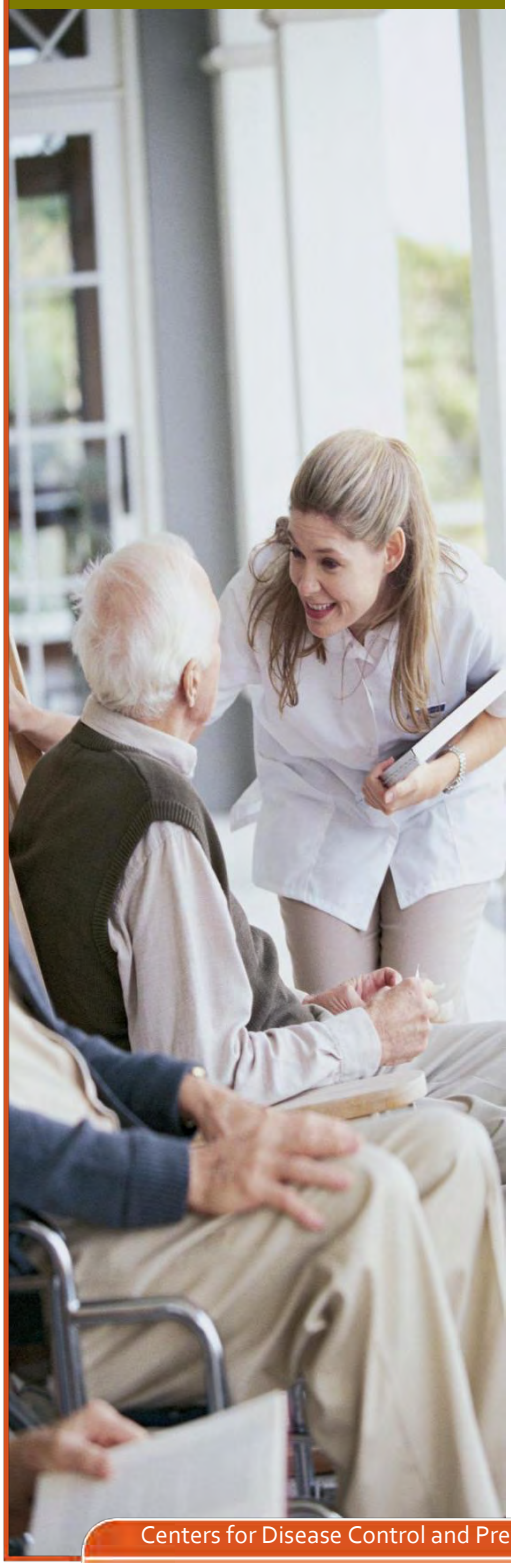
Antibiotic use in long-term care facilities

Get Smart About Antibiotics Week
November 14-20, 2011



Did you know?

1. Antibiotic resistance is one of the world's most pressing public health threats.
2. Antibiotics are the most important tool we have to combat life-threatening bacterial diseases, but antibiotics can have side effects and complications.
3. Antibiotic overuse increases the development of drug-resistant germs.
4. Patients, healthcare providers, healthcare facility administrators, and policy makers must work together to employ effective strategies for improving antibiotic use – ultimately improving medical care and saving lives.

Scope of the Problem

- Antibiotics are among the most commonly prescribed medications in long-term care facilities.
- Up to 70% of long-term care facilities' residents receive an antibiotic every year.
- Estimates of the cost of antibiotics in the long-term care setting range from $38 million to $137 million per year.

Antibiotic resistance in long-term care is associated with:

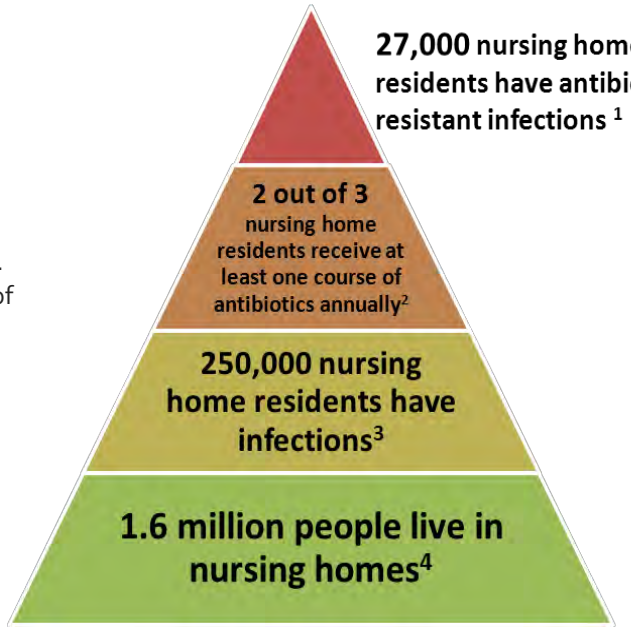
- Increased risk of hospitalization
- Increased cost of treatments
- Increased risk of death

Why we need to act

- Among the antibiotic-resistant organisms most commonly found in long-term care populations are multidrug-resistant gram negative bacteria, methicillin-resistant *Staphylococcus aureus* (MRSA), and vancomycin-resistant enterococci (VRE).
- Antibiotic use may result in the selection of antibiotic-resistant organisms.
- Recent studies indicate that multidrug-resistant Gram-negative bacteria are becoming a more important challenge in long-term care.
- Overuse of antibiotics also increases the problems of drug side effects, allergic reactions, and diarrheal infections caused by *Clostridium difficile.*
- The way we use antibiotics today or in one patient directly impacts how effective they will be tomorrow or in another patient; they are a shared resource.
- Since it will be many years before new antibiotics are available to treat some resistant infections, we need to improve the use of antibiotics that are currently available.

Why focus on long-term care?

1. Long-term care facilities inconsistently use criteria for diagnosing infection and/or initiating antibiotics.
2. Many long-term care residents can be "colonized" with bacteria meaning that germs can live on the skin, wound surfaces or even in the bladder without making the person sick. Challenges with separating colonization from true infection can contribute to antibiotic overuse in this setting.
   - Studies have consistently shown that about 30%-50% of frail, elderly long-term care residents can have a positive urine culture even without any symptoms of a urinary tract infection. Unfortunately, many of these patients are placed inappropriately on antibiotic therapy.
3. Poor communication about antibiotic treatment of a patient, who is transferred from a hospital to a long-term care facility, may result in prolonged or inappropriate antibiotic therapy.
4. Antibiotic-related complications like diarrhea from *C. difficile* can be more severe, difficult to treat, and lead to more hospitalizations and deaths among people over 65 years. Long-term care facility residents are particularly at risk for these complications.

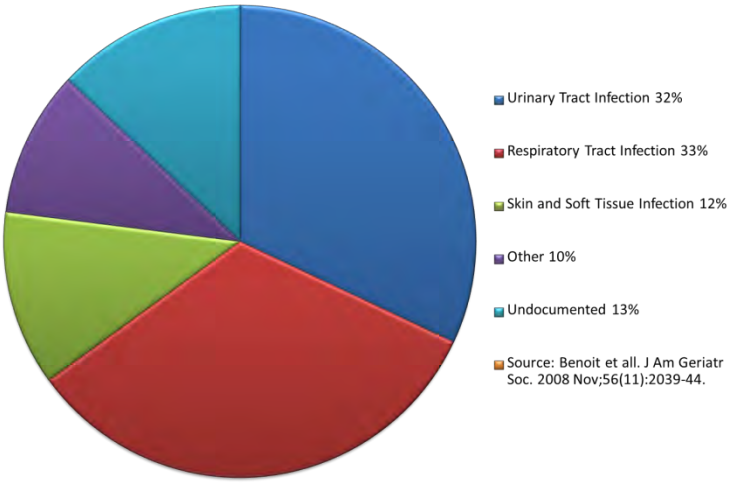


[1] Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident profile table as of 05/02/2055. Baltimore. MD.
[2] Loeb, M et.al. Antibiotic use in Ontario facilities that provide chronic care. J Gen Intern Med 2001; 16: 376-383.
[3] Centers for Disease Control and Prevention, National Center for Health statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.

Long-term care facilities can

- Have clear policies and practices to ensure that patients are not started on antibiotics unless they are needed.
- Review the facility's microbiology reports and antibiogram to detect trends in antibiotic resistance.
- Implement policies that encourage prudent antimicrobial prescribing, including establishment of minimum criteria for prescribing antibiotics and review of antibiotic appropriateness and resistance patterns.
- Implement nursing protocols for monitoring patients' status for an evolving condition if there is no specific indication for antibiotics.

Most common infections treated with antibiotics in nursing homes



Long-term care providers can

- Obtain microbiology cultures prior to starting antibiotics when possible so antibiotics can be adjusted or stopped when appropriate.
- Remember that treatment with antibiotics is only appropriate when the practitioner determines, on the basis of an evaluation, that the most likely cause of the patient's symptoms is a bacterial infection.
- Use antibiotics only for as long as needed to treat infections, minimize the risk of relapse, or control active risk to others. Antibiotics are generally not indicated to treat colonization.
- Avoid use of antibiotics to treat viral illnesses such as colds, influenza, and viral gastroenteritis.
- Engage residents and their family members in addressing the need to improve antibiotic use in your facility.

*Developed in partnership with the **American Medical Directors Association***

Centers for Disease Control and Prevention
For more information please contact Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-63548
Email: cdcinfo@cdc.gov Web: http://www.cdc.gov/getsmart/ Web: http://www.cdc.gov/getsmart/healthcare/

DIVISION OF QUALITY ASSURANCE

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Secretary

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P O BOX 2969
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Telephone: 608-266-8481
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TTY: 888-241-9432
dhs.wisconsin.gov

Date: November 29, 2011 DQA Memo 11-031

To: Nursing Homes NH 21

From: Juan Flores, Director
Bureau of Nursing Home Resident Care

Via: Otis Woods, Administrator
Division of Quality Assurance

Glucose Meters and Infection Control

The Division of Quality Assurance (DQA), Bureau of Nursing Home Resident Care (BNHRC) is an agent of the federal government and conducts nursing home surveys to ensure compliance with federal health and Life Safety Code regulations. Satisfactory performance during these surveys is required for facilities to continue their participation in the Medicare and/or Medicaid programs.

Background

Previously, DQA issued DQA Memo 08-013 Glucose meters and Infection Control and DQA Memo 09-054 Cleaning and Disinfecting Glucose Meters Shared Between Residents. These memos addressed the standards of practice to prevent patient-to-patient transmission of bloodborne pathogens when using glucose meters and also provided information and guidance regarding the cleaning and disinfecting of glucose meters that are shared between residents in the facility. The information in these memos remains a valuable resource in order to comply with infection control requirements related to glucose meters.

Facilities continue to be cited for failing to clean and disinfect meters between residents when the meter is used by multiple residents. One new issue that has arisen is not ensuring the cleaning and disinfecting process is effective. Observations have included staff using cleaning agents that do not kill bloodborne pathogens or staff not adhering to the manufacturer's instructions for the cleaning agents to ensure effectiveness. For example, for a given disinfecting wipe, the manufacturer's instructions direct the disinfecting wipe to have contact time on the surface for 2 minutes to be effective. For this particular wipe, an observation of a violation would be staff using a wipe with a contact time of 30 seconds.

Requirements and Resources

Facilities should evaluate the products that are being used to clean and disinfect the glucose meters to ensure they are effective against bloodborne pathogens. Facilities should also

complete surveillance to ensure staff is following the appropriate instructions for the cleaning agent being used. Most manufacturers have specific product websites that contain instructions for product use.

Please see the following resources for more information:

Resources for Fingerstick Device Standards

EPA Approved Cleaning Agents

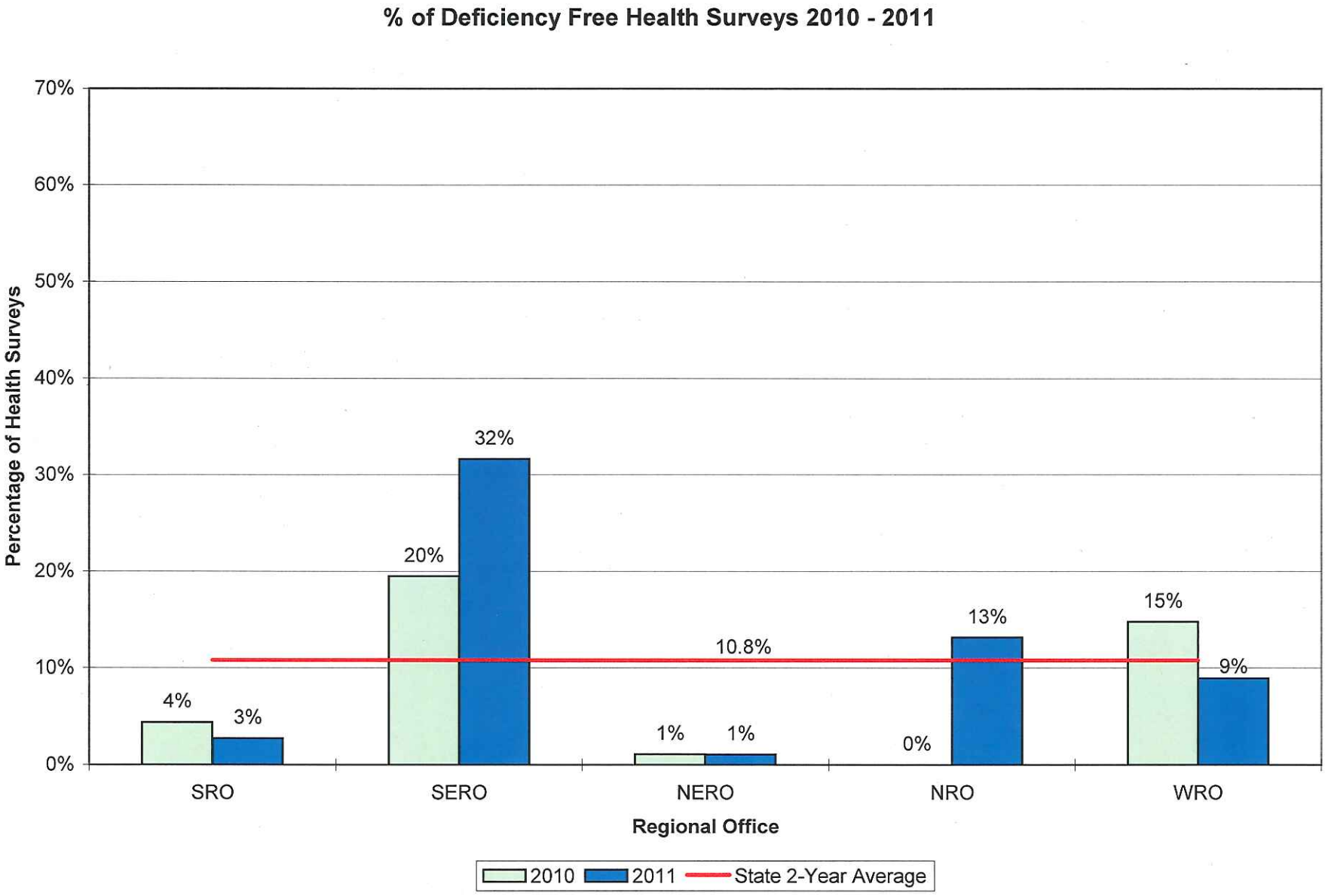
Questions

If you have questions about this memo, please contact Doug Englebert, Pharmacist Consultant, at (608) 266-5388.

STATE AND FEDERAL CITING STATISTICS FOR 2011

State citing information obtained from ASPEN CENTRAL OFFICE
Federal citing information obtained from CMS S & C PDQ

State of Wisconsin
Department of Health Services
Division of Quality Assurance


% of Deficiency Free Health Surveys 2010 - 2011
70%
60%
50%
40%
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Percentage of Health Surveys
4%
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13%
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9%
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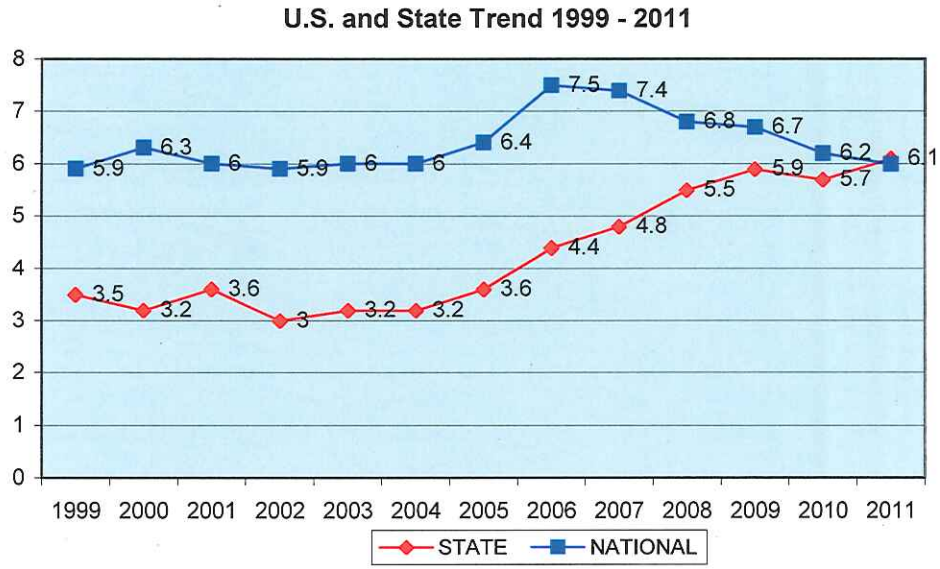
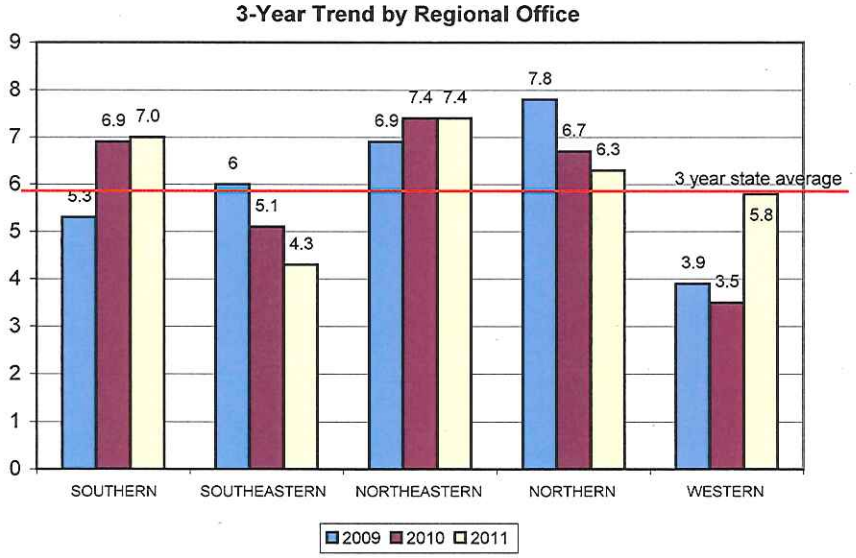
SRO
SERO
NERO
NRO
WRO
Regional Office
2010
2011
State 2-Year Average

Recertification Surveys

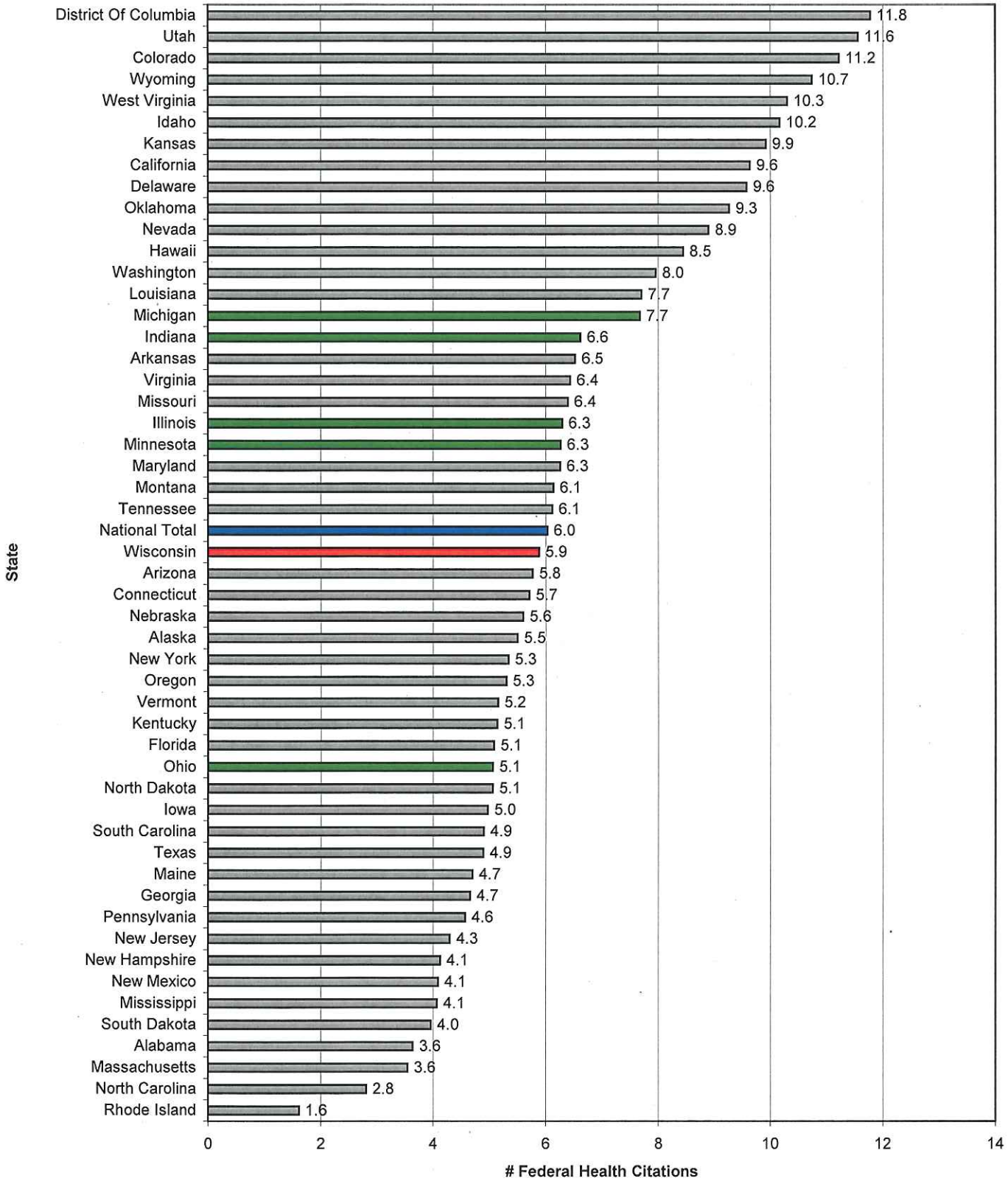
Average # Federal Health Citations





Average # Federal Health Citations per Recertification Survey 2011

S&C PDQ data



TOP TEN FEDERAL HEALTH CITATIONS – NATIONAL, STATE, REGIONAL OFFICE – 2011						
National	State	Southern (Madison)	Southeastern (Milwaukee)	Northeastern (De Pere)	Northern (Rhinelander)	Western (Eau Claire)
F323 – supervision to prevent accidents (6773)	F323 – supervision to prevent accidents (230)	F282 – care in accordance with care plan (48)	F323 – supervision to prevent accidents (45)	F441 – infection control (80)	F441 – infection control (27)	F441 – infection control (48)
F441 – infection control (6228)	F441 – infection control (230)	F371 – food prepared/served under sanitary conditions (48)	F225 – investigate allegations of abuse (44)	F323 – supervision to prevent accidents (77)	F323 – supervision to prevent accidents (26)	F323 – supervision to prevent accidents (38)
F309 - care promotes highest level of functioning and well being (5251)	F282 – care in accordance with care plan (151)	F323 – supervision to prevent accidents (44)	F226 – develop and implement policies prohibiting abuse (40)	F282 – care in accordance with care plan (74)	F225 - investigate allegations of abuse (18)	F371 – store, prepare, distribute food under sanitary conditions (25)
F371 – food prepared/served under sanitary conditions (5045)	F225 - investigate allegations of abuse (148)	F441 – infection control (41)	F441 – infection control (34)	F314 – prevention of pressure (53)	F309 – care promotes highest level of well-being (16)	F514 - documentation (22)
F279 – develop comprehensive care plan (3751)	F371 – food prepared/served under sanitary conditions (140)	F279 – develop comprehensive care plan (35)	F279 – develop comprehensive care plan (29)	F371 – store, prepare, distribute food under sanitary conditions (50)	F314 – prevention of pressure ulcers (15)	F225 - investigate allegations of abuse (20)
F281 –professional standards of practice (3262)	F279 – develop comprehensive care plan (134)	F514 - documentation (31)	F309 – care promotes highest level of well-being (28)	F279 – develop comprehensive care plan (42)	F282 – care in accordance with care plan (14)	F279 – develop comprehensive care plan (20)
F329 – Drug regimen is free of unnecessary drugs (3129)	F314 – prevention of pressure ulcers (130)	F225 - investigate allegations of abuse (29)	F314 – prevention of pressure (25)	F156 – notice of rights, rules, services, charges (40)	F226 – develop and implement policies prohibiting abuse (12)	F156 – notice of rights, rules, services, charges (18)
F514 - documentation (3085)	F329 – Drug regimen is free of unnecessary drugs (102)	F157 – contact MD after significant condition change (27)	F425 – medication system assures accurate receipt/administration (24)	F329 – Drug regimen is free of unnecessary drugs (39)	F312 – Services to help carry out activities of daily living (12)	F226 – develop and implement policies prohibiting abuse (15)
F225 - investigate allegations of abuse (2750)	F309 - care promotes highest level of functioning and well being (49)	F329 – Drug regimen is free of unnecessary drugs (26)	F156 – notice of rights, rules, services, charges (18)	F225 - investigate allegations of abuse (37)	F315 - services to restore bladder function and to prevent UTIs (11)	F314 – prevention of pressure ulcers (14)
F241 – resident dignity (2736)	F226 – develop and implement policies prohibiting abuse (93)	F314 – prevention of pressure ulcers (23)	F157 – contact MD after significant condition change (18)	F425 – medication system assures accurate administration (34)	F371 – store, prepare, distribute food under sanitary conditions (10)	F309 – care promotes highest level of well-being (13)
					F281 – professional standards of practice (10)	

BOLD ITALICS – not in State's top ten New to Top Ten compared to entity's 2010 data

Wisconsin Top Ten Federal Health Citations
2011

Rank	Rank 2010	Tag	Description of Regulation	# Citations	# Cites at Harm or IJ
1	1	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	230	50
1	2	F441	Infection control program designed to prevent the development and spread of infection	230	7
3	6	F282	Services provided in accordance with the plan of care	151	0
4	3	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	148	3
5	4	F371	Food stored, prepared, distributed, and served in a manner that prevents food borne illness	140	0
6	7	F279	Development of comprehensive care plan	134	0
7	9	F314	Services and treatment to prevent and/or to heal pressure ulcers	130	25
8		F329	Unnecessary drugs	102	2
9	8	F309	Services to attain/maintain highest practicable level of well being	94	30
10	5	F226	Development and implementation of policies to prevent abuse, mistreatment, neglect, and misappropriation of property	93	0
11		F425	Pharmaceutical system assures accurate acquiring, receiving, dispensing, and administration of drugs	91	0

Division of Quality Assurance
January 2012

Western Regional Office
Top Ten Federal Health Citations
2011

Rank	WRO Rank 2010	Tag	Description of Regulation	# Citations	# Cites at Harm or IJ
1	2	F441	Infection control program designed to prevent the development and control the spread of infection	48	2
2	1	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	38	11
3	3	F371	Food stored, prepared, distributed, and served in a manner that prevents food borne illness	25	0
4		F514	Documentation is complete and accurate	22	0
5T	5T	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	20	0
5T	9	F279	Develop comprehensive care plan	20	0
7		F156	Information to be posted or provided at admission or when resident becomes eligible for Medicaid	18	0
8	8	F226	Develop and implement policies and procedures prohibiting abuse	15	0
9		F314	Services and treatment to prevent and/or to heal pressure ulcers	14	4
10	4	F309	Care and services to attain/maintain highest practicable level of well being	13	6

Division of Quality Assurance
January 2012

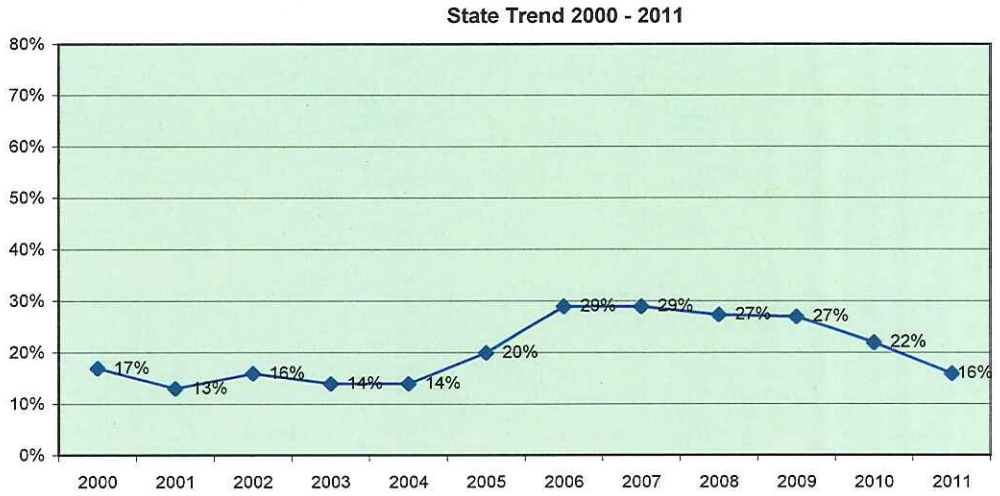
Western Regional Office
Top Ten Federal Health Citations
January 1st – April 24th 2012

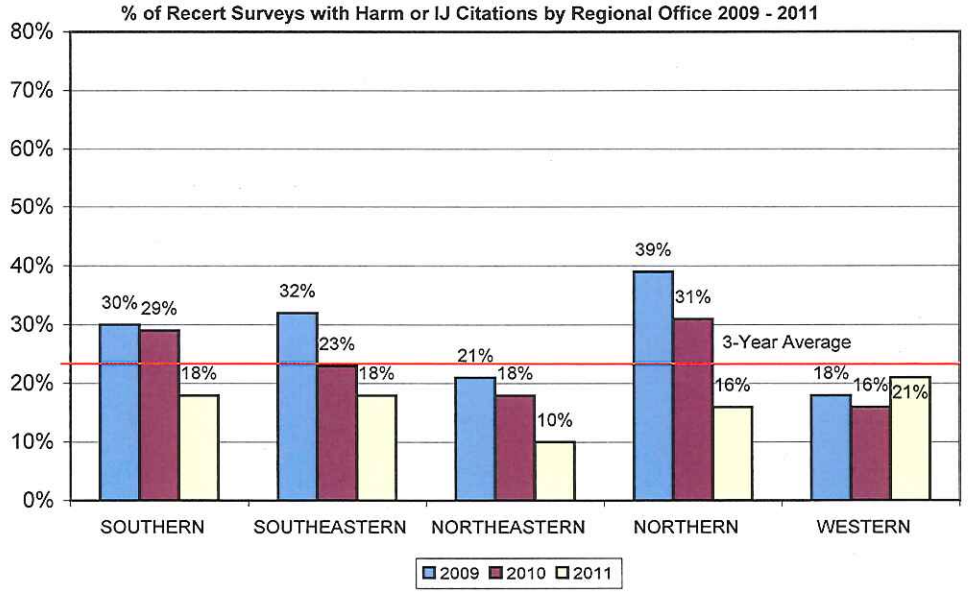
Rank	WRO Rank 2011	Tag	Description of Regulation	# Citations	# Cites at Harm or IJ
1	1	F441	Infection control program designed to prevent the development and control the spread of infection	13	1
2	2	F323	Environment is free of hazards/Supervision and assistive devices to prevent accidents	8	4
3T	5T	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	7	0
3T	3	F371	Food stored, prepared, distributed, and served in a manner that prevents food borne illness	7	0
5T	7	F156	Information to be posted or provided at admission or when resident becomes eligible for Medicaid	4	0
5T	5T	F279	Develop comprehensive care plan	4	0
5T		F280	Periodically review and revise care plan	4	0
5T	10	F309	Care and services to attain/maintain highest practicable level of well being	4	4
5T		F329	Drug regimen free of unnecessary drugs	4	0
5T	4	F514	Documentation is complete and accurate	4	6

Division of Quality Assurance
April 2012

Recertification Surveys

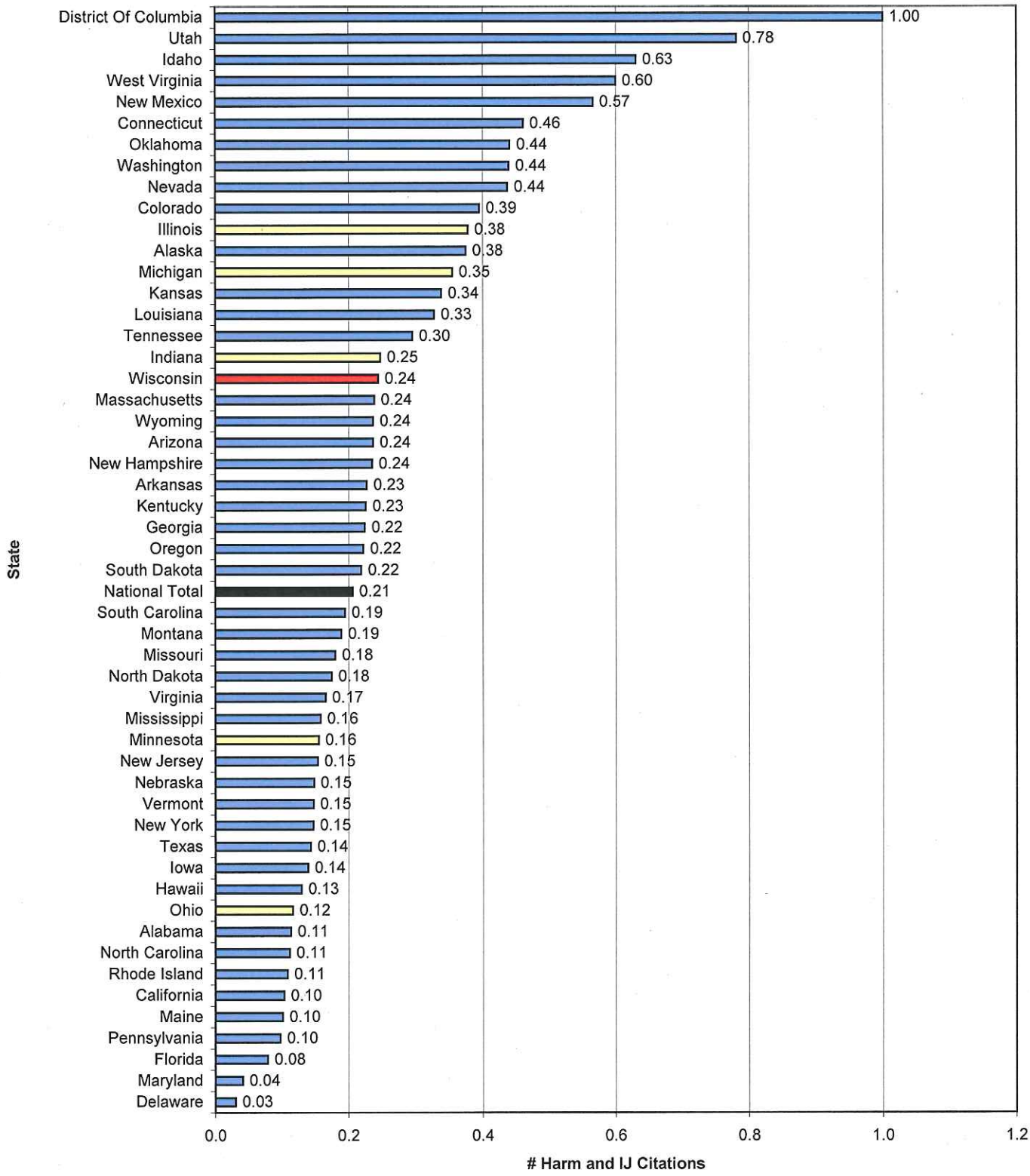
% of Surveys Identifying Actual Harm or Immediate Jeopardy





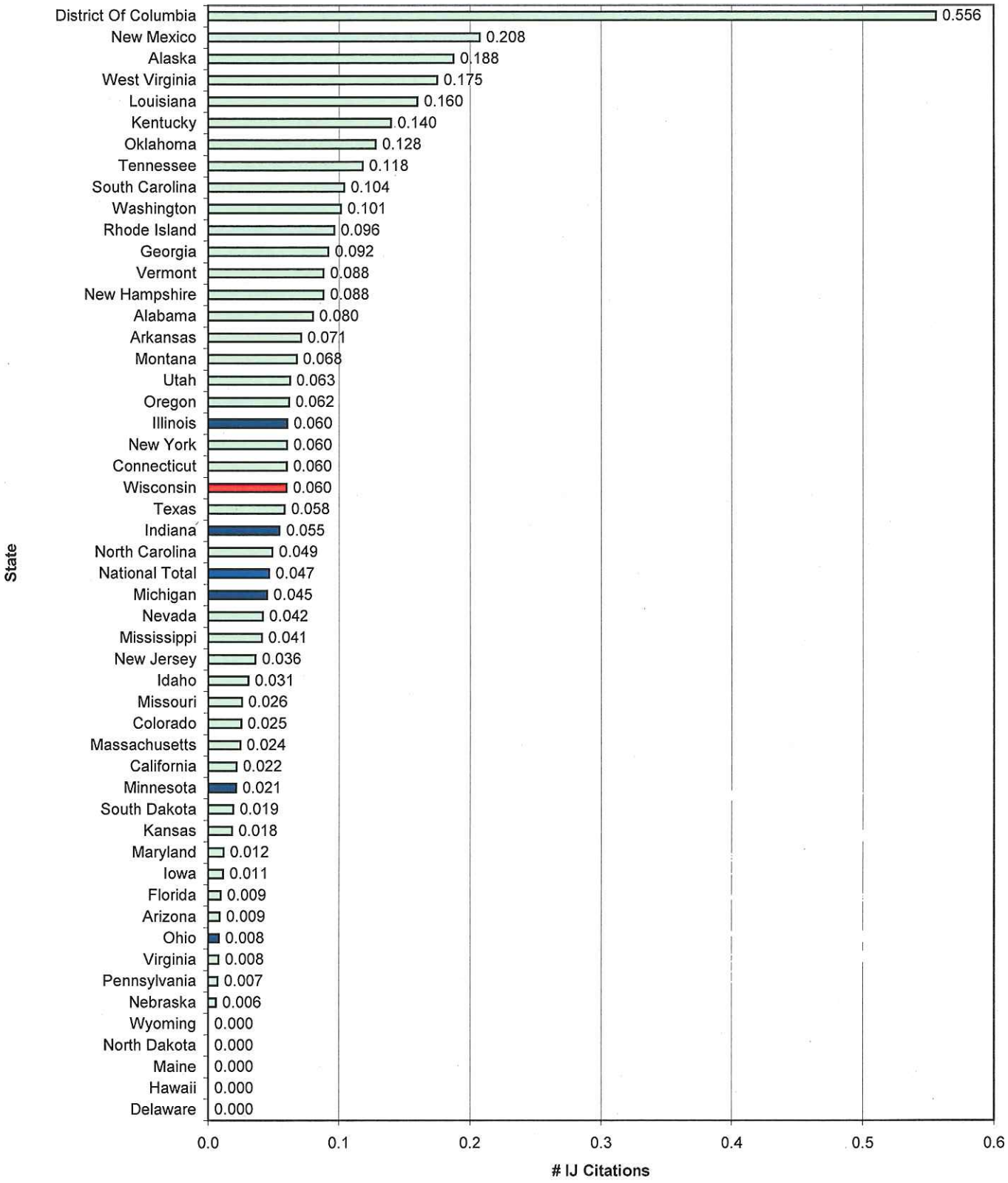
Avergage # Harm and Immediate Jeopardy Citations per Recertification Survey 2011

S&C PDQ data



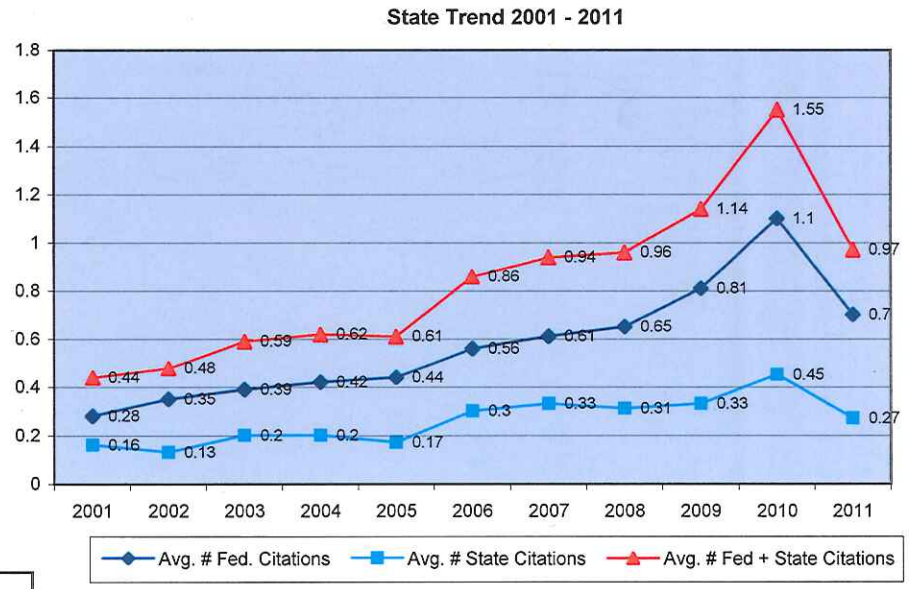
Average # IJ Citations per Recertification Survey 2011

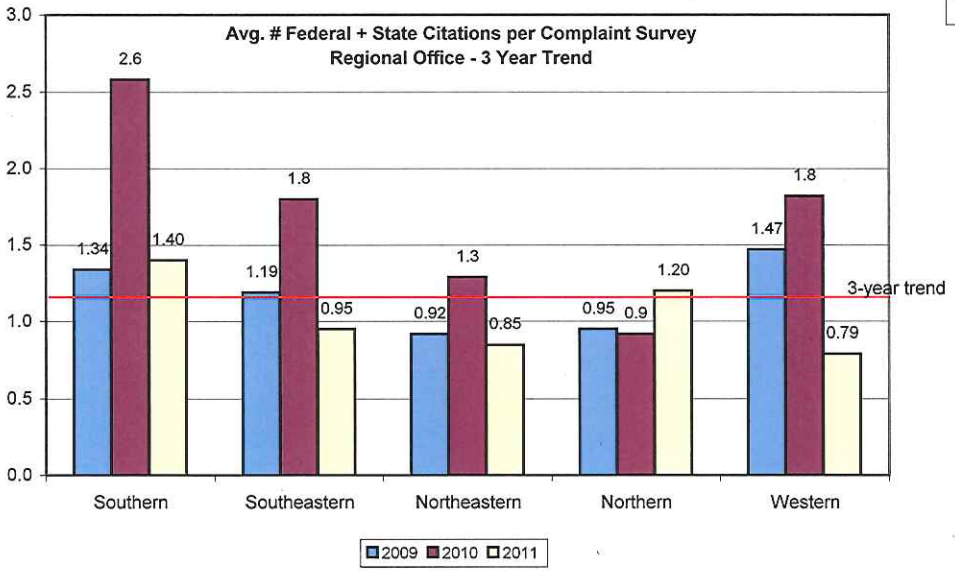
S&C PDQ data



Complaint Surveys

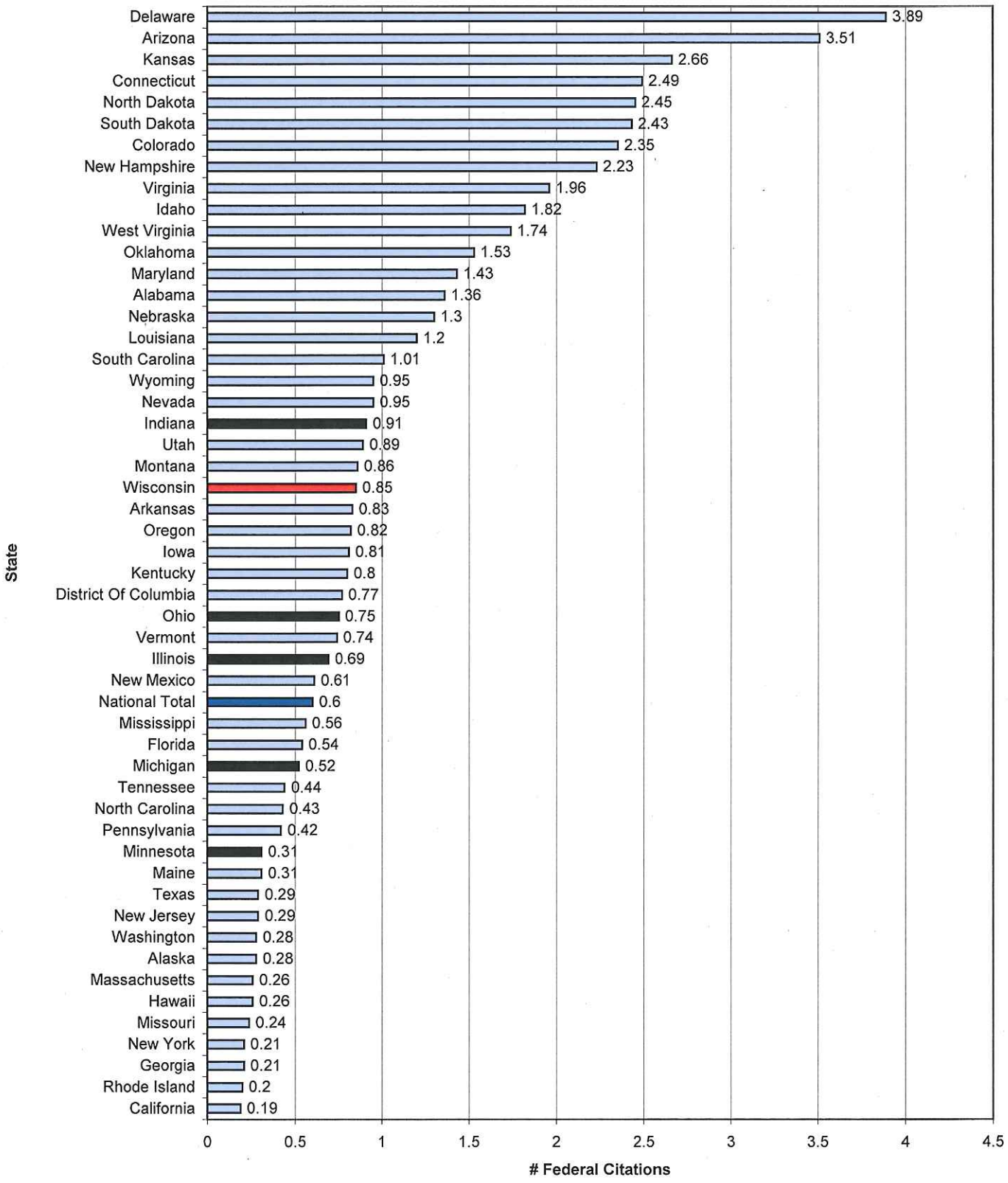
Average # Federal and State Health Citations





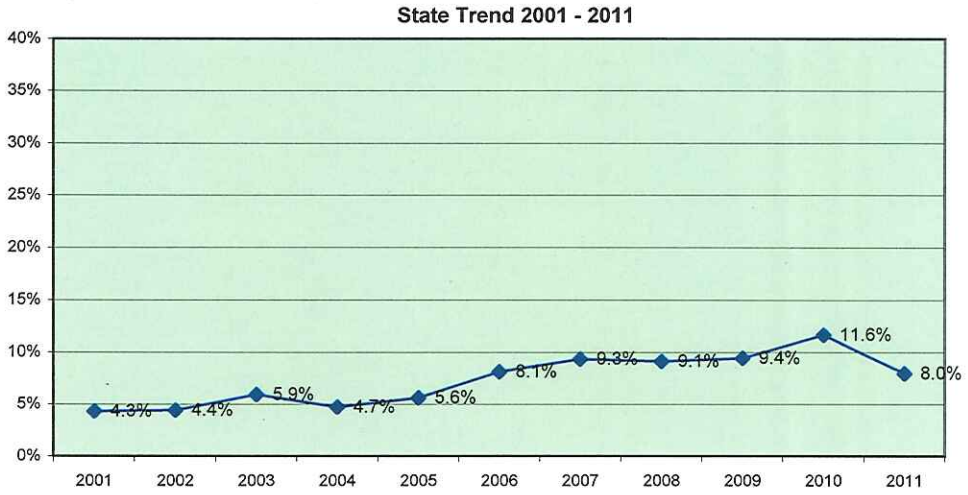
Average # Federal Health Citations per Complaint Survey 2011

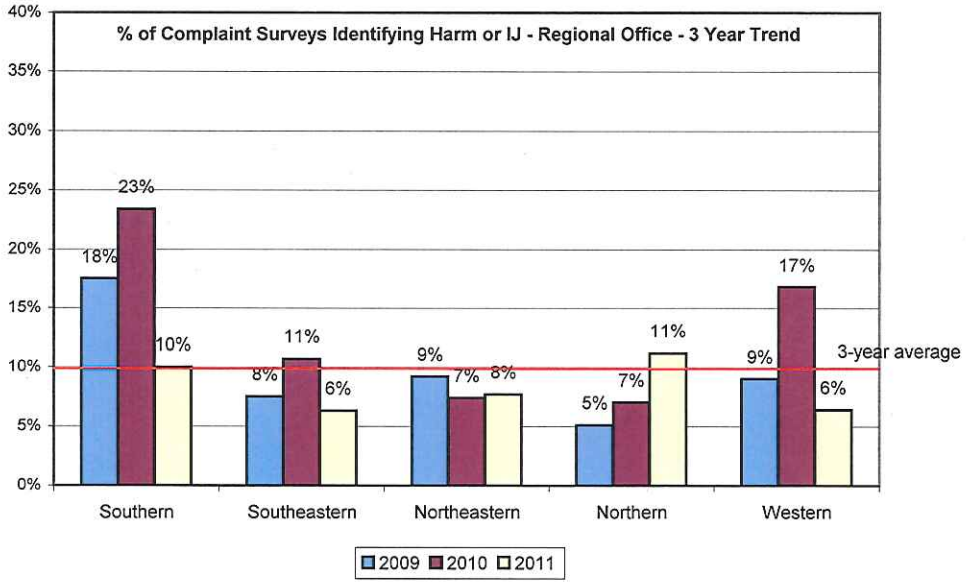
S&C PDQ Data



Complaint Surveys

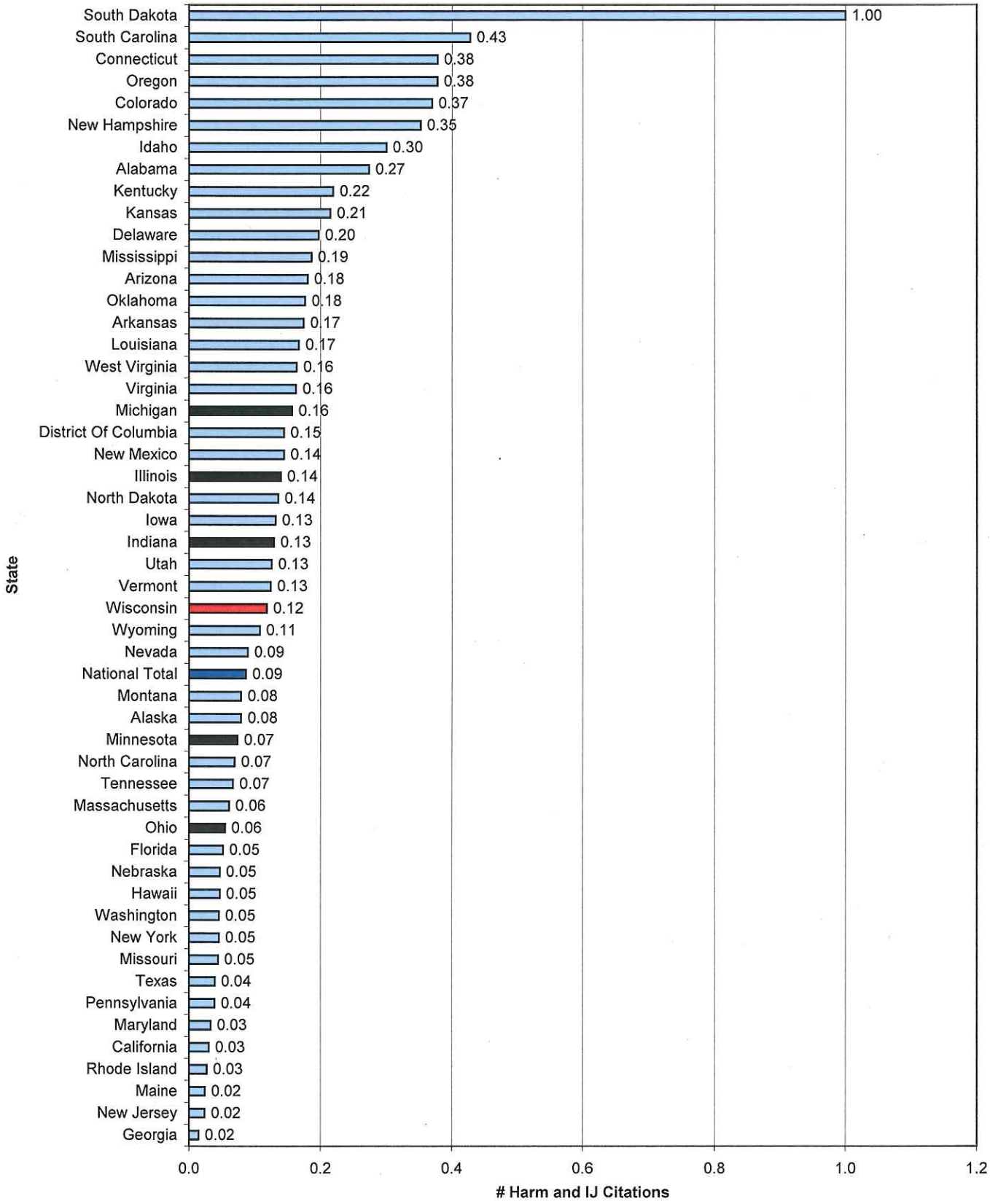
% of Complaint Surveys Identifying Actual Harm or Immediate Jeopardy





Average # Harm and IJ Citations per Complaint Survey 2011

S&C PDQ Data



Wisconsin Top Ten Federal Health Citations Identifying Actual Harm or Immediate Jeopardy 2011

Rank	Rank 2010	Tag	Description of Regulation	# Cites at Harm or IJ
1	1	F323	Facility is free of hazardous environment/Supervision and assistive devices to prevent accidents	51
2	2	F309	Services to attain/maintain highest practicable level of well being	31
3	3	F314	Treatment to prevent and heal pressure ulcers	25
4		F281	Services provided in accordance with professional standards of practice	11
5T	6	F315	Treatment and services to retain/restore as much bladder function as possible	10
5T	4	F157	Immediately consult with physician following a significant change in condition	10
7T	7	F325	Maintain acceptable parameters of nutrition	8
7T	10	F441	Infection control program investigates, controls, and prevents spread of infection	8
9	5	F327	Provide sufficient fluids to maintain hydration	5
10T	9	F225	Reporting and investigation of allegations of abuse, mistreatment, neglect and mistreatment	3
10T	8	F223	Right to remain free of physical, verbal, mental and sexual abuse	3

Division of Quality Assurance
January 2012

TOP 10 FEDERAL HEALTH CITATIONS CITING IMMEDIATE JEOPARDY – NATIONAL, STATE, REGIONAL OFFICE – 2011						
National	State	Southern (Madison)	Southeastern (Milwaukee)	Northeastern (De Pere)	Northern (Rhinelander)	Western (Eau Claire)
F323 – supervision to prevent accidents (402)	F323 – supervision to prevent accidents (12)	F314 – prevention of pressure ulcers (3)	F281 – professional standards of practice (4)	F441 – infection control (4)	F309 – care promotes highest level of well-being (1)	F323 – supervision to prevent accidents (4)
F309 – care promotes highest level of functioning and well being (207)	F309 – care promotes highest level of functioning and well being (9)	F223 – free from abuse (2)	F323 – supervision to prevent accidents (4)	F281 – professional standards of practice (2)	F323 – supervision to prevent accidents (1)	F309 – care promotes highest level of well-being (2)
F490 – administration (200)	F281 – professional standards of practice (9)	F309 – care promotes highest level of functioning and well being (2)	F309 – care promotes highest level of well-being (3)	F309 – care promotes highest level of well-being (2)		F441 – infection control (2)
F225 – investigate allegations of abuse (105)	F441 – infection control (8)	F157 – contact MD after significant condition change (2)	F225 – investigate allegations of abuse (2)	F323 – supervision to prevent accidents (2)		F281 – professional standards of practice (1)
F226 – develop and implement policies prohibiting abuse (105)	F314 – prevention of pressure ulcers (6)	F225 – investigate allegations of abuse (1)	F441 – infection control (2)	F157 – contact MD after significant condition change (1)		F314 – prevention of pressure ulcers (1)
F224 – free from neglect (93)	F157 – contact MD after significant condition change (3)	F226 – develop and implement policies prohibiting abuse (1)	F157 – contact MD after significant condition change (1)	F329 – Drug regimen is free of unnecessary drugs (1)		F353 – Nurse staffing (1)
F281 – professional standards of practice (73)	F223 – free from abuse (3)	F281 – professional standards of practice (1)	F223 – free from abuse (1)	F314 – prevention of pressure (1)		
F157 – contact MD after significant condition change (65)	F225 – investigate allegations of abuse (3)	F333 – significant medication error (1)	F224 – free from neglect (resident-to-resident abuse) (1)			
F441 – infection control (60)	F226 – develop and implement policies prohibiting abuse (2)		F226 – develop and implement policies prohibiting abuse (1)			
F223 – free from abuse (60)	F490 – administration (2)		F314 – prevention of pressure (1)			
			F365 – Diet served as ordered (1)			
			F490 – administration (1)			

State data includes past noncompliance citations, which do not show up in ASPEN reports and would not be reflected in national data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-20

DATE: **March 10, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **All Provider Types - Independent but Associated Deficiency Citations**

Letter Summary

- The purpose of this memorandum is to affirm our expectation that when noncompliance with a federal requirement has been identified, the facility or provider will receive a deficiency associated with the noncompliance.
- This memorandum restates existing CMS policy in Appendix P regarding independent but linked deficiency citations.
- This clarification applies to all provider types.

Attached you will find documents supporting this requirement including:

- Regulatory language that identifies facility compliance requirements; and
- Relevant areas of the State Operations Manual (SOM), Appendix P Task 5C and 6. This guidance addresses the necessity of survey teams to review all requirements in order to determine if there was noncompliance with any of the regulations.

There are instances in which a deficient practice creates noncompliance with more than one regulation. In those situations, noncompliance with each requirement should be cited. This situation may be referred to as "independent but associated" citations. This guidance applies to all provider types.

Some investigative protocols (such as those for pressure ulcers, hydration, and weight loss) include a list of regulations that may or may not be a concern depending upon investigation. The surveyor is expected to conduct further investigation, if concerns are identified, to determine whether non-compliance is present with those additional requirements.

For Example:
If a resident develops avoidable pressure ulcers after admission, the surveyor may make the determination that the facility failed to meet the requirement that a resident entering a facility without a pressure ulcer does not acquire one unless it is unavoidable. In that case, the pressure ulcer (sore) requirement (tag F314) is out of compliance. During the investigation, the surveyor might also find the facility did not conduct a comprehensive assessment of the resident's risk for development of a pressure ulcer. If so, the facility has also failed to comply with the regulatory language at F272. This tag requires a comprehensive assessment and is not specific to just pressure ulcers.

If the facility fails to do a comprehensive assessment of residents in other care areas, these would be combined with the pressure ulcer finding into a citation that describes the facility failure at F272. This example is not simply a matter of referencing non-compliance of one requirement with a second requirement. Rather, it reflects determining two distinct requirements have not been met after conducting a thorough review.

Another facility may have failed to meet the requirement for F314 because the resident developed an avoidable pressure ulcer. During the review the surveyor noted there was not sufficient staff to implement the care plan. In that case, the staffing requirement at F353 would also be out of compliance, since that regulation requires the facility to employ sufficient staff to provide care to the residents based on their care plan. In these two cases only determining non-compliance with F314 does not account for what the facility failed to do. Equally important, it does not inform the facility of the problems they need to fix.

In General:

1. Cite to the regulatory language, summarizing or describing the deficient practice as it relates to the requirement:

    - If the failure led to a negative or potentially negative outcome, cite the appropriate outcome tag; and
    - Cite the specific process and/or structure requirement if specific failures in the areas of process or structure are identified through investigation.

2. While writing the survey finding on Form CMS-2567, it is important to remember that the language for related deficiencies should not merely be repeated. Language should be written at each tag that reflects noncompliance for that specific requirement.

We expect the survey process to be conducted consistent with Federal guidance and the Centers for Medicare & Medicaid Services (CMS) remains committed to monitoring adherence with our program requirements. The expectation that the certification program will be conducted consistent with our guidance is the basis on which the State performance review is conducted.

Concerns:
We have heard from some providers that citation of more than one deficiency for a single type of negative outcome simply represents “piling it on” by states or CMS. The regulations do not support this view. Nor do we agree as a matter of proper management and practice. Often one citation will focus on or manifest cause for a poor outcome, while another citation may focus on a systemic or root cause. It is vital that health care providers address all factors that contribute to negative outcomes.

If you have any further questions or concerns regarding the issues in this letter, please contact Cindy Graunke at (410) 786-6782 or Beverly Cullen at (410) 786-6784.

Effective Date: The information in this memorandum should be shared with survey staff within 30 days of the publication date.

Training: The information contained in this announcement should be shared with all survey staff, their managers and the state/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

ADDENDUM

The survey process requires surveyors to determine a facility's compliance with the applicable requirements. In order to maintain certification in the Medicare/Medicaid program, nursing homes must be in compliance with all of the regulations. This is in regulation at the following:

42 CFR 483.1 (b) - Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a Skilled Nursing Facility (SNF) in the Medicare program, and as a Nursing Facility (NF) in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

42 CFR 483.75 (b) - Compliance with Federal, State and local laws and professional standards. The facility must operate and provide services in compliance with **all** applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility (emphasis added).

42 CFR 488.301 - Definitions. Deficiency means a SNF's or NF's failure to meet a participation requirement specified in the Act or in part 483, subpart B of this chapter.

Excerpts from Appendix P of the State Operations Manual (SOM) – Survey Protocol for Long Term Care Facilities

The survey process contains specific procedures, which are delineated in the SOM, Appendix P, to provide guidance for a surveyor in how to conduct the standard, extended, revisits and complaint surveys. Within the guidance, in order to promote consistency, investigative protocols have been developed that provide specific processes for the surveyor to utilize in evaluating areas of concern such as the following: Hydration; Unintended Weight Loss; Dining and Food Service; Nursing Services - Sufficient Staffing; Adverse Drug Reactions, and the Abuse Prohibition Protocol. Within each protocol, at the end, is a section titled Task 6, Determination of Compliance. This section provides guidance for the surveyor to investigate regulatory requirements related to the issue that may be out of compliance and to cite deficiencies if negative findings are identified. This section includes a list of several regulatory requirements. An example of the Investigative Protocol – Hydration, is attached for review.

TASK 6 - Information Analysis for Deficiency Determination

A component of the survey process is the decision making by the survey team to determine if the facility is in compliance with **all** the requirements (emphasis added). The surveyors are required to conduct a review of all the requirements as a team to ascertain whether they identified any areas of non-compliance and to delineate the areas of non-compliance that will be cited. For the purpose of this paper, only excerpts of the Task 6, which describe the review of the regulatory requirements, will be attached.

This section also defines a "deficiency as a facility's failure to meet a participation requirement." It should be noted that the guidance states that all regulatory requirements that are deficient may be issued based upon findings. (Please refer to Task 6 in the SOM, Appendix P for the complete version.)

Investigative Protocol
Hydration

Objectives:

- To determine if the facility identified risk factors which lead to dehydration and developed an appropriate preventative care plan; and

- To determine if the facility provided the resident with sufficient fluid intake to maintain proper hydration and health.

Task 5C: Use:

Use this protocol for the following situations:

- A sampled resident who flagged for the sentinel event of dehydration on the Resident Level Summary;

- A sampled resident who has one or more QI conditions identified on the Resident Level Summary, such as:

    - #11 - Fecal impaction;

    - #12 - Urinary tract infections;

    - #13 - Weight loss;

    - #14 - Tube feeding;

    - #17 - Decline in ADLs;

    - #24 - Pressure Ulcer

- A sampled resident who was discovered to have any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious processes, dependence on staff for the provision of fluid intake, use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphagia, a history of refusing fluids, limited fluid intake or lacking the sensation of thirst.

Procedures:

- Observations/interviews conducted as part of this procedure should be recorded on the Forms CMS-805 and/or the Form CMS-807.

- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and also whether there were abnormal laboratory test values which may be an indicator of dehydration.

NOTE: A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires. If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?

- Observe the care delivery to determine if the interventions identified in the care plan have been implemented as described.

    - What is the resident's response to the interventions? Does staff provide the necessary fluids as described in the plan? Do the fluids provided contribute to dehydration, e.g., caffeinated beverages, alcohol? Was the correct type of fluid provided with a resident with dysphagia?

    - Is the resident able to reach, pour and drink fluids without assistance? Is the resident consuming sufficient fluids? If not, is staff providing the fluids according to the care plan?

    - Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?

    - If the resident refuses water, are alternative fluids offered that are tolerable to the resident?

    - Are the resident's beverage preferences identified and honored at meals?

    - Does staff encourage the resident to drink? Are they aware of the resident's fluid needs? Is staff providing fluids during and between meals?

    - Determine how the facility monitors to assure that the resident maintains fluid parameters as planned. If the facility is monitoring the intake and output of the resident, review the record to determine if the fluid goals or calculated fluid needs were met consistently.

- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident, should know of, or be able to provide information about the causes of a resident's condition or problem.

NOTE: If a resident is at an end of life stage and has an advance directive, according to State law, (or a decision has been made by the resident's surrogate or representative, in accordance with State law) or the resident has reached an end of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute noncompliance with the requirement for hydration. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with 42 CFR 483.25, F309, Quality of Care.

- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.25(j), F327, Hydration:
    - For this resident, the facility is compliant with this requirement to maintain proper hydration if they properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, cite at F327.
- Compliance with 42 CFR 483.20(b)(1) & (2), F272, Comprehensive Assessments:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they assessed factors that put the resident at risk for dehydration, whether chronic or acute. If not, cite at F272.
- Compliance with 42 CFR 483.20(k)(1), F279, Comprehensive Care Plans:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they developed a care plan that includes measurable objectives and timetables to meet the resident's needs as identified in the resident's assessment. If not, cite at F279.
- Compliance with 42 CFR 483.20(k)(3)(ii), F 282, Provision of care in accordance with the care plan:
    - For this resident in the area of hydration, the facility is compliant with this requirement if qualified persons implemented the resident's care plan. If not, cite at F282.

EXCERPTS FROM SOM APPENDIX P – TASK 6 – Information Analysis for Deficiency Determination
(For complete text refer to SOM Appendix P)

A. General Objectives

The objectives of information analysis for deficiency determination are:

- To review and analyze all information collected and to determine whether or not the facility has failed to meet one or more of the regulatory requirements;

C. Decision-Making Process

Each member of the team should review his/her worksheets to identify concerns and specific evidence relating to requirements that the facility has potentially failed to meet. In order to identify the facility's deficient practices and to enable collating and evaluating the evidence, worksheets should reflect the source of the evidence and should summarize the concerns on relevant data tags.

- In order to ensure that no requirements are missed, proceed through the requirements sequentially as they appear in the interpretive guidelines, preferably section by section. Findings/evidence within each section should be shared by each team member during this discussion. Consider all aspects of the requirements within the tag/section being discussed and evaluate how the information gathered relates to the specifics of the regulatory language and to the facility's performance in each requirement. The team should come to consensus on each requirement for which problems have been raised by any member. If no problems are identified for a particular tag number during the information gathering process, then no deficiency exists for that tag number.

D. Deficiency Criteria

To determine if a deficiency exists, use the following definitions and guidance:

- A "deficiency" is defined as a facility's failure to meet a participation requirement specified in the Social Security Act or in Part 483, Subpart B (i.e., 42 CFR 483.5 - 42 CFR 483.75).

- **To help determine if a deficiency exists, look at the language of the requirement. Some requirements need to be met for each resident. Any violation of these requirements, even for one resident, is a deficiency.**

- Other requirements focus on facility systems.

Certain facility systems requirements must be met in an absolute sense, e.g., a facility must have an RN on duty 7 days a week unless it has received a waiver. Other facility system requirements are best evaluated comprehensively, rather than in terms of a single incident. In evaluating these requirements the team will examine both the individual parts of the system, e.g., the adequacy of the infection control protocol, the adequacy of facility policy on hand washing, as well as the actual implementation of that system.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Office of Clinical Standards and Quality/Survey & Certification Group

Ref: S&C-12-21-LSC

DATE: **March 9, 2012**

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: Instructions Concerning Waivers of Specific Requirements of the 2012 Edition of the National Fire Protection Association (NFPA) 101, the Life Safety Code (LSC), in Health Care Facilities – Clarification Effective Immediately

Memorandum Summary

- **Updates to Previous Instructions:** This letter addresses updates to the Centers for Medicare & Medicaid Services (CMS) policy regarding Capacity of the Means of Egress; Cooking Facilities; Heating, Ventilating, and Air Conditioning; and Furnishings, Mattresses, and Decorations.
- **Permitting Nursing Homes to Utilize Certain Changes to Life Safety Code Provisions Immediately:** Since these changes are included in the 2012 Life Safety Code, CMS is permitting nursing homes to use the new provisions immediately.
- **Waiver Processing:** Waiver requests will be processed in accordance with standard operating procedures.

Recent changes to the NFPA, LSC 2012 edition allow:

- Previously restricted items to be placed in exit corridors;
- The recognition that a kitchen is not a hazardous area and can be open to an exit corridor under certain circumstances;
- Changes allowing the installation of direct-vent gas fireplaces and solid fuel burning fireplaces; and
- Changes to the requirements allowing the installation of combustible decorations.

A National task force developed these changes over three years subsequent to public comments at the CMS/Pioneer Network 2008 National Symposium on Culture Change and the Environment Requirements. These NFPA approved changes give nursing home providers additional ways to enhance resident autonomy and quality of life.

In support of these changes and the positive impact they may have on residents' lives, CMS will allow providers to implement these four changes by considering waivers of the current LSC requirements found in the 2000 edition of the LSC without showing "unreasonable hardship".

These changes include (1) increasing the amount of wall space that may be covered by combustible decorations; (2) permitting gas fireplaces in common areas; (3) permitting permanent seating groupings of furniture in corridors; (4) allowing kitchens, serving less than 30 residents, to be open to corridors as long as they are contained within smoke compartments. The waivers will be applicable to both new and existing health care occupancies. Specifically, CMS will consider a waiver to allow uses that meet the requirements found in the 2012 edition:

- LSC sections 18/19.2.3 Capacity of Means of Egress and more specifically the requirements at 18/19.2.3.4 which allow, under certain circumstances, projections into the means of egress corridor width for wheeled equipment and fixed furniture;

- LSC section 18/19.3.2.5 Cooking Facilities, more specifically the requirements at 18/19.3.2.5.2, 18/19.3.2.5.3, 18/19.3.2.5.4 and sections 18/19.3.2.5.5 which allow certain types of alternative type kitchen cooking arrangements;

- LSC section 18/19.5.2 Heating, Ventilating, and Air Conditioning more specifically the requirements at 18/19.5.2.3(2), (3) and (4) which allow the installation of direct vent gas fireplaces in smoke compartments containing patient sleeping rooms and the installation of solid fuel burning fireplaces in areas other than patient sleeping areas;

- And lastly, CMS will consider a waiver to allow the use of the requirements found at LSC section 18/19.7.5 Furnishings, Mattresses, and Decorations including sections 18/19.7.5.6 which allow the installation of combustible decorations on walls, doors and ceilings.

No changes were made to the Corridor Access provisions at 18/19.2.5.6.1 that requires "every habitable room shall have an exit access door leading directly to an exit access corridor, unless otherwise provided …" Also, previous guidance concerning "not in use" criteria found in S&C-10-18-LSC is still applicable.

Due to the complex nature of some of the requirements, each waiver request will have to be evaluated separately in the interest of fire safety and to ensure that the facility has followed all LSC requirements and the equipment has been installed properly by the facility. All waiver requests will be processed in the regular fashion with input from the State Survey Agency and final approval by the CMS Regional Office.

No other requirements of the 2012 edition of the LSC are being implemented at this time. Further changes to the Fire Safety requirements will be done through the formal rule-making process.

Effective Date: The information contained in this memorandum is current policy and is in effect for all applicable healthcare facilities such as Hospitals and Nursing Homes. This clarification should be shared with all survey and certification staff, fire authorities, plan reviewers, surveyors, their managers and the State/Regional Office training coordinators within 30 days of the date of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management