public health officials (e.g., to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported).
☐ There is evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions). How does the facility convey updates on COVID-19 to all staff?
☐ The policies and procedures are reviewed at least annually.
☐ Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.
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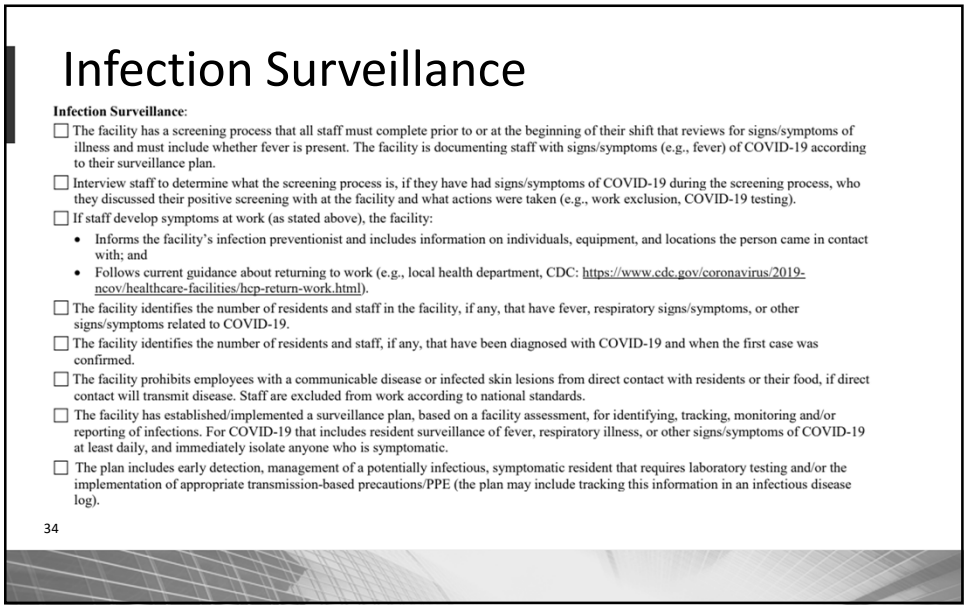
Infection Surveillance
Infection Surveillance:
☐ The facility has a screening process that all staff must complete prior to or at the beginning of their shift that reviews for signs/symptoms of illness and must include whether fever is present. The facility is documenting staff with signs/symptoms (e.g., fever) of COVID-19 according to their surveillance plan.
☐ Interview staff to determine what the screening process is, if they have had signs/symptoms of COVID-19 during the screening process, who they discussed their positive screening with at the facility and what actions were taken (e.g., work exclusion, COVID-19 testing).
☐ If staff develop symptoms at work (as stated above), the facility:
• Informs the facility's infection preventionist and includes information on individuals, equipment, and locations the person came in contact with; and
• Follows current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).
☐ The facility identifies the number of residents and staff in the facility, if any, that have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19.
☐ The facility identifies the number of residents and staff, if any, that have been diagnosed with COVID-19 and when the first case was confirmed.
☐ The facility prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease. Staff are excluded from work according to national standards.
☐ The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections. For COVID-19 that includes resident surveillance of fever, respiratory illness, or other signs/symptoms of COVID-19 at least daily, and immediately isolate anyone who is symptomatic.
☐ The plan includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate transmission-based precautions/PPE (the plan may include tracking this information in an infectious disease log).
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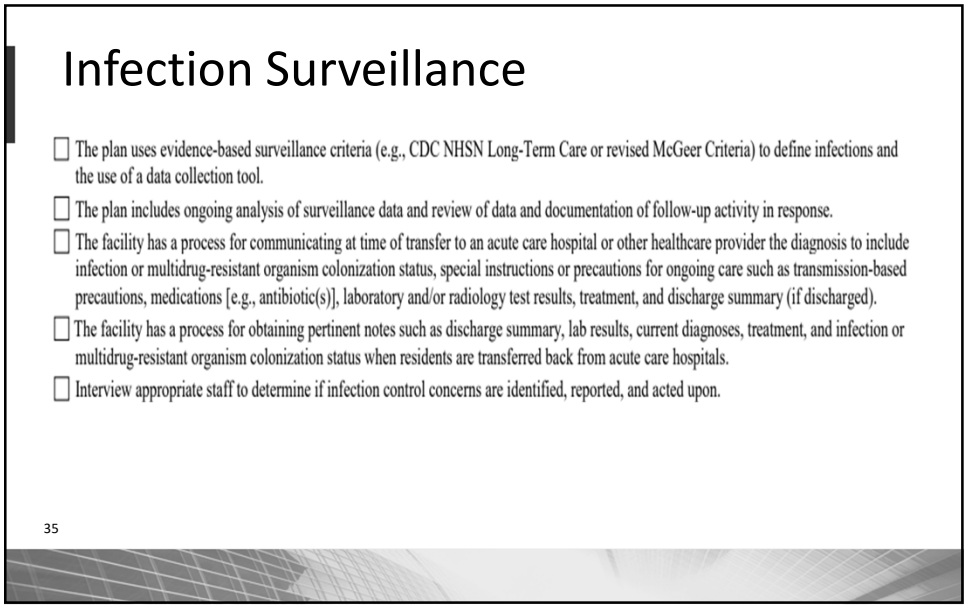
Infection Surveillance
☐ The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.
☐ The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.
☐ The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider the diagnosis to include infection or multidrug-resistant organism colonization status, special instructions or precautions for ongoing care such as transmission-based precautions, medications [e.g., antibiotic(s)], laboratory and/or radiology test results, treatment, and discharge summary (if discharged).
☐ The facility has a process for obtaining pertinent notes such as discharge summary, lab results, current diagnoses, treatment, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.
☐ Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.
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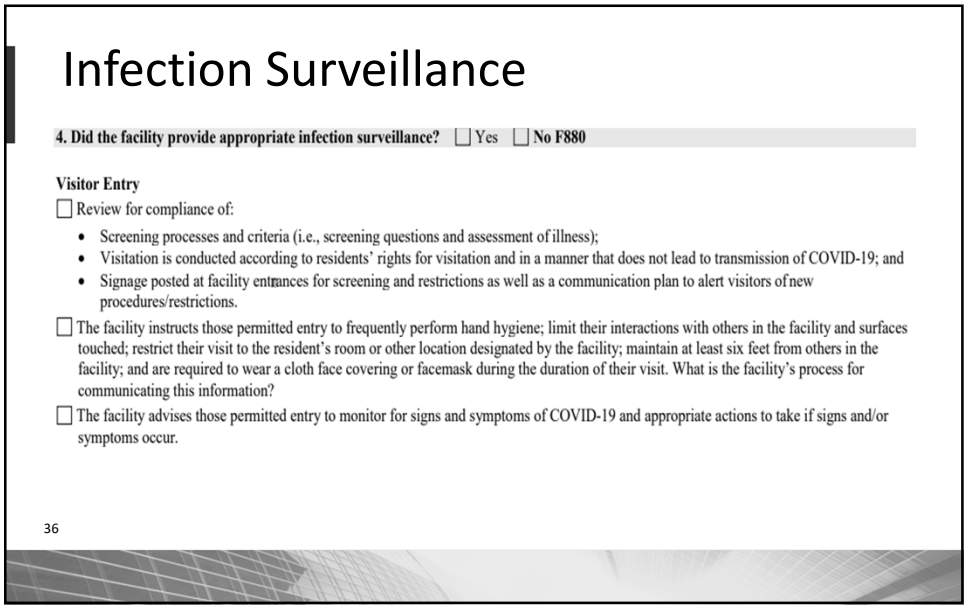
Infection Surveillance
4. Did the facility provide appropriate infection surveillance? ☐ Yes ☐ No F880
Visitor Entry
☐ Review for compliance of:
• Screening processes and criteria (i.e., screening questions and assessment of illness);
• Visitation is conducted according to residents' rights for visitation and in a manner that does not lead to transmission of COVID-19; and
• Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.
☐ The facility instructs those permitted entry to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location designated by the facility; maintain at least six feet from others in the facility; and are required to wear a cloth face covering or facemask during the duration of their visit. What is the facility's process for communicating this information?
☐ The facility advises those permitted entry to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur.
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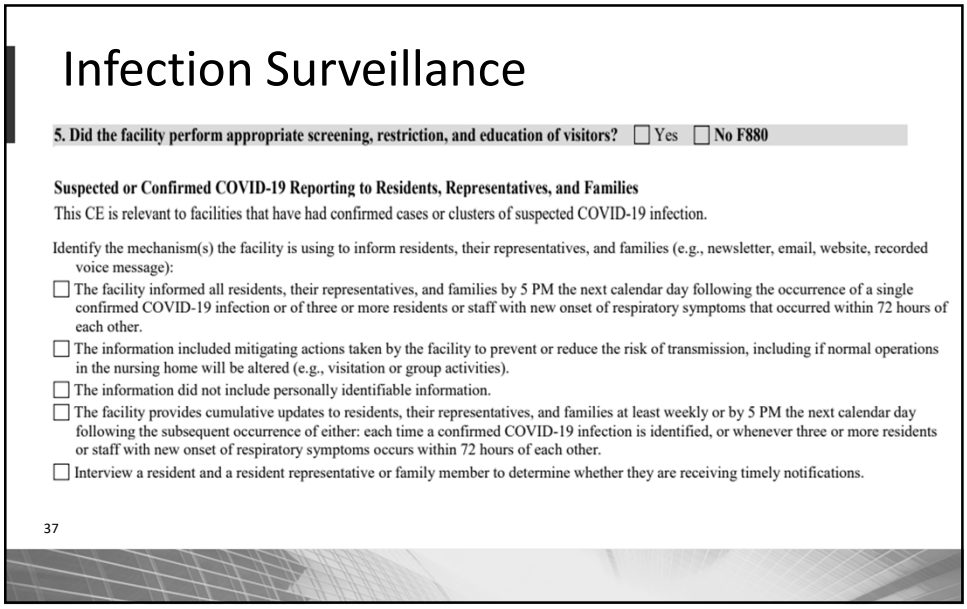
Infection Surveillance
5. Did the facility perform appropriate screening, restriction, and education of visitors? ☐ Yes ☐ No F880
Suspected or Confirmed COVID-19 Reporting to Residents, Representatives, and Families
This CE is relevant to facilities that have had confirmed cases or clusters of suspected COVID-19 infection.
Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, email, website, recorded voice message):
☐ The facility informed all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other.
☐ The information included mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., visitation or group activities).
☐ The information did not include personally identifiable information.
☐ The facility provides cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other.
☐ Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.
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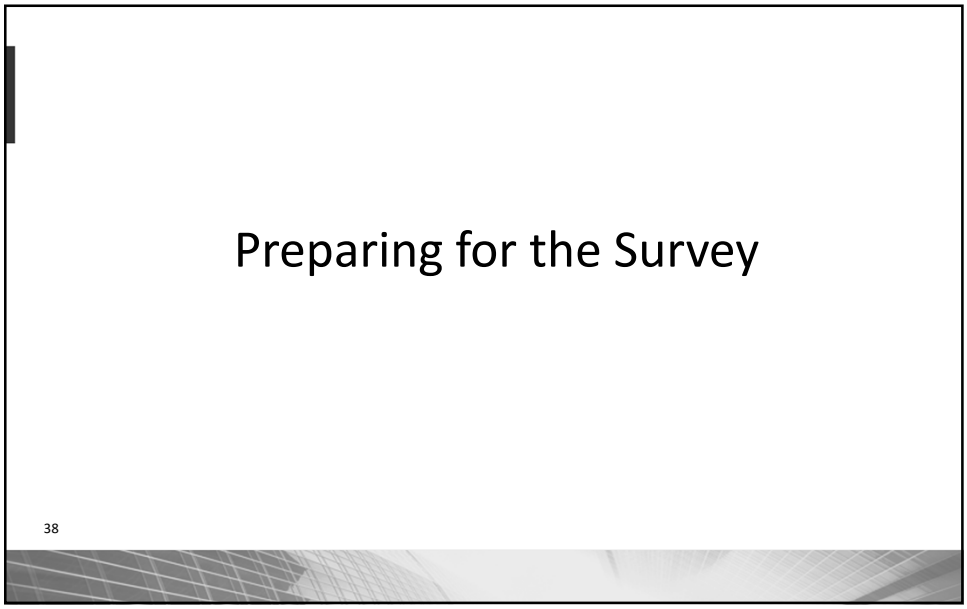
Preparing for the Survey
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How to avoid being cited in the first place?

- Document, document, document and train, train, train
- Know what infection control F-Tags will be cited and interpretive guidelines to F-Tags
- Be aware of Critical Element Pathway on infection control
- Have a thorough understanding of infection control interpretive guidelines (80 pages in State Operations Manual)
- Numerous definitions and footnotes
- Adopt current standards of practice
- Have a thorough understanding of the Long Term Care Survey Protocol

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How to avoid being cited in the first place?

- Review all CMS QSO memos on infection control
- Review CMS and CDC infection control survey tools and use as a self-assessment
- Update Facility Assessment and other relevant policies and procedures
- Establish contacts with state survey agency, CMS and CDC
- Utilize association resources
- The problem really is what standards will SNFs be held to…appears to be a moving target (CMS, CDC, Other?)

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Preparing for an Infection Control Survey

- Maintain all current and updated policies and procedures and have them organized and available
- Ensure all employees have active licenses and are properly credentialed
- Appoint a survey team leader
- Make sure vendor contacts are current and updated as needed
- Educate critical staff on Long Term Care Survey Protocol
- Have process for turning over documents to surveyors
- Educate staff on how to handle interviews by surveyors
- Know options on submitting Plan of Correction

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CMS Infection Control Surveys

- Action Items for SNFs
  - Review QS0-22-20-ALL in detail
  - Conduct and document infection control self-assessment
  - Revise policies and procedures accordingly
  - If PPE lacking, reach out to CMS for suggested resources and document efforts
  - Still be prepared for an on-site survey
  - Routinely check CDC and CMS website for updates
  - Adjust and consistently enforce revised visitor policies

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Survey Results
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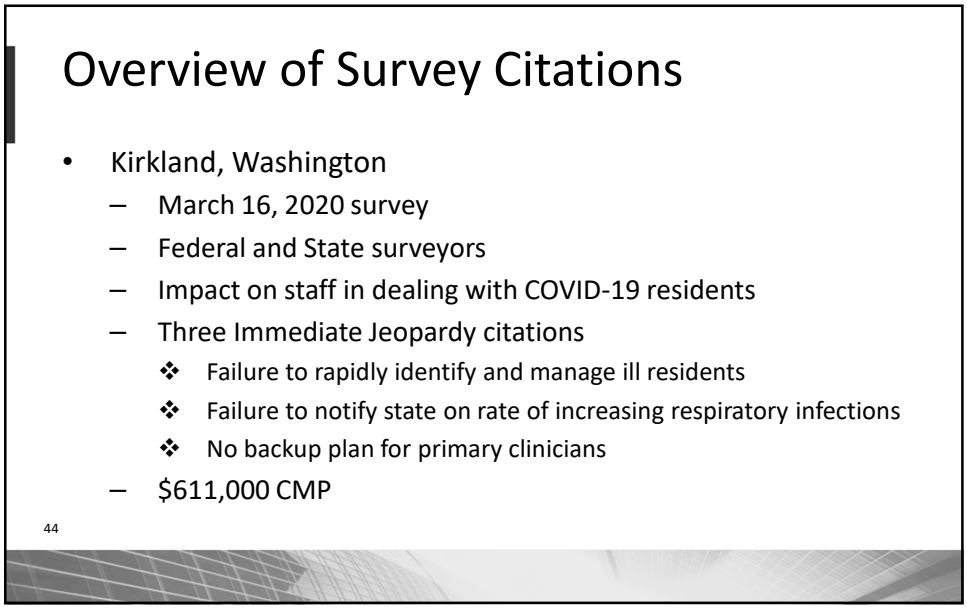
Overview of Survey Citations
• Kirkland, Washington
– March 16, 2020 survey
– Federal and State surveyors
– Impact on staff in dealing with COVID-19 residents
– Three Immediate Jeopardy citations
❖ Failure to rapidly identify and manage ill residents
❖ Failure to notify state on rate of increasing respiratory infections
❖ No backup plan for primary clinicians
– $611,000 CMP
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Overview of Survey Citations

- Factors that contributed to Immediate Jeopardy
  - Staff members working while symptomatic (asymptomatic?)
  - Staff working at more than one facility
  - Failure to adhere to standard contact and droplet precautions
  - Failure to implement infection control practices
  - Failure to recognize suspected COVID-19 cases
- Facility Plan of Correction
  - Implemented enhanced screening procedures
  - Monitoring of residents
  - Social distancing procedures
  - Training on PPE and infection control
  - Plan to address PPE shortages

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Overview of Survey Citations

- Common Citations
  - Poor hand hygiene
  - Failure to implement protective measures during outbreak
  - Improper or lack of isolation measures
  - Improper use or not using PPE
- Lack of Actual Harm
  - 99% of all citations no actual harm
  - 31% had enforcement actions imposed but not implemented

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Overview of Survey Citations

- Survey Findings from Actual 2567s
  - Failure to store masks and inhalers in bags to prevent cross contamination
  - Failure to follow hand washing techniques based on observation of the provided treatment
  - Catheter tubing left on floor
  - Failure to ensure hand washing completed for 1-33 residents but potential to affect 74 residents receiving peri-care

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Survey Findings from Actual 2567s

- CNA eating lunch while feeding resident with no PPE or gown
- CNA fed COVID-19 resident after bed change without washing hands
- Failure to separate or isolate COVID-19 residents
- CNA wearing gown inside out with a hole in it and was designated infection control supervisor

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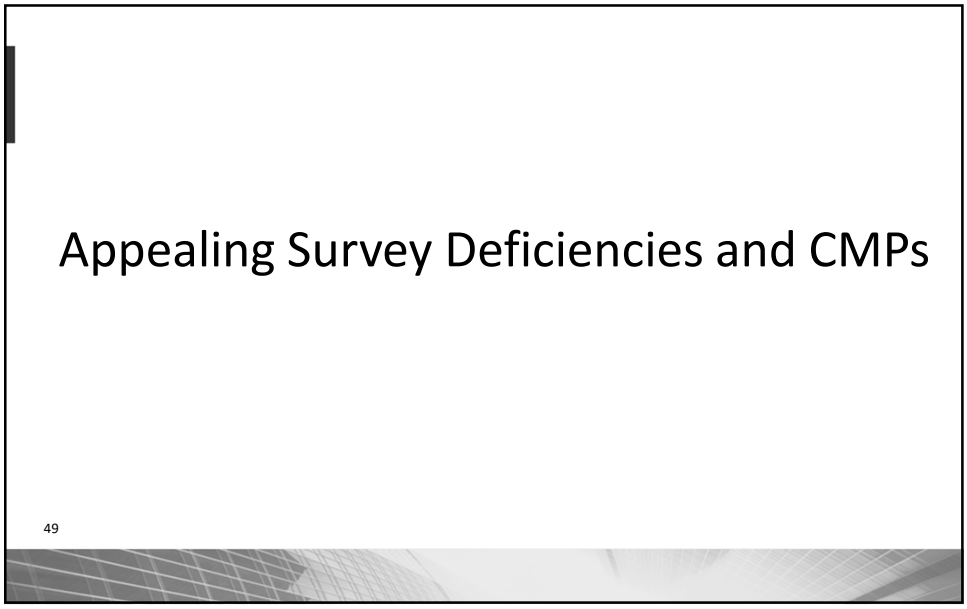
Appealing Survey Deficiencies and CMPs
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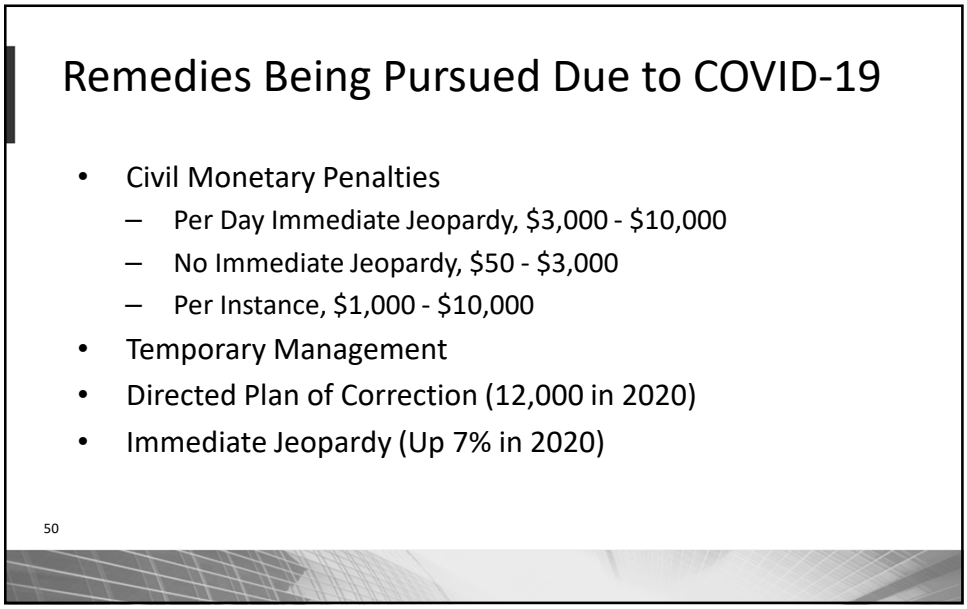
Remedies Being Pursued Due to COVID-19
• Civil Monetary Penalties
– Per Day Immediate Jeopardy, $3,000 - $10,000
– No Immediate Jeopardy, $50 - $3,000
– Per Instance, $1,000 - $10,000
• Temporary Management
• Directed Plan of Correction (12,000 in 2020)
• Immediate Jeopardy (Up 7% in 2020)
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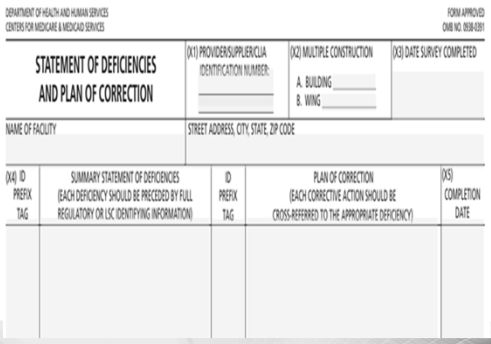
Plan of Correction

- State and Federal
- Enforcement
  - Deficiencies
  - Consequences
  - Remedies
- Plan of Correction



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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Background

- Why is appealing perhaps more important today than in the past?
- Already numerous surveys leading to CMPs due to COVID-19
- Surveys likely to spike next 2-5 years
- Why? Negative perception of the industry despite what facts truly say

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Appealing Survey Deficiencies and CMPs

- Informal Dispute Resolution ("IDR")
  - 42 CFR 488.331 and 42 CFR 488.431
  - Ability to dispute survey findings and CMPs
  - Conducted by State Survey Agency or Independent Review Organization
  - Proposed RoP would require decision on IDR within 60 days of request

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§ 488.331 Informal dispute resolution.

- REGUATIONS
- (a) *Opportunity to refute survey findings.*
  - (1) For non-Federal surveys, the State must offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.
  - (2) For Federal surveys, CMS offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.
- ..
- (c) If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

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Informal Dispute Resolution

- IDR process provides nursing homes a single, informal opportunity to dispute survey findings after the receipt of the official Statement of Deficiencies (Form 2567).
- 42 CFR 488.331 requires the CMS and the state's offer facility representatives an informal opportunity, at their request, to dispute survey findings subsequent to the receipt of the official Form 2567.
- If successful, the findings should be removed or modified and a revised Form 2567 will be issued.

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Informal Dispute Resolution

- The IDR process:
  - Scope and severity of non-Substandard Quality of Care or Immediate Jeopardy deficiencies
  - Remedies
  - Requirements of survey process
  - Inconsistency of the survey team in citations
  - Inadequacy or inaccuracy of the IDR process

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Process

- Every state handles the IDR process a little differently
- EX: Reviewed by panel of experts (e.g., three to seven person committee or panel that may include representatives from the agency, a trade association, a nursing home administrator and/or director of nursing)
- Arizona IDR Process
  - In writing within 10 days of receiving 2567
  - Separate from Plan of Correction
  - Provide deficiency disputed and detailed reason for dispute
  - Attach documentation
  - Cannot dispute surveyor judgement
- IDR does not delay any enforcement action

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Appealing Survey Deficiencies and CMPs

- Information Dispute Resolution
  - When should a SNF file an IDR?
  - If successful with IDR, make sure 2567 is revised or redacted
  - Should a facility file an IDR for an adverse infection control survey?

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Appealing Survey Deficiencies and CMPs

- The Appeals Process
  - CMS sends formal notice which includes:
    - ❖ Dates of notice and appeal deadlines
    - ❖ What laws/regulations are not in compliance
    - ❖ Procedure for formal reconsideration or hearing before an ALJ
    - ❖ Proposed remedies

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Appealing Survey Deficiencies and CMPs

- Filing an Appeal
  - Federal regulations allow SNF to appeal the proposed termination or CMPs
  - Appeal must be filed within 60 days of receipt. The Appeal is usually titled as a Request for Hearing ("Request")
  - Appeal is filed with the Departmental Appeals Board (“DAB”)
  - Make sure you date stamp and forward all notices from CMS to your legal counsel to ensure all appeal deadlines are met

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Appealing Survey Deficiencies and CMPs

- Filing an Appeal
  - Highly recommended that appeal filed by legal counsel.
  - Why? Appeals are not notice appeals and must follow strict guidelines as set forth in federal regulations. Cases have been dismissed due to lack of specificity in appeals
- The Hearing Process
  - The provider can choose to either have an in-person hearing or simply file a written brief with the ALJ
  - If an in-person hearing is conducted by the ALJ, the hearing is usually held where the provider is located or the nearest CMS Regional Office
  - Most hearings are now held over the phone

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Appealing Survey Deficiencies and CMPs

- The Hearing Process
  - The ALJ will rule in favor of CMS or the provider
  - Either party has a right to appeal the ALJ's decision. This appeal is usually titled as a Request for Review. This is the appellate stage of the appeal

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Appealing Survey Deficiencies and CMPs

- The Hearing and Appellate Process
  - The appeal is filed with the DAB within 30 days of the ALJ's decision
  - CMS then has 30 days to respond to the Request for Review to the DAB
  - The SNF then has another 15 days to reply to the response by CMS
  - Generally, no new evidence can be provided at this stage of the appeal. Decision is made solely from record of ALJ hearing

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Pros and Cons of Filing an Appeal with the DAB

- Pros:
  - If terminated, a SNF may have no choice but to appeal
  - SNF gets its day in court
  - Ability to directly confront surveyors
  - Appealing may increase odds of negotiated settlement with CMS
  - May help in the event litigation is instituted against the SNF

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Pros and Cons of Filing an Appeal with the DAB

- Cons:
  - Filing an appeal is costly
  - Appeals process can take a considerable amount of time
  - DAB decisions are very much slanted in favor in CMS
  - Some deficiencies are very difficult to have overturned
  - Almost impossible to win attacking the survey process

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Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

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317.977.1472
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