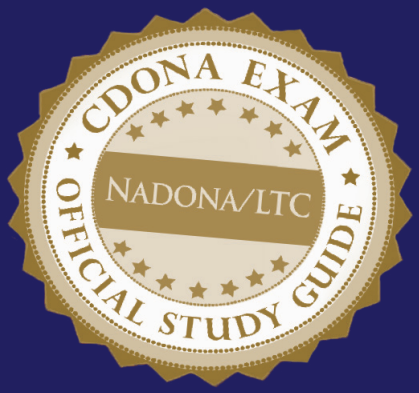

THE Long-Term Care Director of Nursing FIELD GUIDE

Third Edition

Barbara Acello, MS, RN

Foreword written by Sherrie Dornberger, RNC, CDONA, FACDONA

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The Long-Term Care Director of Nursing Field Guide, Third Edition, is published by HCPro, an H3.Group division of Simplify Compliance, LLC.

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ISBN: 978-1-68308-649-9

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Dedication

Laura Christine Acello Fowler

(1971 – 2017)

This book is dedicated to my loving, giving, beautiful,
and intelligent daughter who was taken from us far too soon.

Godspeed, my child.

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www.hcpro.com/downloads/12610

Contents

Foreword

Having been a DON for over 30 years, one of my biggest complaints was there is a lack of reference materials geared to help me do my job. No one had put together a comprehensive guide of policies, employee issues, leadership, successful orientation for the newly hired employee, conflict management, risk management, benchmarking, and delegation to name a few.

I have always said that DONs need a bit of attention deficit disorder to do a great job. If we concentrate on any one area for too long, 20 more issues would have passed us by. DONs have 20 issues or crises coming at them at once. They need to learn delegation, and documentation to survive. After all we are endangered species, aren't we?

I think this book will be the DONs' bible. It brings many pieces of information that are needed to do a great job together into one book. For new DONs, or DONs who may be looking to sit for the certification exam, it is a great learning tool. Seasoned DONs will also benefit by brushing up on areas that may not be our 'favorites' or best things to do. No one is an expert at everything, but this book will definitely enhance what you know and are able to do well! You will find additional useful information and geriatric clinical content at *www.hcpro.com/downloads/12610.*

This book was developed with the NADONA certification exam in mind, taking subject areas of the exam and creating chapters of the books to mirror the subject matter. As a nurse administrator we are much too busy to, as "they say," recreate the wheel. The information is here, all in a comprehensive format, and easy to understand, well-written, and reviewed by nurses working in the long-term care continuum on a daily basis. This will be one of the most used resources in your office library!

For those who are not DONs, it would also be a great motivator, and perhaps even a stepping stone to prepare our colleagues who may want to move up in the long-term care continuum as a supervisor, nurse manager, ADON, clinical care coordinator, wellness nurse, and on and on! Whether you work in assisted living, skilled care, adult day care, rehab short stay, this book will help you. We all have the same situations in different areas of work, but the same goal of providing the best quality of care for those under our supervision, and I am sure you will not regret owning this wonderful resource!

Sherrie Dornberger, RNC, CDONA, FACDONA
National Association Directors of Nursing Administration
President

Introduction

We are in a time of great transition. The long-term care rules were overhauled in 1987 in the Omnibus Budget Reconciliation Act (OBRA). How time flies when you're having fun! It doesn't seem like that was 30 years ago! Those rules became effective in 1991. Considering the time, the rules were very progressive and forward thinking. The Minimum Data Set (MDS) was new to us. That alone has made a profound impact on long-term care. The introduction of the MDS evolved into a large nursing specialty with numerous resources. A group of forward-thinking nurses created a professional organization for MDS nurses in 1999. Today, this group is 14,700 members strong. The MDS nurse has proven to be one of the most important nurse leaders in the facility. The nurses who organized the MDS nurses and established the professional organization have made an exemplary contribution to long-term care, affecting both caregiving and reimbursement.

Laws are also called statutes. Your state and federal legislators write the laws that determine what each license holder can do. They also establish guidelines and grant authority for regulatory agencies to make rules. A number of federal agencies also have rules affecting health-related businesses. Your State Board of Nursing and Department of Health are the two primary agencies that write rules for nursing practice and long-term care facilities in your state. They also determine how the rules will be applied.

Rules and regulations are much more comprehensive and specific than laws. They explain how to correctly implement the law. Rules also address standards of conduct and can be changed or updated frequently. In some situations, state and federal rules conflict. In this case, follow the rules that are the strictest.

Stay informed regarding issues affecting nursing practice. Rules and laws are always changing. They usually become stricter. They are seldom relaxed. Resident acuity has increased because hospitals discharge patients earlier and sicker than before. Healthcare is very reimbursement driven. This affects admission, discharge, length of stay, and whether the resident requires readmission to the hospital within 30 days of discharge. Some areas of the United States have a nursing shortage, and complying with regulations and caring for residents has become much more difficult than it was in the past. Something new is always trending, and there is much important information to share.

The Centers for Medicare and Medicaid services (CMS) has recently overhauled the long-term care facility rules and regulations. We wish we had a crystal ball so we could give you detailed information on how to implement these rules. Unfortunately, CMS will not disclose their secrets to us. It is probable that the new rules will be tweaked and modified. We are all

learning, and chances are that we will need to update this book in a year or two, when additional information is available.

Regulatory demands are changing rapidly. Many nurse managers and administrators are approaching the new rules with fear and trepidation. We did the same thing with OBRA. You are in this business because you are committed to long-term care and enjoy working with the geriatric population. You can do this. Take it one step at a time. Keep your goals in mind.

This book contains updated regulatory information. Infection control is another area that is evolving quickly, so we have included significant infection-related information. Note that CMS has added new emphasis to infection *prevention*. To this point, infection *control* has been the focus. Most facilities give flu shots and pneumonia shots, and apply the principles of standard precautions. Yes, these measures prevent infection, but much more can be done. Facilities with a comprehensive program for addressing both prevention and control of infection will have healthier residents and staff.

Read the new rules and commit them to memory. Yes, this is a lot of reading, but it is the only way to become familiar with them. Keep them handy, and make sure your key staff can access them 24 hours a day and know how to use them. We have provided various sources of information and references. There is an abundance of information in the search engines as well. Make sure you are using credible sources, such as CMS and other government agencies and professional long-term care and nursing organizations for RNs and licensed practical nurses.

Do not forget to check the downloads section of the book. You will find additional helpful information and resources there. Please check it periodically. We will add important new changes to this section as they evolve. Surveyors often request copies of specific policies and procedures. Some regions have reported that surveyors have reviewed the same procedures in every building. We have included procedures that have been frequently requested. If there are others, please let us know.

I am honored if you are a reader who selected this book to study for a certification exam. I sincerely hope this information is useful to you. The Institute for Credentialing Excellence (ICE) defines certification as "a voluntary process instituted by a non-governmental agency by which individuals are recognized for advanced knowledge and skill." Professional certification affirms the advanced skill, professional knowledge, and experience of distinguished leaders.

Good luck with your mission to provide quality long-term care and management of the largest and most complex department in the facility. Geriatric care is my first love, and I sincerely admire those who work in the difficult financial and regulatory environment we call long-term care. I believe in you, support you, admire your commitment, and sincerely hope that this information is useful to you in providing quality care and making a difference in the lives of the residents. If you have suggestions, questions, or comments, feel free to email me at *bacello@aol.com*. We also welcome suggestions for the next edition of this book.

Barbara Acello, October 2017

Acknowledgments

The Long-Term Care Director of Nursing Field Guide was written with the personal and professional collaboration of an interdisciplinary group of colleagues. I am sincerely grateful for the assistance and cooperation of:

Christin Delahay, LNHA, CDP, and Michael Hotz, LNHA, CNHA, FACHCA, made a major contribution to the information on budgeting in Chapter 4. This is difficult subject matter, and they explained it succinctly, in an understandable manner.

Genevieve Gipson, MEd, CNA, RNC, is always interested and willing to help. I sincerely appreciate her editing the procedures and reviewing nursing assistant information.

Betty Bruner, RN, BS, NHA, CDONA, FACDONA, and Sherrie Dornberger, RN, CDP, CADDCT, GDCN™, CDONA™, FACDONA, IP-BC™ of the National Association of Directors of Nursing Administration. Thank you for your suggestions and thoughtful reviews.

Olivia MacDonald, Managing Editor, has really extended herself in providing assistance and support. She has exceeded my expectations and has gone way above and beyond her job requirements during a difficult transition in my personal life.

Adrienne Trivers, Product Director, is always there when I need her and has never let me down. I feel fortunate that both she and Olivia are committed to quality, and I appreciate their unfailing assistance when I have needed help.

Many unnamed individuals at HCPro handle the manuscript as it makes its way through the production process. Each makes a contribution that ultimately enhances the value of the book, and I feel fortunate that they were assigned to this project. I appreciate the careful attention to detail. Many thanks!

Barbara Acello

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Disclaimer:

In addition to the care provided by physicians, some facilities are also fortunate to have the services of advanced practice nurses (including nurse practitioners and clinical nurse specialists) and physician assistants. These well-educated and highly qualified individuals provide excellent care to residents in long-term care facilities. In some situations, we note that physician notification is necessary. We are using the term "physician" for brevity only. This is not intended to minimize the important work of advanced practice nurses and physician assistants. When the reader is advised to notify the physician, facilities may also notify the advanced practice nurse or physician assistant, if available, and as required by state law and facility policies.

Every effort has been made to ensure that this material is timely and accurate at the time of publication, but long-term care involves evidence-based practices that change frequently. The author, editors, and publisher have done everything possible to ensure this book is current and in compliance with the standards of care.

The author, editors, and publisher are not responsible for errors or omissions or for consequences from application of the book, and make no warranty, expressed or implied, in regard to the contents of the book. Neither the author nor publisher or any other individual or party involved in the preparation of this information will be liable for any special, consequential, or exemplary damages resulting in whole or part from any individual's use of or reliance upon this material. The practices described in this book should be applied in accordance with facility policies and procedures, state and federal laws, the nurse practice act for your state, professional standards of practice, and the individual circumstances that apply to each resident encounter and situation.

CHAPTER

1

The Director of Nursing's Role in Leadership

The Director of Nursing

The purpose of the long-term care facility is to provide nursing care. Because of this, the director of nursing (DON) position carries a tremendous amount of weight, second only to the administrator. An RN must be the designated full-time director of nursing, according to the federal rules.

Director of Nursing Responsibilities

The DON is responsible for ensuring the provision of quality healthcare to the residents in the facility, in consideration of resident wishes and preferences, individual needs, physician orders, and state and federal regulations. The DON supervises and is responsible for administrative oversight of the entire nursing staff, consisting of licensed and unlicensed support personnel.

The DON must also ensure that nursing services comply with the State Nurse Practice Act and professional standards of care. Nursing care is delivered in compliance with the facility's mission, guidelines, policies, and procedures. He or she is expected to set a positive example for staff at all times.

The DON position is a full-time position with variable hours. He or she is responsible for the nursing department 24 hours a day, seven days a week. The DON can expect to be on call. He or she must be accessible after hours according to the facility's on-call rotation. He or she must also be available during certain emergencies. The DON monitors and evaluates nursing care given by staff each day. You cannot do this from your office. You must spend some time on the units to know what is happening. You must also make periodic rounds on the evening and night shifts.

A considerable number of the DON's duties involve interacting with attending physicians. In skilled nursing facilities, the DON is responsible for making sure resident certifications are completed in a timely manner. The certification is done to ensure that the resident is appropriate for the skilled level of care, and this care can only be provided in a long-term care facility. The care must be related to the condition for which the resident was hospitalized. The physician or nonphysician provider (NPP) certifies the level of care is appropriate on admission, at day 14, at day 30, and every 30 days thereafter. The DON must ensure that the residents'

continued stay is justified, and the physician can provide a clear rationale for the recertification. The physician or NPP validates that the skilled level of care is needed and estimates how long this level of care will be necessary. Coordinate the certification dates with the Minimum Data Set (MDS).

The DON frequently audits the nursing notes to make sure documentation is complete, accurate, and consistent. If the resident's payment source is Medicare, a nursing note is required at least once every 24 hours, related to the Medicare-covered diagnosis.

The DON will examine other aspects of the record, making sure the documentation is complete, clear, and timely. The DON will review the care plan to be sure it matches the resident's needs and staff is following the plan. Assessments must be timely, complete, and consistent with state and federal regulations.

The DON also:

- Addresses pertinent nursing issues
- Determines whether the prescribed treatment and medication are consistent with the diagnoses
- Ensures physician telephone orders are signed within the required time frame
- Identifies the need for inservices and competency checks

The DON makes daily clinical and operational rounds, making observations, teaching, listening, and interacting with staff. He or she uses critical thinking to evaluate staff performance and identify opportunities to improve clinical outcomes.

The DON is responsible for maintaining a schedule of all nursing staff, hours worked, and shifts worked for a minimum period promulgated by the laws of his or her state. Facilities are required to submit nursing hours in relation to the facility's census electronically to verify adequate staffing. The regulations also require facilities to post staffing information in a visible location for each shift every day. The federal regulations do not mandate specific numbers of staff. However, they make it very clear that staffing must be sufficient to meet resident needs. Many states have very specific rules related to staffing. The DON is responsible for evaluating staffing patterns to ensure compliance with state and federal regulations.

The DON is also responsible for maintaining, on record, all accident and incident (A/I) reports. The DON (or designee) reviews these reports daily to ensure that:

- The report is complete and accurate
- Proper protocol was followed
- Follow up investigation has been done
- Documentation is complete and accurate
- The care plan has been updated and is being followed
- Care being given reflects the resident's needs related to the incident

- Neurological checks are being done for unwitnessed falls and head injuries
- The physician and responsible party have been notified
- Deficient practices have been corrected
- The resident is being assessed every shift (or as appropriate) for 72 hours or until resolved
- Abuse, neglect, or exploitation are not suspected
- The incident has been reported to your state agency, if required
  - — Abuse and neglect must be reported in all states. In addition, some states require reporting of "serious incidents and accidents."
  - — Each state specifies the types of incidents to report. For example, a subdural hematoma, multiple fractures, or resident death related to an incident would be reportable in many states.
- Please also refer to the abuse and neglect section of Chapter 14. This is an exhaustive subject, and the rules have been expanded. Please also review §483.12, F223, F224, F225, and F226. Training requirements are listed at §483.95. QAPI Program requirements are listed at §483.95.

The DON analyzes the incident reports monthly looking for trends in:

- Types of incidents
- Implications of incidents
- Commonalities of incidents such as location, time of day, staff on duty, etc.
- Potential triggers such as loud noise, uncomfortable temperature, need to use the bathroom, unmet needs, etc.
- Potential deficient practices

To be successful, the DON must be a good communicator. Keeping your staff informed pays more dividends than you can imagine. Let them know that you expect them to communicate with you as well (refer to Chapter 3). The DON prepares a written summary of the findings and provides copies to the administrator, MDS nurse, and persons responsible for appropriate committees, such as the safety committee.

The DON and Nursing Home Administrator (NHA) are the chief representatives of the facility. As such, they are vested with enormous responsibilities and must have an extensive understanding of the state and federal regulations as well as the business being conducted by the facility. Together, they must work as a team and always keep the lines of communication open (refer to Chapter 3). The administrator must also be licensed. The licensure requirements vary from one state to the next. The criteria for licensure typically include having a four-year college degree, completing a special long-term care Administrator in Training externship, and passing a state and federal examination. Continuing education is required to maintain licensure.

What Is Leadership?

Simply stated, leadership is the act of getting things done through other people. Doing so is not always simple—in fact, author Max Dupree believes that leadership is an art. He defines it as "liberating people to do what is required of them in the most effective and humane way possible." Further, leadership is different than management in that:

- Management focuses on efficiency (i.e., "Doing things right")
- Leadership focuses on effectiveness (i.e., "Doing the right things")
- Management is about getting things done
- Leadership focuses on what needs to be done and why
- Management deals with systems and structures
- Leadership is about relationships and engagement with people
- Management stresses consistency and control
- Leadership requires creativity, innovation, and "out-of-the-box" thinking
- Managers are concerned about results and the bottom line
- Leaders see the need to have a vision and look over the horizon

Stephen Covey summarizes these thoughts by explaining that managers focus on climbing the ladder in an efficient manner and leaders are concerned about the ladder being up against the right wall.

In the changing world of healthcare, there is clearly a need for both. The question is not "Am I a leader or a manager?" but rather "How do I develop both dimensions in my role as I work with staff on a daily basis?"

Qualities of effective leaders

Successful leadership is dependent on one's ability to:

- Inspire confidence
- Show personal interest
- Keep the lines of communication open
- Produce results and quality outcomes
- Inspire, gather, and use employees' ideas
- Lead rather than "boss"
- Foster teamwork and a sense of community
- Show kindness without being considered "easy"
- Coach staff to reach their potential
- Be a role model for balancing work and home
- Delegate properly

- Demonstrate self-confidence without being "cocky"
- Make hard decisions when needed

Successful leaders also share characteristics of emotional maturity (sometimes defined as an emotional quotient, or EQ), which set them apart. This emotional maturity is so important that many organizations include characteristics of it in the list of qualifications for a leadership or management role. They include the following:

- **Self awareness—**an awareness and respect for your gut feeling. This characteristic allows you to use emotions as sources of insight about yourself, others, and situations.
- **Mood management—**a proficiency in expressing feelings appropriately and controlling impulses.
- **Self-starter—**an innate drive to achieve, motivated internally by creative energy.
- **Empathy—**an ability to thoughtfully consider another's feelings (i.e., understand what makes them tick).
- **People skills—**an ability to manage relationships and bridge differences.

Emotional intelligence for leaders and managers is analogous to critical thinking skills for staff: it provides a key measure of success in the role. If you are interested in developing your own emotional intelligence, consider the following suggestions:

- Get feedback from a person you trust by asking these questions:
  - In a sentence, how do you see me?
  - If you could change one thing about me, what would it be?
  - If I were to keep doing one thing I'm doing, what should it be?
  - What is your definition of an effective leader?
- Stay in touch. Take time for small talk with staff, especially with your quieter members.
- Be ruthlessly honest with yourself rather than blaming others.
- Remove barriers. Ask the staff about barriers they encounter in trying to get their work done and then follow up on those that you can impact.
- Avoid "us and them" or "win–lose" thinking—the goal is collaboration, not polarization.

Situational leadership

Everyone agrees that effective leadership is vital to a group's success. But trying to reach a consensus about which behaviors constitute effective leadership is not so easy. This lack of agreement suggests that, depending on the situation, a wide range of leadership behaviors can be effective.

Situational leaders change their leadership styles depending on the situation and person with whom they are working. Three skills are involved in being a situational leader:

- **Diagnosing:** Pinpoint the needs of the people with whom you work
- **Flexibility:** Use a variety of leadership styles
- **Partnering:** Come to some agreements with staff about the leadership style they need from you

Four Basic Leadership Styles

For a long time, people thought there were only two leadership styles—autocratic and democratic. In fact, people used to shout at each other from these two extremes, insisting that one style was better than the other. Democratic managers were accused of being too soft and easy, while their autocratic counterparts were often called too tough and domineering. Today's manager, however, is flexible and is able to use all four of the leadership styles described below.

Leadership and staff empowerment

For many years, leaders were believed to be effective because of personality or personal charisma. This was called the "trait theory" of leadership, and it was not until the Ohio State management and leadership studies by Paul Hersey and Ken Blanchard in the late 1960s that this conventional wisdom was debunked. Through their research, they found effective leaders had a talent for aligning the style they used with the particular needs of the person or group with whom they were dealing. This approach became known as "situational leadership," reflecting that the leader varies his or her style and uses "different strokes for different folks."

To use this approach effectively, learn to diagnose which style is needed when and become comfortable moving between four different styles depending on the situation. Over the course of usually three to five years, the staff with whom you are working should progress from requiring a directing style (e.g., orientation) to a coaching style (e.g., they are competent and developing talents) to a more independent phase in which you support their decisions and can finally delegate, knowing that you can trust their judgment.

Because staff gain authority as they develop, leaders, in a sense, work themselves out of a job. It has often been said that "the effectiveness of a leader is measured by what happens in his or her absence." The four basic leadership styles leaders can use to develop staff are described in more detail below.

1. **Directing—**In this style, the leader provides specific direction and closely monitors the accomplishment of tasks. Communication is largely one-way: You tell staff what, when, where, and how to do something, then carefully monitor their performance. Explain what the goal is and what a good job looks like, then describe the plan for meeting that goal. Essentially, you solve the problem. You make the decisions and the person carries out your ideas. A directing style is appropriate:
   - When a decision has to be made quickly and the stakes are high
   - For inexperienced people with the potential to be self-directive

- For someone with good potential who is not familiar with the organization (e.g., the past history, established protocols, or political implications of a situation)

Usually, staff will not resent direction and close supervision when they are first learning a task. Most are enthusiastic beginners who want to do a good job and welcome any advice that will help them succeed.

2. **Coaching—**change to two-way communication and coaching as the new manager begins to understand the expectations and begins developing the necessary skills and abilities. Good coaches bring out the best in people by helping them see their talents and abilities and the value they add to the team. They also are adept at pointing out the "rough edges" that need more work or the skills that need to be added to the basic ones they acquired in the first year of employment. The new manager begins as a novice and progresses to independent success. Questions such as, "What can I do to help you become more effective?"

Many managers find this phase in the staff development process to be very rewarding as they watch staff blossom in their roles and grow in their senses of self-esteem. The coaching style works best with:

- Staff that want to develop a particular technical skill or specialized interest, such as patient teaching, discharge planning, or competence in a new process
- A group that has a sense of what it wants to accomplish but needs direction
- Employees who have transferred from another department and know facility policies, but need to learn and grow in their new positions

3. **Supporting—**As staff accept more responsibility for and become proficient in their roles, the leader shares with them the decision-making and problem-solving responsibilities and supports them in applying their ideas. The leader can be much less directive in this role due to the proficiency of the person or group, and, in a sense, it becomes the leader's job not to give answers but to ask the right questions. For example, you might say, "Tell me what needs to happen. What are the pros and cons of this policy as we have developed it? What needs to be done to be done to finalize and implement it?" Asking for their opinion shows you have confidence in them. Make sure to show your appreciation with comments such as, "You have done a great job putting it together and I know this project will be successful."

Supporting style works best with:

- Staff who are two or three years into the job and have developed their ideas about what needs to be done to improve the work environment
- Experienced staff who are brought together on a short-term task force that needs to produce results
- Staff who have transferred from another facility (who have demonstrated proficiency in the role) and want to implement some ideas that worked at a previous employer

4. **Delegating—**In this style, the leader turns over the responsibility for day-to-day decision-making and problem solving to staff. This style offers the most latitude for authority in decisions and autonomy. Delegating is appropriate for people who are self-reliant achievers—people who are competent and committed and need little direction. They are also able to provide their own support. For example, top performers do not need much supervision or praise as long as they know how well they are doing. Leaders using this style present the problem and then get out of the way as staff develop a solution. Delegating works best with:
    - Seasoned experts who are ready for "job enrichment," so they can stay enthusiastic and invested in their role
    - Issues like staff scheduling, because staff know what needs to happen and can make it happen using guidelines agreed upon by the group
    - Task forces that have implemented a process and need to fine tune it or maintain and update its structure

Identifying the Best Leadership Style for the Situation

There is no best way to influence others. The right choice of leadership style depends on your ability to determine whether your staff have all the skills and experience they need to do the job they are assigned and your sense of whether they want to or believe they can do it.

Assess readiness as determined by the level of competence and commitment the person or group brings to the job to be done. Taking the time to accurately diagnose how to best align leadership style with staff needs is the characteristic feature of situational leadership. Leaders who fail to accurately assess these needs often rely on instinct, assumptions, or their own favorite styles and miss the opportunity to really engage with their staff.

Micromanagement and being left to "sink or swim" are just two examples of the lack of alignment between a leader and follower(s). To increase the chances of aligning with the readiness of staff or the group, give thought to the concepts of competence and commitment, as they are equally important to successful completion of a task.

Competence—Competence is a function of knowledge and skills, which can be gained from education, training, and experience. Competence is not another word for ability. Competence develops with the appropriate direction and support. You are not born with competence—you learn it.

Commitment—Commitment is a combination of confidence and motivation. Confidence is a measure of a person's self-assuredness—a feeling of being able to do a task well without much supervision—and motivation is a person's interest in and enthusiasm for doing a task well. If employees have the competence and confidence but no motivation, they are not committed to the job. People lose motivation for a myriad of reasons. One of the most common is realizing the task is going to be harder to complete than they thought.

When we examine the relationship between the four leadership styles, commitment, and competence, we find the following:

- Directing is for those who lack competence and because of their insecurity (e.g., orientees or new grads in their first year of employment).
- Coaching is for those who are committed and more secure but need guidance, praise, and feedback to continue developing their competence (e.g., staff with 15–36 months on the job).
- Supporting is for those who are competent with well-developed skills, but need support and guidance in trusting their own judgment and making decisions that build their self esteem (e.g., a proficient staff nurse who is chosen to chair a task force of her peers).
- Delegating is for those who have both competence and commitment. They are willing and able to work on a project by themselves and with little supervision or support.

Consider explaining your choices. The proficient staff nurse who has never been involved in a problem-solving task force will need a great deal of direction. The competent charge nurse who has been a preceptor for new grads will probably need direction and support when dealing with an irate or disruptive physician. Reviewing the leadership styles—directing, coaching, supporting, and delegating—in a staff meeting assists staff in understanding why you may be using "different strokes for different folks" and intentionally treating people differently as their needs change.

Self-assessments

It is important for the leader to thoughtfully assess the style needed by a person or group, but it is also helpful to have the person or group use these ideas to assess themselves and ask for the style they need from the leader.

This framework can shed light on what staff need in terms of guidance and support. They may report to a director who naturally prefers a delegating style. However, if they are new to management, a directing style is often best. Seasoned expert managers may find themselves micromanaged as a new director determines how much guidance they need. Candid and honest discussions about such alignments can be instrumental to everyone's overall effectiveness. Use situational leadership as a framework for these important conversations.

Case study: Applying leadership styles to problem solving

Q A seasoned employee has approached you with concerns about a new medication administration policy. In the past, this employee has been reluctant to participate in problem-solving processes. You identify this as an opportunity to use a combination of the leadership styles you learned in this module: directing, coaching, supporting, and delegating.

A Consider this response: "You have identified a real potential problem with this new policy. It is good that you brought it to my attention—thank you so much. I understand the pharmacy committee is meeting Wednesday to address concerns that have been voiced by staff, and it would be very beneficial for them to hear your perspective. Since you are already scheduled for that day and the meeting is at 10 a.m., I will cover your assignment for you while you attend. If you need any references or resources to support your ideas, please feel free to use any of the materials on my bookshelf or let me know if I can be of any help. Thanks again for bringing this to my attention. It will be interesting to see the outcome of the meeting, won't it?"

CMS *State Operations Manual* (*SOM*)

You will find the information and rules you need in the *State Operations Manual*.

The *SOM* details CMS policy regarding survey and certification activities. Healthcare facilities must comply with federal requirements as stated in the Medicare Requirements of Participation (RoP) in order to receive payment with Medicare or Medicaid money. Although they are technically not the same thing, you may hear the RoP called *Conditions of Participation (CoP)*. Facilities must comply with the RoP published in 42 *Code of Federal Regulations (CFR)*, part 483, Subpart B. The regulations are different for each type of facility. Surveyors visit the facility unannounced. The facility must pass at least a *Standard Survey* and a *Life Safety Code (LSC)*® survey. The *SOM* describes and defines regulations and survey activities. You will find off-site activities and other information with the *SOM*, but we are going to focus on the on-site federal survey activities only. The surveyors will also be checking for compliance with your state regulations. If they are different from the federal regulations, always use the highest standard of care. Each state is different, so we will not be discussing the state regulations here. The federal rules are the most comprehensive, and your Medicaid and Medicare payments depend on them, so we are limiting the discussion to strictly federal regulations.

TIP

Download the two-page Table of Contents from *http://tinyurl.com/y7buzudz*. The information you need will be found in an appendix. If you are in a skilled, long-term care facility, review appendices P and PP. If you are in a different type of facility, find the appendix that is appropriate to your facility on the list.

- Click on the letter representing the manual you need and begin your download. Save the file.
- Please note that manuals are downloaded in PDF format. They take up a fair amount of space on the hard drive. You may not be able to download them directly to a handheld device without converting them to a different format. If you are comfortable with the program that you regularly use to convert file types, use it. Otherwise, a simple, free program is available at *http://www.online-convert.com/*

Where to begin?

Each person who reads this book is in a different place, knowledge and experience wise. The information here may seem elementary to some of you, and enlightening to others. Please read it anyway and see if you learn anything new. If not, use it for inservice or to orient new managers and supervisory nursing staff.

Your goal as a manager is to make sure the nursing department delivers quality care. One of the ways you do this is by knowing, understanding, and following the regulations. Refer to them as often as necessary to check for compliance. Make walking rounds times each day so

you know what is happening on each unit. Speak with staff and residents. Be visible. Also monitor unit reports, incident reports, and documentation of residents who are unstable and/or those who require frequent charting. Help your staff learn and understand the rules. The *SOM* is your primary source of information. It is impossible to prepare for a survey. Making rounds and being involved helps you to ensure that your facility is survey ready every day.

Dr. Black, You Have a Call on Line 4!

It is a routine day until the receptionist announces on the intercom, "Dr. Black, you have a call on line 4." That gets your attention! This is your facility code that means surveyors are in the building. The staff is like a well-oiled machine. They know how to respond when they hear this page. When you see this in print, it sounds a bit ridiculous, and it is. Many facilities have a code to alert staff to the presence of inspectors in the building. Don't bother. The surveyors know what you are doing, and they wonder what you are trying to hide. The information will travel quickly by word of mouth. If you are survey ready every day, it should not matter.

The rules have changed and so has the survey, so you must be prepared for both. You are not alone in this. Surveyors must also learn the rules and the new survey practices. CMS has been very transparent in making the same material available to both providers and surveyors. The purpose of a long-term care facility survey is to evaluate facility practices to determine whether the facility is in compliance with the regulations. The goal of moving to a uniform new survey is to combine the Quality Indicator Survey (QIS) with the regular survey. Deficiencies are citations of noncompliance written for violations of the regulations, as assessed by surveyor observation and evaluation. Surveyors must also know the regulations and use certain protocols when they are inspecting a facility. The *SOM* is like a global reference book to them. The survey protocols and interpretive guidelines in the *SOM* explain the intent of the regulations. All surveyors are required to use them in assessing compliance with federal requirements. For consistency, surveyors use the Interpretive Guidelines to clarify the meaning of the regulations. (This consistency is from one surveyor to another, and one facility to the next so everyone is on an equal playing field.) Surveyors want good care just like you do. They are not trying to trap you or catch you doing something against the rules.

Studying the Interpretive Guidelines is one of the most important things you can do to ensure you understand the purpose and intent of the regulations. Networking with your peers, taking classes, viewing webinars, and participating in professional organizations will help you learn how others are implementing the regulations and give you ideas on how to best adapt them in your facility.

Moving Right Along

After you have located and downloaded the *SOM* you need, begin at the beginning. You have downloaded and opened the *SOM*.

This writer's best advice is to read the *SOM* from cover to cover. Reading 739 pages may seem overwhelming, but there is no easy way to do it. Although many of the regulations pertain to other departments, the director of nursing is the number two person in most facilities. He or she is responsible for management, supervision, and decision-making in the administrator's absence. To do this effectively, you must be familiar with all of the rules.

Changes to the *SOM* are anticipated. This book is updated periodically, so be sure you are using the most current revision. Begin preparing now and do not wait for more changes.

Text to Speech (TTS) software is available to read text files to you out loud. This may be an option, particularly if you have a long commute and can listen to it in the car. Although I am familiar with the availability of these products, I have not personally used them and cannot make recommendations regarding their efficiency. Please refer to the information at *http://tinyurl.com/yc2ugm3a*.

Red ink

It is easy to assume that the subjects described in red ink are the most important. Everything is important in the *SOM*. The red ink means that the information is new or has been changed. The interpretive guidelines are standards of care. Many of them have not been changed for many years and remain current. Some have been updated, and a new section has been added to others. Another new section called "Key Elements of Noncompliance" was included to provide clear examples of the practices and behaviors identified in the regulation.

Making a plan

You will learn that the new rules are implemented in three phases. Some requirements, such as infection prevention and control, overlap all three phases. Discuss the new information with your QAA committee and staff at all levels. Ask for suggestions. Asking staff for their input lets them know they are valued employees, and they are much more likely to get things done if they have an investment in the plan.

Consider making a care plan for your facility to comply with the rules. What this means is to identify what needs to be done and set priorities for each task. Lists the steps you plan to take and the potential completion dates. List your goal, approaches, implementation, and evaluation. Distribute the information to your key staff and start getting things done. Revisit this document frequently, as you would a care plan. Evaluate your progress, and modify the plan if needed. This may seem elementary, but it is an effective method of keeping everyone on the same track and getting things done.

Identify policies, procedures, orientation, and inservices that must be changed because of the new requirements. Review what you have and see if it must be modified or deleted. Determine whether you need new policies and/or procedures. If so, appoint a team to start working on them.

The Long-Term Care Facility Survey

The long-term care facility survey is new and we will not try to second-guess it. Remember that your goal is to be survey ready every day. Surveys are unannounced and conducted on a 9- to 15-month cycle with a statewide average of 12 months. We do not expect this to change. The penalties are severe for notifying a facility of survey dates in advance. Although most surveys are conducted during business hours, the survey may be done 24 hours a day, seven days a week.

Upon completion of the survey, the regional office (RO) or state survey agency (SA) will review the surveyors' documentation and mail you a paper listing their findings. A deficiency is a written notice of violation of the rules set by the agency conducting the survey. Nursing deficiencies often reflect inadequate care or substandard practices. Resident rights violations and infection control problems are major causes of deficiencies in surveys. Pressure injuries and failure to notify the physician of a change in condition are examples of common harm (injury) citations.

If a facility is found to have provided substandard quality of care, surveyors must conduct an extended survey within 14 days. This survey will include a detailed review of:

- Policies and procedures related to the substandard quality of care
- An examination of staffing, training, and a larger sample of residents' assessments

If the facility has a nurse aide training program, or is a clinical site for a community college or trade school program, it will be prohibited from participating for a two-year period of time from the date corrections (if any) are made. This prohibition results from having an extended survey, even if no deficiencies were written. For example, a facility that this writer consulted for sent five residents to the hospital during the first day of a survey. This aroused the surveyors' suspicion and they went into extended survey mode. No significant deficiencies were written, but the facility lost the nurse aide training program. Truth was, the potential transfers had been in effect prior to surveyor arrival, but the surveyors did not ask questions. They suspected that nurses were trying to empty the facility due to the survey. The hospital admitted all five residents, and the survey outcome would likely have been much worse had they stayed in the facility and continued to decline.

Substandard quality of care requires specific corrective actions such as a specific, mandated plan of correction (called a directed plan of correction), temporary management change, or termination of the provider agreement.

The most serious problem surveyors identify is categorized as immediate jeopardy. This is a situation where the infraction of the rules has caused or is likely to cause serious injury, harm, impairment, or death.

Monetary penalties that are imposed for deficiencies are called remedies. In order to determine the remedies, the survey agency will carefully review the problem and identify the scope and severity of the deficiency(ies). CMS will impose remedies if one or more residents is seriously harmed. In some situations, CMS may allow the facility to correct the problem before

remedies are imposed, but there is no requirement to do so. Civil Money Penalties (CMPs) are mandatory fines imposed for immediate jeopardy . In an immediate jeopardy situation, the regional office is required to initiate CMPs immediately with no opportunity to correct.

Scope and severity

The scope and severity grid is an important part of the survey scoring system. The surveyors will determine the level of harm to the resident(s). They will assign a severity value from A through L to the deficiency, with A being the least serious and L being the most serious. The scope reflects the number of residents affected by the problem. The three levels are isolated, pattern, or widespread.

The severity is determined by the outcome of the deficiency and the level of harm it caused. The four levels are:

1. No actual harm with potential for minimal harm
2. No actual harm with a potential for more than minimal harm that is not immediate jeopardy
3. Actual harm that is not immediate jeopardy
4. Immediate jeopardy to resident health or safety (Tables 15.1-15.3)

Table 15.1		Scope and severity definitions	
S/S	**Scope**	**Severity**	**Description**
A	Isolated	Level 1	No actual harm, potential for minimal harm
B	Pattern	Level 1	No actual harm, potential for minimal harm
C	Widespread	Level 1	No actual harm, potential for minimal harm
D	Isolated	Level 2	No actual harm, potential for minimal harm
E	Pattern	Level 2	No actual harm, potential for minimal harm
F	Widespread	Level 2	No actual harm, potential for minimal harm
G	Isolated	Level 3	Actual harm that is not immediate jeopardy
H	Pattern	Level 3	Actual harm that is not immediate jeopardy
I	Widespread	Level 3	Actual harm that is not immediate jeopardy
J	Isolated	Level 4	Immediate jeopardy to resident health or safety
K	Pattern	Level 4	Immediate jeopardy to resident health or safety
L	Widespread	Level 4	Immediate jeopardy to resident health or safety

Please note this is the old format of this chart. Some people find the alphabetical chart easier to read. Others like having the immediate jeopardy information at the top. The data is the same in both.

Definitions

Isolated: When one or a limited number of residents or staff are affected and/or the situation has occurred only occasionally or in a limited number of locations.

Pattern: Occurs when more than a few residents or staff are involved or the situation occurs in separate locations, or the same person has been involved in multiple instances of the same deficient practice. However, the practice is not widespread or pervasive in the facility.

Widespread: Occurs when the problem is pervasive and/or represents a systemic breakdown that has affected or has the potential to affect a large number of residents. This refers to deficient problems affecting the entire facility, not a single unit. It may be considered a systemic failure.

Immediate Jeopardy: A deficient practice or situation that is so severe that it has caused or is likely to cause harm, impairment, serious injury or death of a resident. It must be corrected in the time specified by the department. If it is not corrected within 23 days of the last day of the survey, the facility will lose all Medicare and Medicaid funding.

Severity levels and definitions

Level 1: A deficiency with no more than minimal negative impact on the residents.

Level 2: Noncompliance that results in (or has the potential to result in) no more than minor physical, mental, or psychosocial impact or effect the resident's ability to attain or maintain his or her highest level of well-being. (As defined by an accurate MDS, plan of care, and provision of services.)

Level 3: Noncompliance that results in a negative outcome that has compromised the resident's ability to attain or maintain his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.

Level 4: Immediate jeopardy, or a situation in which the noncompliance is so severe that it is likely to cause or has caused serious harm, injury, impairment, or death. Requires immediate corrective action.

The scope and severity system also applies to life safety code deficiencies. In addition to monetary penalties, the survey office has the ability to appoint a temporary manager for the facility. This person is usually appointed by the CMS RO, but the facility is expected to pay his or her salary and expenses.

The 2567

2567 is the CMS form number for the Statement of Deficiencies that you will get in the mail after the survey. Please refer to: *http://tinyurl.com/ex-2567.* 2786R is the CMS form number for the LSC Statement of Deficiencies. Please refer to: *http://tinyurl.com/LSC2786R.*

Reading the 2567

In order to differentiate state and federal deficiencies, look at the two columns on the far left side of the 2567. Deficiency numbers may also be called "tag" numbers. Each number corresponds with a violation of the regulation associated with that number in the state or federal rules.

- Deficiency numbers preceded by an "F" are violations of federal (CMS) rules, such as F309.
- You may also see a number, such as 42CFR. This is the number for the federal law. Facilities are required to be in compliance with the requirements at 42 *CFR* Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs.
- Deficiencies preceded by the first initial of your state (such as O for Oklahoma, or T for Texas) and AC (such as OAC or TAC) are violations of state laws. "AC" is the abbreviation for "administrative code," which is the name used when referring to the various regulations. Some states use a single letter representing the state, such as M093. Others use a series of numbers, such as 300.1610a)1). The number represents the number for the state law violated.
- Nursing service is only indirectly involved with the life safety code. These begin with the letter K. Life safety regulations and other information is available at *http://tinyurl.com/life-safe*.

Plan of Correction (POC)

Most facilities get about 6 to 7 F-tag deficiencies per survey. The facility has 10 calendar days in which to respond to each deficiency by returning a Plan of Correction (POC). Incomplete or inadequate responses will not be accepted. This document is a public record, so avoid mentioning names and circumstances that could be used to easily identify the resident. The facility response should include a complete answer to each deficiency, such as:

- Respond to the original deficiencies cited, one at a time. Identify the processes leading to the deficiency.
- State how this deficiency was corrected (i.e., the acceptable plan of correction for the deficiency that was cited).
- Describe how you will monitor this problem to ensure that the deficiency remains corrected and the plan of correction is effective and in compliance with regulatory requirements.

- The position or title of the person(s) responsible for implementing and monitoring the acceptable plan of correction.
- Dates when the corrections will be completed.

Write your response in the two far right-hand columns of the 2567 opposite the federal tag number. You may attach a piece of paper with additional information and you may attach exhibits if you wish. The administrator must sign the first page. If the plan is acceptable, the survey office will sign it and return it. At this point, you are required to post the survey and plan where it is accessible to the public. Surveyors will return to ensure the deficiencies have been corrected. They will revisit them during subsequent surveys to be sure they remain corrected.

Informal Dispute Resolution (IDR)

Each state is required to have an informal system for facilities to dispute deficiencies. There are no standardized criteria for filing a dispute. Each state has set its own criteria, and none are uniform. This process is called Informal Dispute Resolution (IDR). The facility has 10 days from the date of receipt of the 2567 to file an IDR.

Disputing deficiencies can be resource intensive. The facility must determine whether the benefits outweigh the expense and time devoted to preparing and disputing deficiencies in person via the IDR process.

The primary reason that facilities use the IDR process is because deficiencies affect the five-star rating system that is posted on the Nursing Home Compare web site: *https://www.medicare.gov/nursinghomecompare/.*

A technical user guide for Nursing Home Compare is available at *http://tinyurl.com/yavtbsdl.*

You have seen comments elsewhere in this book about how many facility managers dislike this site and can point out numerous reasons why the "star" rating system is inaccurate for measuring nursing home quality care. We are not debating this point.

Consultants, experts, and analysts are supporting facilities on this issue. Many also agree that hospitals are not providing information and support for patients who must choose a long-term care facility. Some hospital discharge planners and social service personnel believe that HIPAA and various other regulations forbid them from initiating or facilitating an information exchange them between patients and long-term care providers. This is ironic since hospitals are penalized if Medicare patients are readmitted after discharge. Readmission would be a much lower risk if patients were referred to quality long-term care facilities. (D. A. Tyler, E. A. Gadbois, J. P. McHugh et al.).

McGarry and Grabowski do not mince words in their August 29, 2017, blog (D. E. McGarry and D. Grabowski) where they note that "tools that help with decision-making exist, but they are often complicated, incomplete, and potentially misleading."

One major issue is that the star system is affected by surveys, and deficiencies can decrease the star rating. The general public does not understand the complexities, difficulties, or regulations related to managing a facility. Many expect the level of care to be exactly as it is in the hospital. They do not understand our sliding scale healthcare system. Since Nursing Home Compare is a government site, they accept the information as gospel. Some people use this rating system when selecting a facility for their loved ones. Others use it as a means of monitoring facilities in which their loved ones reside. It is important to ensure the rating is as high as possible to enhance the facility image in the eyes of those who are not well-versed in the intricacies of managing a long-term care facility. Some family members note that they get more accurate information from Facebook and other social media sites.

Disputing deficiencies is resource intensive. Review the rules for your state carefully before making a decision to initiate the IDR process. Carefully review Table 15.2 and Table 15.3 to see how each deficiency level is scored. This will give you an idea of whether filing an IDR will make a difference in your star rating. If you decide to proceed, dispute only the most severe deficiencies. There is no point in disputing those with little to no impact on your star rating. Contesting insignificant citations will only create unnecessary work and tarnish your integrity in the eyes of the survey team. Although they are not determining the outcome of the IDR, the process will create extra work for them as well.

Table 15.2 **Health inspection score: Weights for different types of deficiencies**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 points	B 0 points	C 0 points

Note: Numbers in parentheses indicate points given for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR §483.13 resident behavior and nursing home practices; 42 CFR §433.15 quality of life; 42 CFR §483.25 quality of care.

•If the status of the deficiency is "past non-compliance" and the severity is "immediate jeopardy," points associated with a "G-level" deficiency (i.e., 20 points) are assigned.

Source: Centers for Medicare & Medicaid Services.

Table 15.3 **Weights for repeat revisits**

Revisit Number	Noncompliance Points
First	0
Second	50% of health inspection score
Third	70% of health inspection score
Fourth	85% of health inspection score

Note: The health inspection score includes points from deficiencies cited on the standard annual survey and complaint surveys during a given survey cycle.

Source: Centers for Medicare & Medicaid Services.

The facility must determine whether the potential benefits outweigh the expense and time devoted to preparing and disputing deficiencies in person. Low scope and severity deficiencies are probably not worth disputing. Disputing a deficiency is not a guarantee that you will prevail.

Independent Informal Dispute Resolution (IDR)

The Affordable Care Act (ACA) brought us another avenue for disputing certain deficiencies. The Independent Informal Dispute Resolution (IIDR) may be used to dispute deficiencies for which a CMP has been imposed. The facility has 10 days of receipt of CMS's offer and must be completed within 60 days of the imposition of these CMPs. The documentation that supports your reason for disputing the deficiencies must be submitted with the initial IIDR request during the first 10 days. Stick to the facts. Avoid emotion. Do not state that the surveyors were unfair. Address only the deficiencies in which CMP were imposed. You may not address shortcomings, deficiencies, inefficiency or inconsistency of the survey team, or surveyor behavior.

Surveyors are instructed not to be consultants to the facility. They are responsible only for evaluating resident care and determining how well the facility is meeting the residents' needs. This is important to know, because if you ask them for advice, they may not give it. If a surveyor does give you advice, it is his or her opinion, and may not reflect the policies of the survey agency. Thus, implementing a widespread practice based on surveyor advice may cause you to receive a deficiency the next time a different surveyor visits with a different opinion. The facility is responsible for hiring their own consultants and finding ways of correcting the problems, and this is really best to ensure compliance with the rules.

Value-Based Care

Surveyors will review the Quality Measures during the survey. Value-based care is a program that ties facility payment to quality of care. The first year quality measure is hospital readmission from all causes. This will affect the Medicare payment rate beginning October 1, 2018. The system is designed to withhold 2% of the Part A payment if free admissions to the hospital increase. The facility has an opportunity to earn the 2% payment back, depending on readmission scores. For additional information, refer to Chapter 4. For additional information, refer to *http://tinyurl.com/h6t6cym*.

Special Focus Facility (SFF) Program

The Special Focus Facility (SFF) Program is not well understood. Most managers know that inclusion on the special focus list is not an honor. Facilities that are selected for inclusion on the special focus list have several things in common:

- They consistently have about twice as many deficiencies as other facilities. You have learned that the average nursing facility has roughly 6 or 7 deficiencies for each survey.

This means that facilities on the SFF list have approximately 12 to 14 deficiencies on each survey, although this can be highly variable.

- The nature of the problems is more severe, including harm or injury to the residents.
- A pattern of serious problems that has persisted over a three-year period. The facility may come into substantial compliance, but the same problems recur repeatedly. Although the facility cleared the deficiency, they failed to correct the underlying problems that gave rise to the deficiency to begin with.

If a facility is selected for inclusion in the program, the SA must notify the facility and all other responsible parties in writing. Next, they must conduct a meeting either on site or by telephone to notify all parties of the reasons for selection and the criteria for graduation from the program or termination from Medicare/Medicaid funding. For example:

- **Selection:** The facility has been selected as an SFF due to its "persistent pattern of poor quality on its last three standard surveys and complaint surveys"
- **Graduation:** SFFs have about twice as many surveys as other facilities. Penalties progressively become more severe if problems persist. Surveyors expect the facility to identify the system problem causing the recurrent deficiency and correct it. Facilities are expected to improve within 18 to 24 months or they will be terminated from the Medicare program. If the facility has made significant progress, they may request an extension. There is no guarantee it will be granted. CMS will evaluate the facility's progress and determine whether an extension is warranted. In order to graduate from the SFF program, the selected facility must have:
  - Completed two standard surveys with no deficiencies cited at a Scope/Severity of F or greater and S/S not of "G" or greater for *LSC* deficiencies
  - The facility must also have no complaint surveys with deficiencies cited at a S/S of "F" or higher ("G" for *LSC*) in between those two standard surveys, the exception to this is if the only S/S "F" deficiency is related to food safety; the RO may allow the facility to graduate
- **Imposition of remedies:** If the facility fails to achieve and maintain significant improvement in correcting deficiencies on the first and each subsequent survey after it is designated as a SFF, CMS or the SA will impose an immediate remedy/remedies on the facility.
  - What is "significant improvement?" Per CMS, this is when the SFF demonstrates that its practices have resulted in no deficiencies with an S/S of "E" or higher ("F" or higher for LSC citations)
- **Enforcement remedies:** SFFs that do not show significant improvement with each standard survey and intervening complaint survey will see enforcement remedies of increasing severity. Remedies include:
  - CMPs

  - — Discretionary Denial of Payment for New Admissions (DPNA)
  - — Directed Plan of Correction (DPOC)
  - — Temporary Management

- **Last chance survey:** If a nursing home remains in the SFF Program after three consecutive standard surveys (a full survey cycle), and the most recent standard survey had deficiencies cited at a S/S of "F" or greater ("G" or greater for *LSC*), then the SA will schedule another standard survey—a "last-chance" survey.
- **Appeal:** A facility cannot appeal its selection as an SFF. It can appeal the noncompliance resulting in an enforcement remedy determined under an SFF survey to an Administrative Law Judge of the HHS Department Appeals Board.
  - — IDR/IIDR: An SFF facility has the right to IDR/IIDR.

Facility response

Within five business days, the facility must also respond in writing by providing the RO and SO with the following information:

Names, phone numbers, email addresses, and physical addresses of:

- Chairperson of the governing body
- Holder of the provider agreement
- Any party who owns 5% of greater of the facility
- Management company (if applicable)
- Landlord (if applicable)
- Mortgage holder
- Any corporate owner if the nursing home is part of a chain

The facility must also notify certain others that it has been selected as an SFF due to its persistent pattern of poor quality on its last three standard surveys and complaint surveys and provide information to:

- Residents
- Resident representatives
- Families
- Resident Council and/or Family Council primary contacts

CMS's goal

It is evident that CMS is not playing around. The facility must make improvement rapidly, or their funding will be substantially reduced or eliminated entirely. Generally, they are allowed a period of time in which they are monitored and making a good-faith effort to correct the problems, but if surveyors do not see rapid, substantial progress, they can terminate the

funding and impose Denial of Payment for New Admissions (DPNA) at any time. This will almost always shut the facility down. For additional information, please refer to:
http://tinyurl.com/y87sxmpl
http://tinyurl.com/y9lzjrhw

Hurricane Katrina

Early in the morning of August 29, 2005, Hurricane Katrina hit the New Orleans area with 130+ mile per hour winds. The hurricane caused a levee to break, sending 20-30 foot waves crashing into the St. Rita's Nursing Home and flooding 80% of the New Orleans area. Thirty-five residents of St. Rita's were trapped and drowned in their beds. The owners, themselves an elderly couple, were charged with negligent homicide and acquitted. Twelve years has elapsed since this catastrophe occurred. They are still viewed as villains in the parish.

After Katrina struck New Orleans, Memorial Medical Center, a coastal hospital, was surrounded by water, power was out, and the backup generators failed. Temperatures were more than 100 degrees inside. Evacuations were difficult and erratic and had been made by carrying patients up the stairs to the roof, where a helicopter picked them up. Since the power was off, the stairwells were dark. This was a dangerous mission. A number of critically ill patients remained in the building, and they were suffering. People on ventilators were initially supported by battery backup, but as batteries failed, patients began to die. Gunshots could be heard outside, and looters were in the area. The police were forcing people to leave the building.

The seventh floor of the hospital had been leased to another company called Lifecare and was licensed as a long-term care acute hospital (LTAC). The Memorial census had only decreased to 130, and the Lifecare census was 72. The patients were in different locations in the building, so staff were spread thin. Grouping them all together would have been much more practical, but many were impossible to move without an elevator. The facility was running out of food, water, medicine, and supplies. Erratic helicopter evacuations continued, but people began shooting at the rescuers in the dark, putting an end to nighttime evacuations. Several nurses and one physician remained to care for the Lifecare patients. Many patients died.

Eventually the last living patient was evacuated, and an exhausted staff were transported to the airport to care for patients who had been dropped there. Thirteen days later, the coroner's office was finally able to enter the hospital to remove many decomposing bodies. A year-long investigation began. One physician noted that the laws of man had broken down, and only the laws of God applied. A pharmacist reported he had overheard a physician and two nurses discussing euthanizing patients. All three were indicted for murder, although the charges were subsequently dropped. A comprehensive account of the situation at Memorial Medical Center is available at *http://www.nytimes.com/2009/08/30/magazine/30doctors.html.*

Hurricane Rita

One month after Hurricane Katrina battered the Gulf, Hurricane Rita moved in. The predictions were ominous. Johnson Space Center in Houston (NASA) gave control of the International Space Station to Russia. Texas Gov. Perry ordered mandatory evacuation of the Houston area. Most people drove north, many with no destination in mind. Some spent their rent money and had no idea how they were getting back. There were traffic jams on the highway heading north, and the gas stations along the route ran out of fuel. There was concern about the remaining refineries that were not damaged by Hurricane Katrina. ATM machines ran out of cash, and loss of power meant people could not use debit or credit cards. This posed a real dilemma for people who were evacuating long distances. Most were traveling from Houston to Dallas, which is about 239 miles using Interstate 45, which is the most direct route. It finally became so congested that the governor ordered contra lane reversal so that all lanes on the highway were for northbound traffic. Southbound traffic was made to exit. Several other east-west highways were also changed to single-direction roads.

Marvin Zindler, the 80-something consumer reporter on the ABC affiliate in Houston, ended one report singing a few stanzas of "The Sidestep" (the Governor of Texas & Company's song in Best Little Whorehouse in Texas) off key, referring to gas prices. Although his response was humorous, he was correct. Gas was $3.29 near his TV station and $4.50 on a street a mile away. Gas prices increased from about $2.75 per gallon to $4.89 per gallon on some northbound roads out of town. Texas subsequently changed the law and prohibits price gouging in an emergency or natural disaster. For additional information, refer to: *http://tinyurl.com/yc6qotxe* and *http://tinyurl.com/y77znbwd*.

A Houston area SNF leased several buses to transport residents to one of their Dallas facilities. One bus containing 34 residents and six staff experienced mechanical problems when they were just south of Dallas. A subsequent investigation revealed that the rear axle was inadequately lubricated and overheated, causing a fire in the wheel well. Smoke and flames quickly entered the cabin, igniting the residents' oxygen tanks, feeding the fire. Twenty-four people died in the fire. This occurred during the early morning rush hour, when traffic helicopters are routinely in the air and traffic reporters on duty. This horrendous scene was televised live in the major Dallas metropolitan area. One helicopter picked it up on camera as soon as the bus began smoking. It seems like it was less than a minute before the bus was engulfed in flames. At that point, it was impossible to get anyone out. All they could do was watch it burn. By the time the fire department arrived in this rural area, nothing could be done. A picture of the shell of the bus is available at: *http://tinyurl.com/y8we7xc6*.

It was a difficult time and people responded to these disasters in various ways. Many people helped their neighbors and strangers alike. Some took advantage of storm victims and stole from them. Others, like Marvin, used humor to elevate people's spirits. Hurricane Katrina and Hurricane Rita opened everyone's eyes. It was evident that our overall healthcare facility

disaster planning was inadequate and something needed to be done to prevent loss of life in emergencies and natural disasters like this again. Various laws were changed, and facilities were required to improve disaster planning, but there were no uniform requirements.

Appendix Z

These two hurricanes exposed the need for a uniform, cooperative, proactive response in disasters and effective mutual aid between other healthcare facilities and suppliers. FEMA and others posted disaster guidelines on their website. However, some states did not change their requirements, and the new policies and procedures were primarily paper compliance. Although we improved our policies, response to a widespread disaster would have been very disjointed. This need is why Appendix Z was born. At least planning began, and meetings, drafts, and peer review were initiated. Developing anything for a diverse group of providers and suppliers in different states is a slow process. Getting various parties to agree and sign off on them may take longer yet. The targeted release date was changed several times.

Appendix Z is not yet available as we go to press. An advance copy is available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf.*

By the time you hold this book in your hands, you should be able to download the complete, final appendix at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf.*

The 72-page advance copy is different from anything long-term care facilities have seen before. At this time, all types of Medicare providers and suppliers are listed in the same document. Each provider and supplier type has an assigned number. Some rules apply to many different types of providers. Others are more limited in scope. Regardless, they are all published in the same document. Rules that apply to long-term care facilities have been assigned number §482.73. It is not known whether the final copy will be formatted in the same manner.

For example, you are reading tag E0006 and want to know if it applies your facility. It says:

"E-0006

(Issued XX-XX-17)

§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.22(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)[(a)."

Number §483.73 is listed, so this rule applies to your facility.

On the other hand, you are reading E-0002. It says, "E-0002 (Issued XX-XX-17) §482.78"

Rule number §483.73 is not listed, so the rule does not apply to your facility. In fact, this particular rule applies only to one type of facility.

Several tags near the end of the appendix say, "E-TAG NON-CITABLE (No assigned tags)

Reference Only (PACE) (Issued XX-XX-17)"

These (non-citable) tags are informational only. If your facility is cited, you will not be penalized.

Education

Earlier in this book, you saw the comments about staff not breaking rules on purpose. If staff breaks a rule, it is usually because they do not know any better. If you want them to adhere to the rules, someone must teach them what the rules are. Please remember the new CMS definition for direct care staff when you review the information below.

Direct care staff are persons who, through interpersonal contact with residents or residents case management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

The new requirements have made some significant changes to the education section:

- **Abuse, neglect, and exploitation:** At a minimum, facilities must educate staff on abuse, neglect, exploitation, misappropriation of property, abuse prevention, and reporting procedures for these events. Remember that this program includes all new and existing staff, persons providing services under contract, and volunteers receive this training consistent with their roles and responsibilities in the facility. Abuse prevention is required annually for nursing assistant staff. The rules do not specify the frequency for other direct care staff.
- **Resident rights and facility responsibilities:** Facilities are required to ensure that staff are educated on resident rights and facility responsibilities to properly care for the residents as set forth in the regulations.
- **Communications:** Effective communications is a mandatory in-service for all direct care personnel. This writer is assuming that the frequency of the mandatory in-service is annually, but at this time the rules do not specify.
- **QAPI & infection control:** Facilities are required to include mandatory in-service as part of their Quality Assurance and Performance Improvement (QAPI) and infection prevention and control program. The goal of these inservices is to educate staff on the elements and goals of the program(s), written standards, policies and procedures for each program.
- **Nurse aide in-service:** Nurse aides are required to have 12 hours of in-service per year. Facilities are required to include abuse prevention and dementia care and management.

- **Compliance and ethics:** Requires the organization that operates each facility to include training as part of the compliance and ethics program. If the organization operates five or more facilities, this subject matter must be presented annually. The facility may use any effective way of teaching this program's standards, policies, and procedures. Role-play, situations, and problem solving are effective methods for teaching this content, but you may use any method that ensures your target audience will understand and retain the information.
- **Behavioral health:** Requires facilities to provide behavioral health training to all staff, based on the data collected in the Resident Assessment Instrument (RAI), care plan, and required facility self-assessment at §483.70(e). Dementia training is a required annual in-service for nursing assistants. Remember that this program includes all new and existing staff, persons providing services under contract, and volunteers receive this training consistent with their roles and responsibilities in the facility. CMS does not specify the frequency of training for direct care staff other than nursing assistants. It is most likely annually.
- **Feeding assistants:** A facility may not use any individual as a paid feeding assistant unless that individual has successfully completed a state-approved program for feeding assistants.

Important information

The new rules require facilities to ensure that all new and existing staff, persons providing services under contract, and volunteers receive abuse prevention and dementia management training consistent with their roles and responsibilities in the facility.

When considering each resident's physical, mental, and psychosocial well-being, use the RAI and plan of care to collect individual data. Determine acuity and diagnoses of the resident population by using the data that were collected in the facility self-assessment.

Although many nursing assistant programs have expanded the abuse and neglect terminology, CMS did not require teaching the term "exploitation" prior to this appendix. The term is now a required part of the abuse and neglect information. CMS defines exploitation as taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

CMS has given facilities flexibility in teaching and training their staff. Any and all effective methods are acceptable (Table 15.4).

- A new and significant change is to use the mandatory annual facility self-assessment to determine which competencies and skills are needed by employees. These must be addressed in the in-service programs.

- Staff that has not had training in these subjects must be brought up to speed. This should not be a problem because most of these requirements are not phased in until 2019.
- CMS will be adding additional interpretive guidelines to clarify their expectations for this content.
- Record-keeping and documentation will be carefully reviewed by surveyors, particularly the feeding assistant's program.
- Surveyors will be observing how staff applies this information in meeting the residents' needs. They note that the adequacy of the in-service program is measured not only by documentation of in-service hours, but also by demonstrated competencies in consistently applying the interventions necessary in resident care.
- CMS is focusing on the importance of dementia care and behavior management. They did a series of dementia focused surveys and probably will do some more. Check sheets and other materials were created as a result of the surveys and their findings. They assembled this material into a toolkit of sorts. Additional material may be added in the future, but the current material should add clarity to several of the new requirements. The current toolkit is available in S&C 16-04NH, which is available at *http://tinyurl.com/y9zvl6py*.
- Unfortunately, CMS has failed to specify the frequency for the new in-service programs listed above. This writer is presuming they must be presented annually, but CMS will undoubtedly clarify this information on a subsequent revision of Appendix PP.

TIP **Students remember...**

10% of what they read

20% of what they hear

30% of what they see

50% of what they see and hear

70% of what they say

90% of what they see and do

Note the 90% retention when students see and do something. This is the only hands on activity of those listed. The "doing" part is important to your in-service.

Also please note that many nursing assistants are visual learners. They may not understand if you lecture or they are assigned to read a paper. However, if you use pictures such as PowerPoint slides or real examples of equipment, they are more likely to remember.

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes

Reference	Education Requirements and/or Survey Probes
F150-156 Resident Rights	Surveyors should look, particularly during observations and record reviews, for ongoing efforts on the part of facility staff to keep residents informed of their rights.
F155 Advance Directives	Surveyors should interview staff who is involved in informing residents about treatment options and documenting resident wishes to determine: • How the facility determines whether the resident has an advance directive (or other documentation related to life-sustaining treatment). • What training staff receives regarding advance directives and their initiation.
F156 Advance Directives	Educate staff regarding the facility=s policies and procedures on advance directives.
F157 Advance Directives	Educate your community regarding the right to formulate an advance directive and the facility's written policies and procedures regarding the implementation of these rights. This must include a summary of the State law.
F221/F222 Restraints	Properly trained staff should be able to respond appropriately to resident behavior.
F223 Abuse & Neglect	Teach employees, through orientation and ongoing inservice sessions on issues related to abuse prohibition practices such as: • Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; • How staff should report their knowledge related to allegations of abuse or neglect without fear of reprisal; • How to recognize signs of burnout, frustration and stress that may lead to abuse; and • What constitutes abuse, neglect and misappropriation of resident property.
F226 Reporting Abuse	The facility must develop and implement policies and procedures that include the seven components: screening, training, prevention, identification, investigation, protection and reporting/response. The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.
F309 Quality of Care	The principles for quality include, but are not limited to, the facility ensuring that nursing assistants are able to demonstrate competency in skills and techniques necessary to care for residents' needs as identified through resident assessments, and as described in the plan of care. The facility must provide staff, both in terms of quantity (direct care as well as supervisory staff) and quality to meet the needs of the residents. The facility must strive to staff in a way that optimizes familiarity with residents. The principles for quality include, but are not limited to, the facility ensuring that nursing assistants are able to demonstrate competency in skills and techniques necessary to care for residents' needs.

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
F309 Quality of Care (cont.)	Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic principles for quality in the provision of care. Nursing assistants must receive a performance review at least once every 12 months and receive regular in-service education based on the outcome of the reviews. (See F497) In addition, the facility must provide training in care of individuals with dementia and related behaviors to nursing assistants when initially hired and annually thereafter. (This tag also provides information on delirium and differentiating delirium from dementia.)
F309 Quality of Care	If a resident receives dialysis care, staff should understand: • Medications that must be administered before and after dialysis (as ordered by the physician) to ensure optimal timing to maximize effectiveness and avoid adverse effects. • How to manage emergencies and complications, including equipment failure and alarm systems (if any), bleeding/hemorrhaging, and infection/bacteremia/septic shock. • The care of shunts/fistulas, infection control, waste handling, nature and management of end stage renal disease [ESRD] (including nutritional needs, emotional and social well-being, and aspects to monitor). • Whether the treatment for this (these) resident(s), affects the quality of life, rights or quality of care for other residents, e.g., restricting access to their own space, risk of infections.
F309 Quality of Care	In order to provide effective pain management, it is important that staff be educated and guided regarding the proper evaluation and management of pain as reflected in or consistent with facility protocols, policies, and procedures.
F315 Urinary Incontinence	Behavior programs involve efforts to modify the resident=s behavior and/or environment. Critical aspects of a successful behavioral program include education of the caregiver and the resident, availability of the staff and the consistent implementation of the interventions.
F322 Nasogastric Tubes	The facility must ensure that nurses are trained to check for placement of enteral tubes and check for tube placement consistently and correctly.
F323 Accidents	Evaluate each resident's hazard and accident risk data, analyze potential causes for each hazard and accident risk, and identify or develop interventions based on the severity of the hazards and immediacy of risk. Consider time of day, location, etc. Communicate the approaches to relevant staff, assign responsibility, provide training as needed, document approaches, and ensure that they are put into action.
F323 Accidents	An example of facility-specific modification is additional training of staff when equipment has been upgraded.
F323 Accidents	Ensure ongoing staff training and supervision, including how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms.

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
F323 Accidents	Training of staff, residents, family members and volunteers on the proper use of assistive devices/equipment is crucial to prevent accidents. It is also important to clearly communicate care plan approaches to all staff, including temporary staff. It is important to train staff regarding resident assessment, safe transfer techniques, and the proper use of mechanical lifts including device weight limitations. Staff must ensure assistive devises properly fit the resident and the resident has received proper training in the use of the assistive device.
F323 Accidents	The presence or absence of effective facility practices that provide a safe environment can influence the likelihood of an accident occurring and subsequent harm to a resident(s). If surveyors identify care delivery, hazards or potential hazards, or a history of accidents, the survey team should investigate the facility's systems for identifying, evaluating and preventing avoidable accidents or hazards. Review of facility practices may involve a review of policies and procedures, staffing, staff training, and equipment manufacturer's information, as well as interviews with staff and management.
F329 Unnecessary Drugs	Educating staff and providers in addition to implementing non-pharmacological approaches to resident conditions prior to, and/or in conjunction with, the use of medications may minimize the need for medications or reduce the dose and duration of those medications.
F361 Dietary Services	The dietitian is responsible for developing and implementing continuing education programs for dietary services and nursing personnel.
F371 Sanitary Conditions	Proper food preparation, storage, and handling practices are essential in preventing foodborne illness. Education, training, and monitoring of all staff and volunteers involved in food service, as well as establishing effective infection control and quality assurance programs help maintain safe food handling practices.
F371 Sanitary Conditions	Determine if the facility has systems (e.g., policies, procedures, training, and monitoring) in place to prevent the spread of foodborne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food safety.
F371 Dietary	Determine if the food service employees have received training related to such compliance with dietary policies and procedures, such as those related to compliance with food sanitation and safety.
F407 Specialized Rehabilitation	If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with mental illness (MI) or intellectual disability (ID), how has the facility arranged for the necessary direct or staff training services to be provided?
F425 Pharmacy Services	The facility assures that all persons administering medications are authorized according to state and federal requirements, oriented, and have access to current reference information. Examples of procedures addressing authorized personnel include: • How the facility assures ongoing competency of all staff (including temporary, agency, or on-call staff) authorized to administer medications and biologicals; • Training regarding the operation, limitations, monitoring, and precautions associated with medication administration devices or other equipment, if used, such as:

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
F425 Pharmacy Services (cont.)	– IV pumps or other IV delivery systems including calculating dosage, infusion rates, and compatibility of medications to be added to the IV; – Blood glucose meters, including calibration and cleaning between residents; and – Using, maintaining, cleaning, and disposing of the various types of devices for administration including nebulizers, inhalers, syringes, medication cups, spoons, and pill crushers. – Provisions to assure that staff were trained or competent to use new medication-related devices. The pharmacist is responsible for identifying facility educational and informational needs about medications and providing information from sources such as nationally recognized organizations to the staff, practitioners, residents, and families. (The pharmacist is not responsible for personally presenting all the educational programs.)
F441 Infection Control	Facilities should develop and implement appropriate infection control policies and procedures, and train staff on them. Education should include infection prevention and control practices, to ensure compliance with facility requirements as well as State and Federal regulations; and antibiotic review including reviewing data to monitor the appropriate use of antibiotics. Updated education is appropriate when policies and procedures are revised or when there is a special circumstance, such as an outbreak, that requires policy modification or replacement. In addition to general infection control information, some training is discipline specific (e.g., insertion of urinary catheters, suctioning, IV care). Follow-up competency evaluations identify staff compliance. Essential topics of infection control training include, but are not limited to routes of disease transmission, hand hygiene, sanitation procedures, MDROs, transmission-based precaution techniques, and the federally required OSHA education. Surveyors should review the infection control policies, procedures, and documentation of staff training, and interview staff who oversee the infection control program, as necessary. They should review employee records to determine if employees receive initial and ongoing education regarding critical elements of the infection control plan.
F441 Infection Control	Staff training includes critical areas such as hand hygiene, areas for improvement from surveillance data, and appropriate use of protective equipment and isolation precautions; how staff are apprised of changes in policies and procedures. Facilities should have written policies & procedures which should include training for staff who will handle linens and laundry. Facilities should review their policies and procedures and educate their staff regarding safe use of insulin pens.
F490 Assessment based	Facilities are required to assess certain environmental and resident situations during regular operations and emergencies. They will plan and provide in-service based on their findings.
F495 Nurse Aide	Nurse aide training must include initial and annual dementia management and patient abuse prevention training for all nurse aides.

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
F495 Communication	[To be implemented beginning November 28, 2019 (Phase 3)] No additional information is available at this time.
F497 Nurse Aide	Each nurse aide must receive 12 hours of inservice education every 12 months. The inservice must be sufficient to ensure the continuing competence of nurse aides. The facility must complete a performance review of every nurse aide at least once every 12 months. Note: Check with your state survey agency to determine what they consider acceptable actions for meeting this requirement. Some states require an annual check off of all the skills required in the state-approved nurse aide class. The facility must provide regular inservice education based on the outcome of these reviews. The inservice training must address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Note: The adequacy of the in-service education program is measured not only by documentation of hours of completed in-service education, but also by demonstrated competencies of nurse aide staff in consistently applying the interventions necessary to meet residents= needs. Note: Calculate the date by which a nurse aide must receive annual in-service education by the employment date rather than the calendar year.
F498 Nurse Aide	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. These needs include competencies in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services and resident rights.
F501 Medical Director	Areas for medical director input to the facility may include: • Identifying practitioner educational and informational needs. • Helping educate and provide information to staff, practitioners, residents, families and others. The medical director is responsible for providing information to the facility practitioners from sources such as nationally recognized medical care societies and organizations where current clinical information can be obtained. (The medical director is not responsible for personally presenting all the educational programs.)
F518 Emergencies	The facility must train all employees in emergency procedures when they begin work and periodically thereafter. They must carry out unannounced staff drills using these procedures.
§483.85(d) Corporate/governing body issues	Organizations with five or more facilities have additional requirements.

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
§483.95(d) Quality assurance and performance improvement	Quality assurance and performance improvement (QAPI). The facility must educate staff on the policies, procedures, activities, elements, and goals of the quality assurance and performance improvement.
§483.95(f) Compliance and ethics.	Beginning November 28, 2019 - An effective method of communicating the program's standards, policies, and procedures through a training program or in another practical manner that explains the requirements of the program.
§483.95(i) Behavioral health.	Beginning November 28, 2019 - Assessment based behavioral health training
45 CFR 164.530(b) HIPAA	Provide training on HIPAA policies & procedures at orientation and with change to rules.
29 CFR 1910.1030 CPL 2-2.69 CPL 2.106 OSHA	OSHA requires orientation and annual training on bloodborne pathogens, personal protective equipment (PPE), and exposure control.
29 CFR 1910.1200(h) OSHA	OSHA ARight to Know@ Provide employees information & training on hazardous chemicals and health hazards on orientation and with introduction of new hazards.
29 CFR 1910.147(C)(1) OSHA	Energy control program (This is commonly called Lockout/Tag out.). The employer shall establish a program consisting of energy control procedures, employee training and periodic inspections to ensure that before any employee performs any servicing or maintenance on a machine or equipment where the unexpected energizing, startup or release of stored energy could occur and cause injury, the machine or equipment shall be isolated from the energy source and rendered inoperative.
31U.S.C3279 Federal False Claims Act Deficit Reduction Act 2005	Educate employees and contracted staff on Federal False Claims Act upon orientation. Required for healthcare providers making/receiving annual Medicaid payments of 5 million dollars or more (most facilities do). Additional requirements related to hiring prohibitions on individuals listed on the exclusion list at http://exclusions.oig.hhs.gov/Default.aspx .
E-0036	The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and communication plan and procedures. The training and testing program must be reviewed annually.
E-0037	The facility must provide: • Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. • Provide emergency preparedness training at least annually. • Maintain documentation of all emergency preparedness training. • Demonstrate staff knowledge of emergency procedures.
E-0039	The LTCF must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTCF must do all of the following:

Table 15.4	Long-Term Care Facility Education Requirements and/or Survey Probes
E-0039 (cont.)	• Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. • If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. • Conduct an additional exercise that may include, but is not limited to the following: – A second full-scale exercise that is community-based or individual, facility-based. – A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. – Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.
Note that the effectiveness of in-service education is measured by monitoring performance and determining whether staff demonstrate competencies and applying the interventions residents need. Be discreet when evaluating skills. Avoid making staff feel as if you are testing them.	

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THE Long-Term Care Director of Nursing FIELD GUIDE

Third Edition

Barbara Acello, MS, RN

Foreword written by Sherrie Dornberger, RNC, CDONA, FACDONA

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ISBN-13: 978-1-68308-649-9
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