Connecticut Department of Public Health

Facility Licensing and Investigations Section

Connecticut College of Administrators

February 14, 2019

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Rose McLellan, Licensing Processer Supervisor

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Agenda

- FLIS Staffing Updates
- Water Management Plan
- Duty Officer Updates
- Posting Plans of Correction
- E-License Update
  - Nursing Home Book
- Quality, Certification, and Oversight Reports (QCOR)
- Top 10 Deficiencies

Agenda

- Immediate Jeopardy
- Web Based Reportable Events
  - Abuse Reporting
- Payroll Based Journal (PBJ)
- ESRD in LTC
- Phases 2 and 3 LTC
- SOAR Reports
- 5 Star Freeze

Staffing Updates

Branch Chief: Barbara Cass

Section Chief: Donna Ortelle

PHSM S & C: Kim Hriceniak

PHSM Complaints: Cheryl Davis

SNC: Vacancy

NC: Vacancies

Staffing Updates

New Nurse Consultants

- Jean Overbye
- Henrietta Simmons
- Roger Hanock
- Melissa Garvey
- Carla Laroque
- Josie Moore
- Vicky Golab
- Care Urban
- Ron Arnone
- MaryAnn Lynch

New SNCs

Jackie Ruot

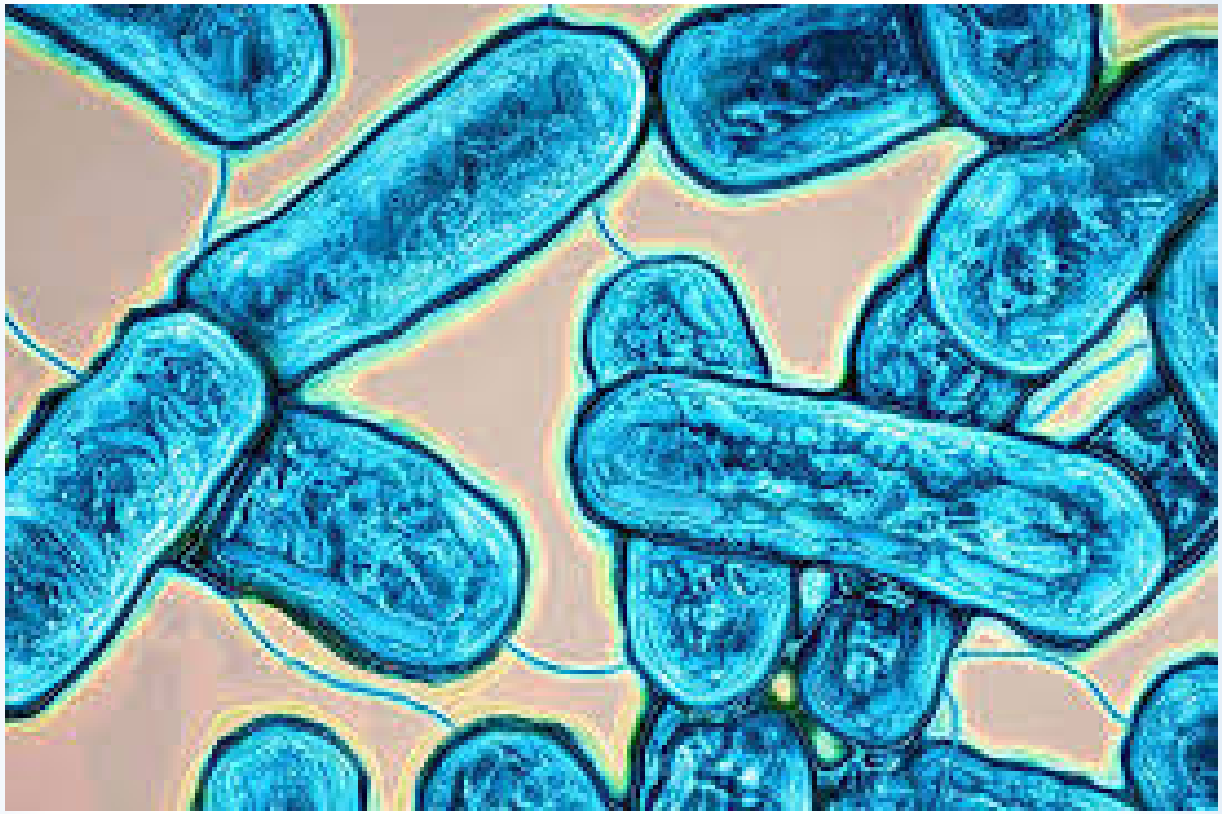
Lisa DiLorenzo

JudyBirtwistle

Generalist

Linda Gagnon

Legionella



Expectation

- Facilities must develop and adhere to policies and procedures that inhibit microbial growth in water systems
- Facilities are expected to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems
- SNF "The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections
- Healthcare facilities are expected to comply with CMS requirements to protect the health and safety of its patients
- Facilities unable to demonstrate measures to minimize the risk of LD are at risk for citation for non-compliance with CMS Conditions of Participation
- Effective date- immediately

Surveyor Role

Surveyors will be responsible to review policies, procedures, reports documenting water management implementation results to verify that facilities:

- Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system
- Implement a water management program that considers the ASHRAE industry standard and the CDC toolkit
- Includes measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens
- Specify testing protocols and acceptable ranges for control measures, and document the results of testing and the corrective actions taken when control limits are not maintained

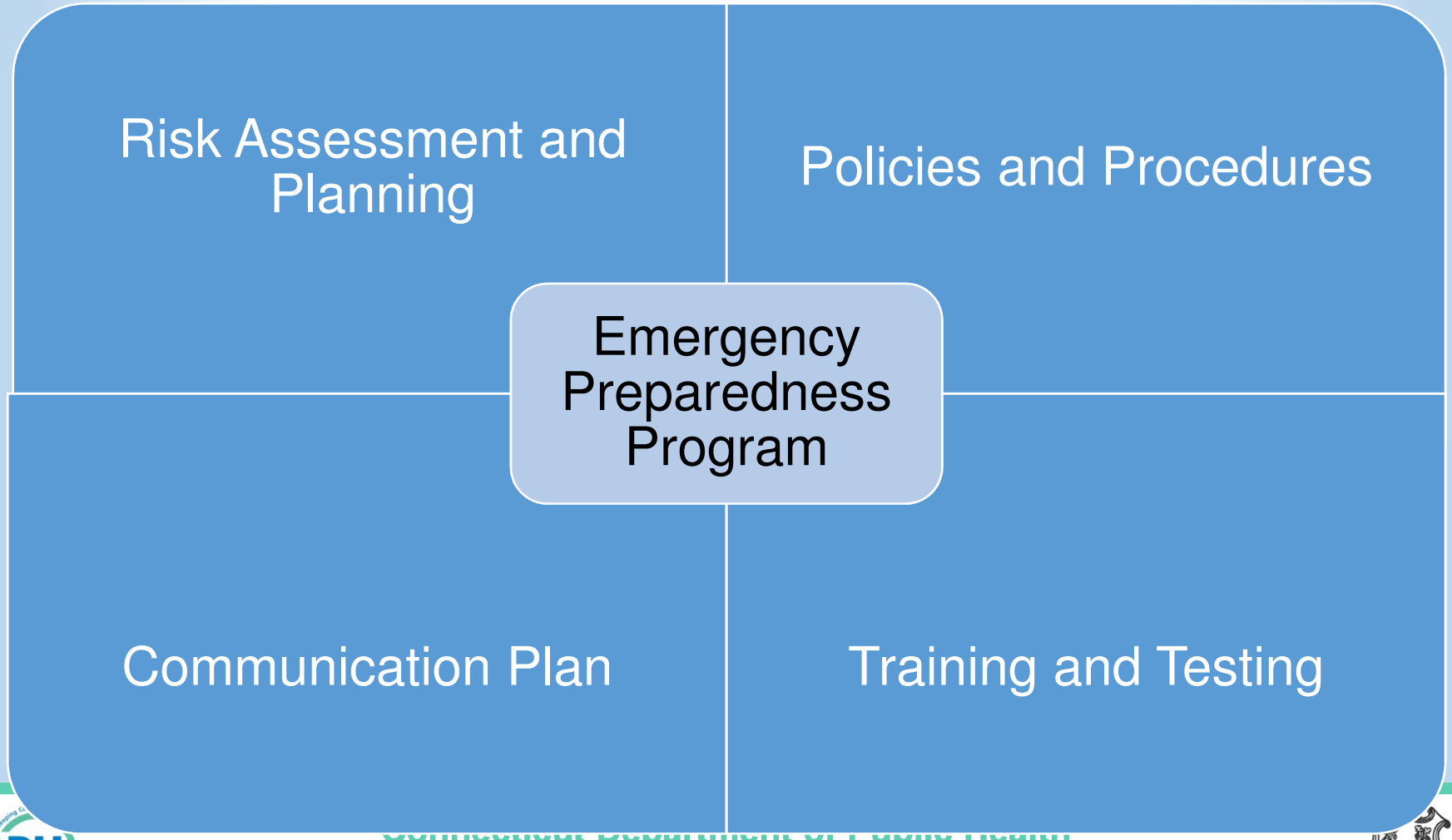
CDC Toolkit

- Perform a full investigation for the source of Legionella when:
  - >1 case of **definite** healthcare-associated Legionnaire's disease is identified (A case where the patient spent the entire 10 days before symptoms began at the same facility)
  - >2 cases of **possible** healthcare-associated Legionnaire's disease are identified within 6 months of each other
- Conduct a retrospective review of cases positive for pneumonia with etiology unknown back 3 months from the illness onset date of the resident.
- Conduct prospective surveillance to identify additional Legionellosis cases for 3 months starting from the illness onset date of the resident.
- If any new suspect cases are identified during the reviews, urine should be collected for the legionella antigen test as well as a sputum or other respiratory secretions for culture.
- Conduct an environmental assessment and water sampling based on CDC recommendations identified in the toolkit

Emergence Preparedness (EP) Regulations

- Published September 16, 2016
- Applies to all 17 provider and supplier types
- Implementation date November 15, 2017
- Compliance required for participation in Medicare
- Emergency Preparedness is one new CoP/CfC of many already required

Four Provisions for All Provider Types



Risk Assessment and Planning

- Develop an emergency plan based on a risk assessment.
- Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.
- Update emergency plan at least annually.

All-Hazards Approach:

- An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas. **These may include, but are not limited to, care-related emergencies, equipment and power failures, interruptions in communications, including cyber-attacks, loss of a portion or all of a facility, and interruptions in the normal supply of essentials such as water and food.**

Policies and Procedures

- Develop and implement policies and procedures based on the emergency plan and risk assessment.
- Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency.
- Review and update policies and procedures at least annually.

Communication Plan

- Develop a communication plan that complies with both Federal and State laws.
- Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.
- Review and update plan annually.

Training and Testing Program

- Develop and maintain training and testing programs, including initial training in policies and procedures.
- Demonstrate knowledge of emergency procedures and provide training at least annually.
- Conduct drills and exercises to test the emergency plan.

Training & Testing Requirements

- Facilities are expected to meet all Training and Testing Requirements by the implementation date (11/15/17).
    - Participation in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise.
- Conduct an additional exercise that may include, but is not limited to the following:
    - A second full-scale exercise that is 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.

Training & Testing Program Definitions

- **Facility-Based:** When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

- **Full-Scale Exercise:** A full scale exercise is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and “boots on the ground” response (for example, firefighters decontaminating mock victims).

Training & Testing Program Definitions

- **Table-top Exercise (TTX):** A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures.

The SCG Website

- Providers and Suppliers should refer to the resources on the CMS website for assistance in developing emergency preparedness plans.
- The website also provides important links to additional resources and organizations who can assist.
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

E-Licensing

- Online Applications
  - Addition of fields to create mailboxes vs name mailbox and solicit additional information (union contract expiration, categories of unionized staff)
- Nursing Home Book
  - Facility will update
- Posting 2567/Violation Letters with POC/ Citations

Posting POC's and Citations

License Details

State of Connecticut

Lookup Detail View

Name

Name
[redacted]

License Information
FLIS

License Type	License Number	Expiration Date	Granted Date	License Name	License Status
Chronic & Convalescent Nursing Home	[redacted]	09/30/2020	10/01/2008		ACTIVE

Inspection Reports
For Inspection Reports on or after 12/1/2018

Credential	Type	Document Date	Document Link
CCNH.000991C	Plan of Correction	11-29-2018	Plan of Correction-072618 health survey federal a.pdf
CCNH.000991C	Plan of Correction	11-29-2018	Plan of Correction-072618 health survey federal b.pdf

1/26/2019 6:36:19 PM

Printable View | Close

Viewing Federal Deficiencies, Violation Letters, and Citations

www.ct.gov/dph

- Verify a License, Healthcare Facilities
- Online Services, Look up a License
- Enter search information (Facility Name), Search
- Select facility, then select the document link to open the document

Complaints / Incidents

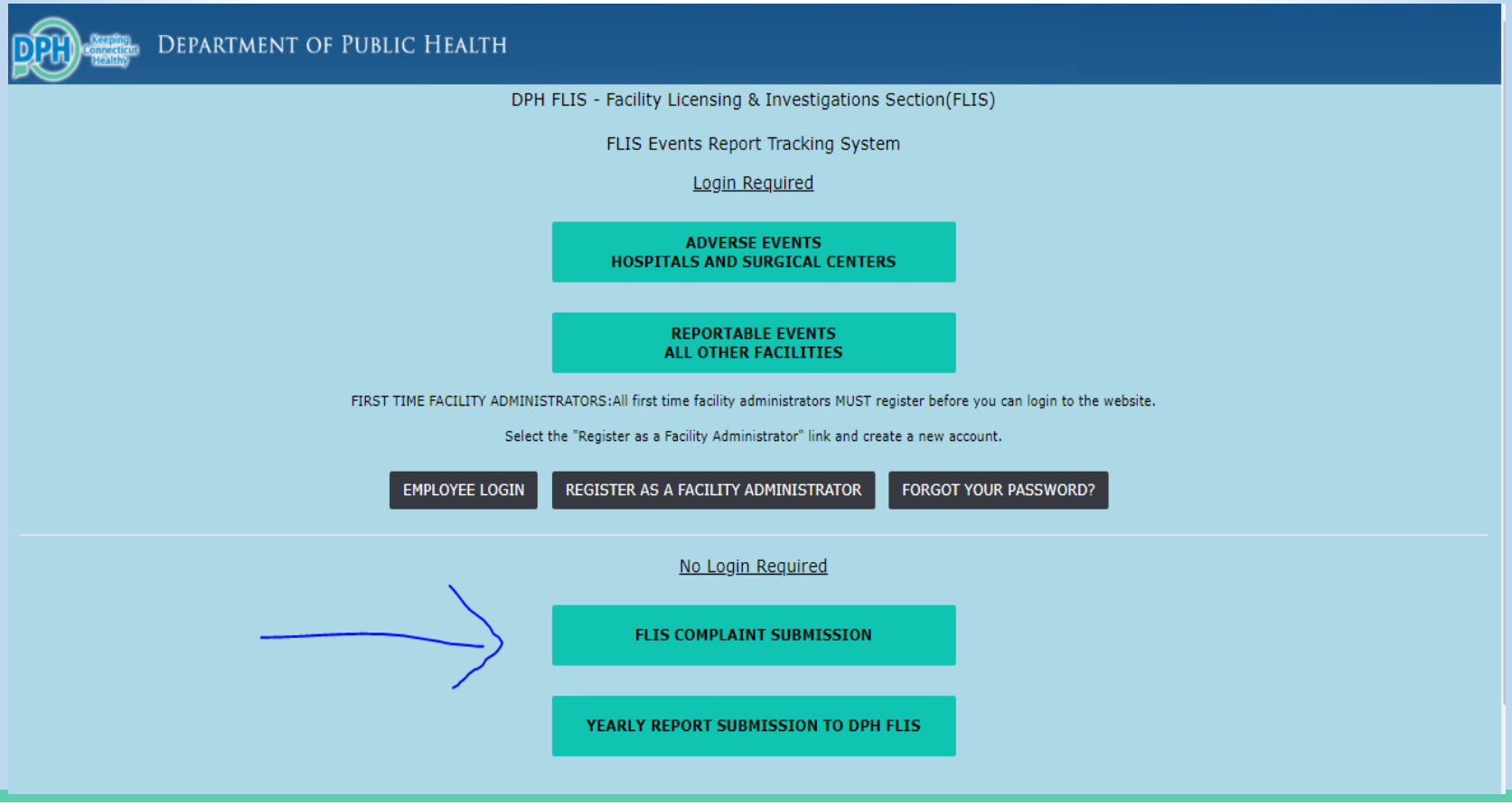
Calendar Year 2016 - **1525**

Calendar Year 2017 - **1455**

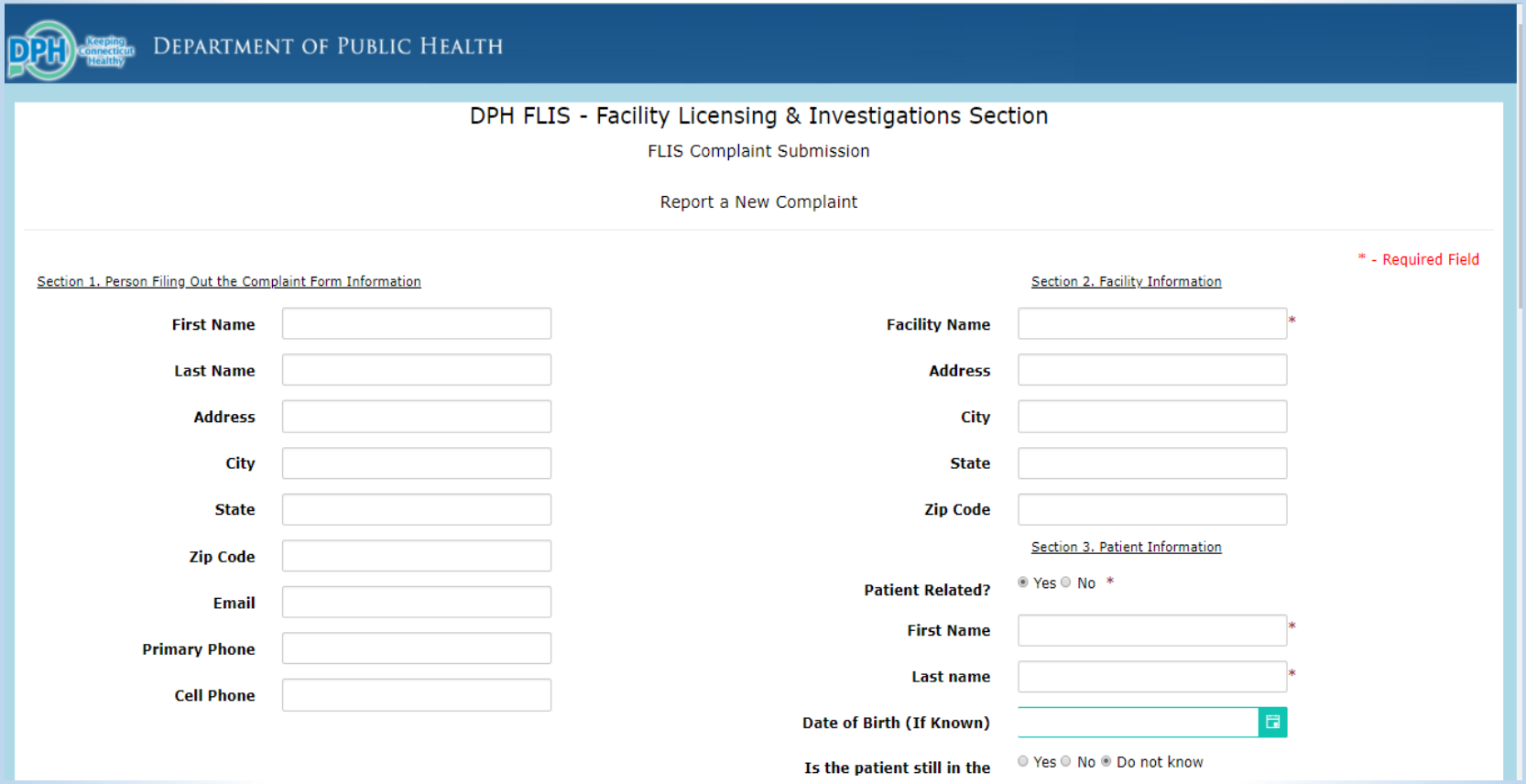
Calendar Year 2018 – **1729**

897/1729 = 52% LTC complaints

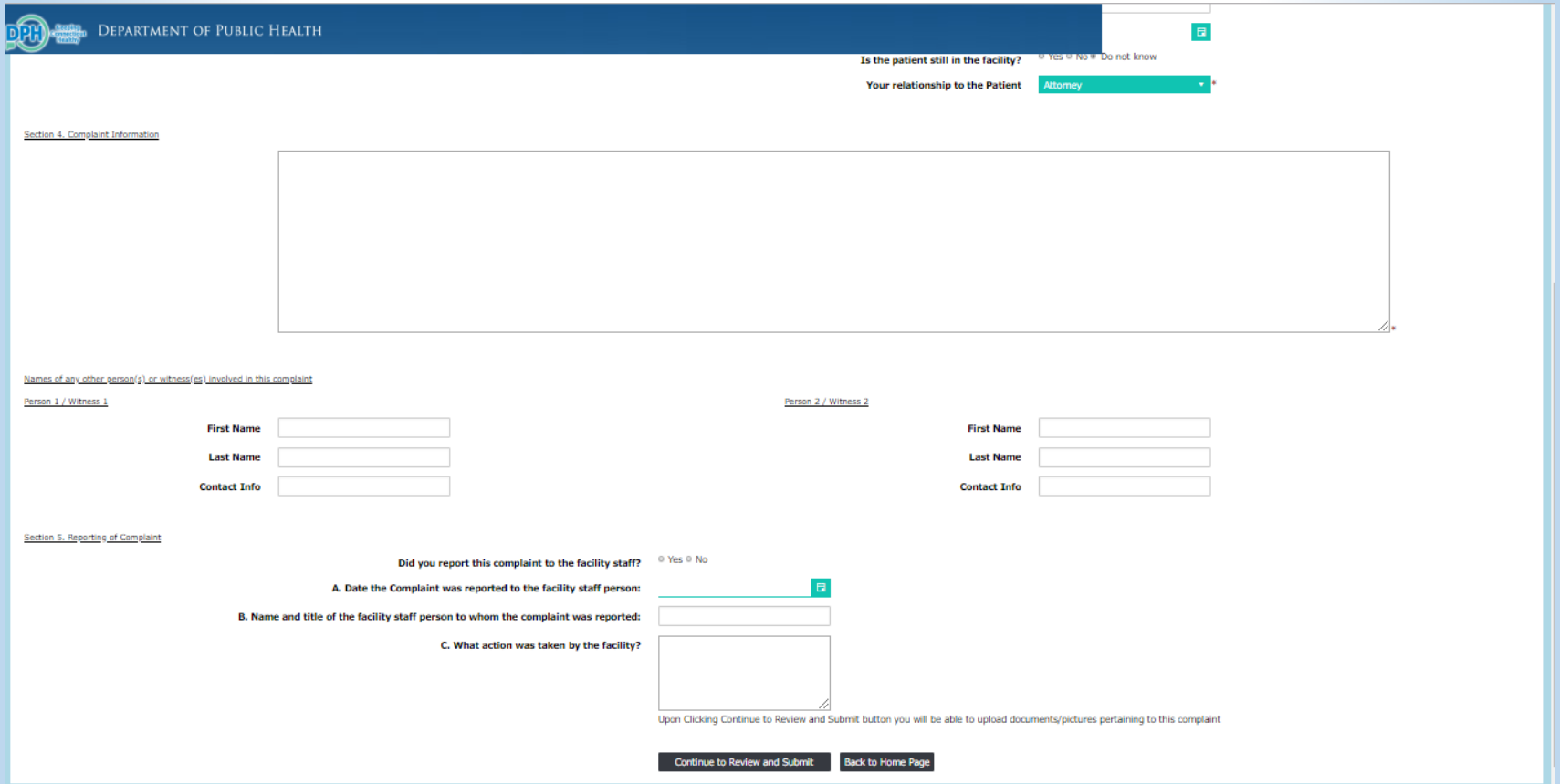
Complaint Submission
dphflisevents.ct.gov



FLIS Complaint Submission



FLIS Complaint Submission



Complaint Submission

Email

dph.fliscomplaint@ct.gov

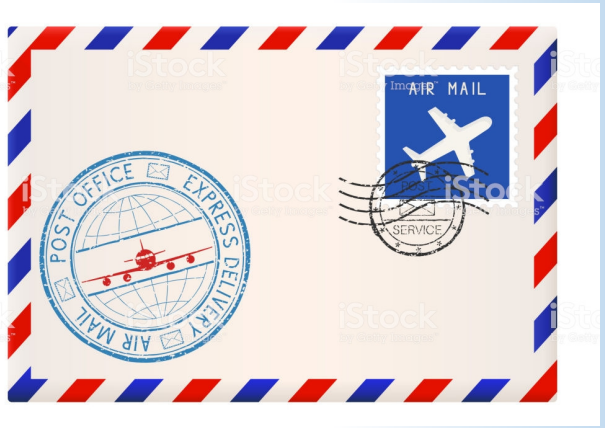
Mailing Address

Complaint Unit

410 Capitol Avenue, MS #12FLIS

P.O. Box 340308

Hartford, CT 06134



Timeframes for Investigation

Immediate Jeopardy (IJ) – State Agency (SA) must initiate an onsite survey within 2 working days of receipt.

Non IJ High - SA must initiate an onsite survey within 10 working days of prioritization.

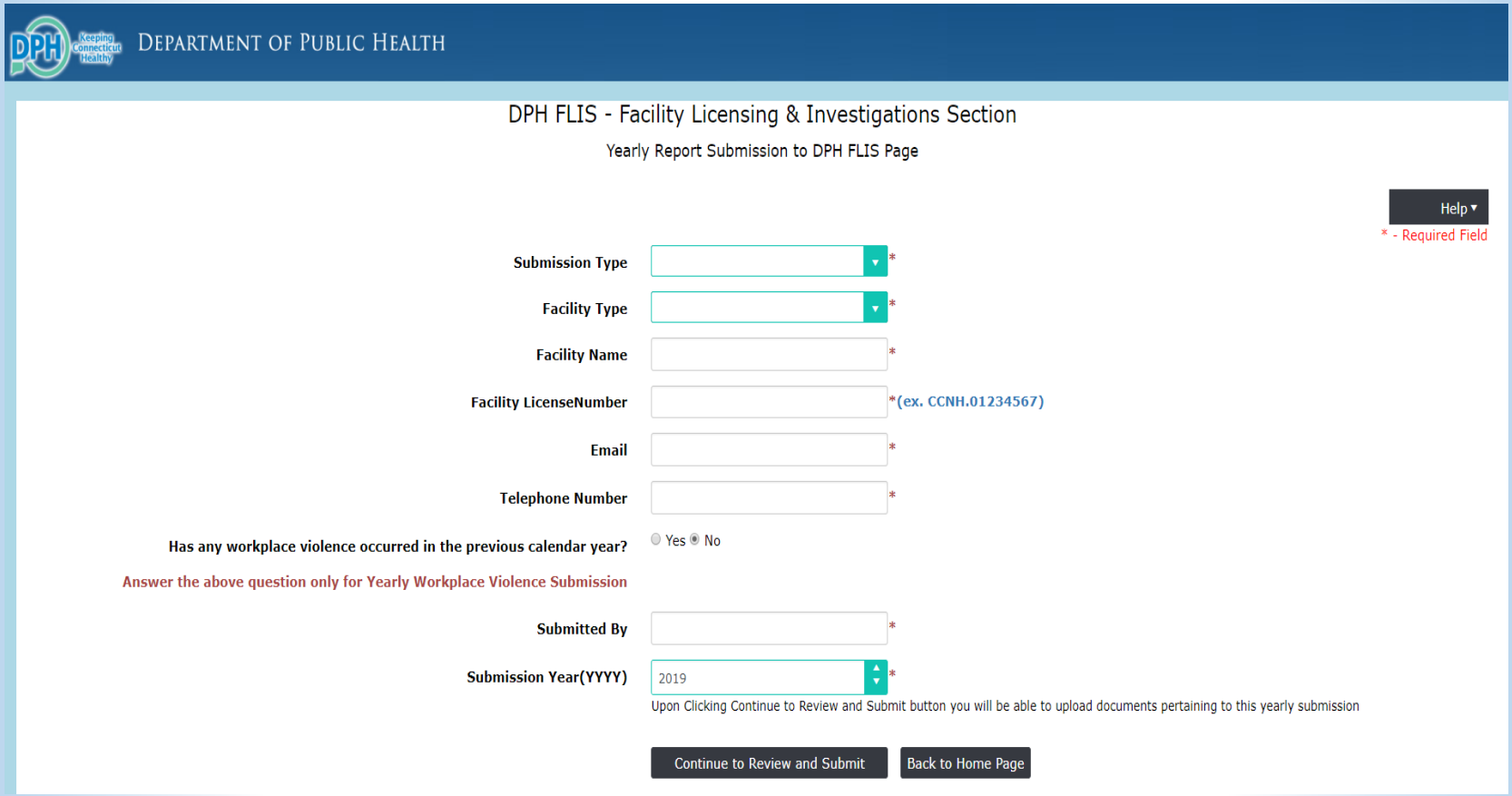
Non IJ Medium - No timeframe specified, but an onsite survey must be scheduled.

Non IJ Low - SA must investigate during the next onsite survey.

Workplace Violence Submission

19a-490r (P.A.15-91)

Workplace Violence Submission

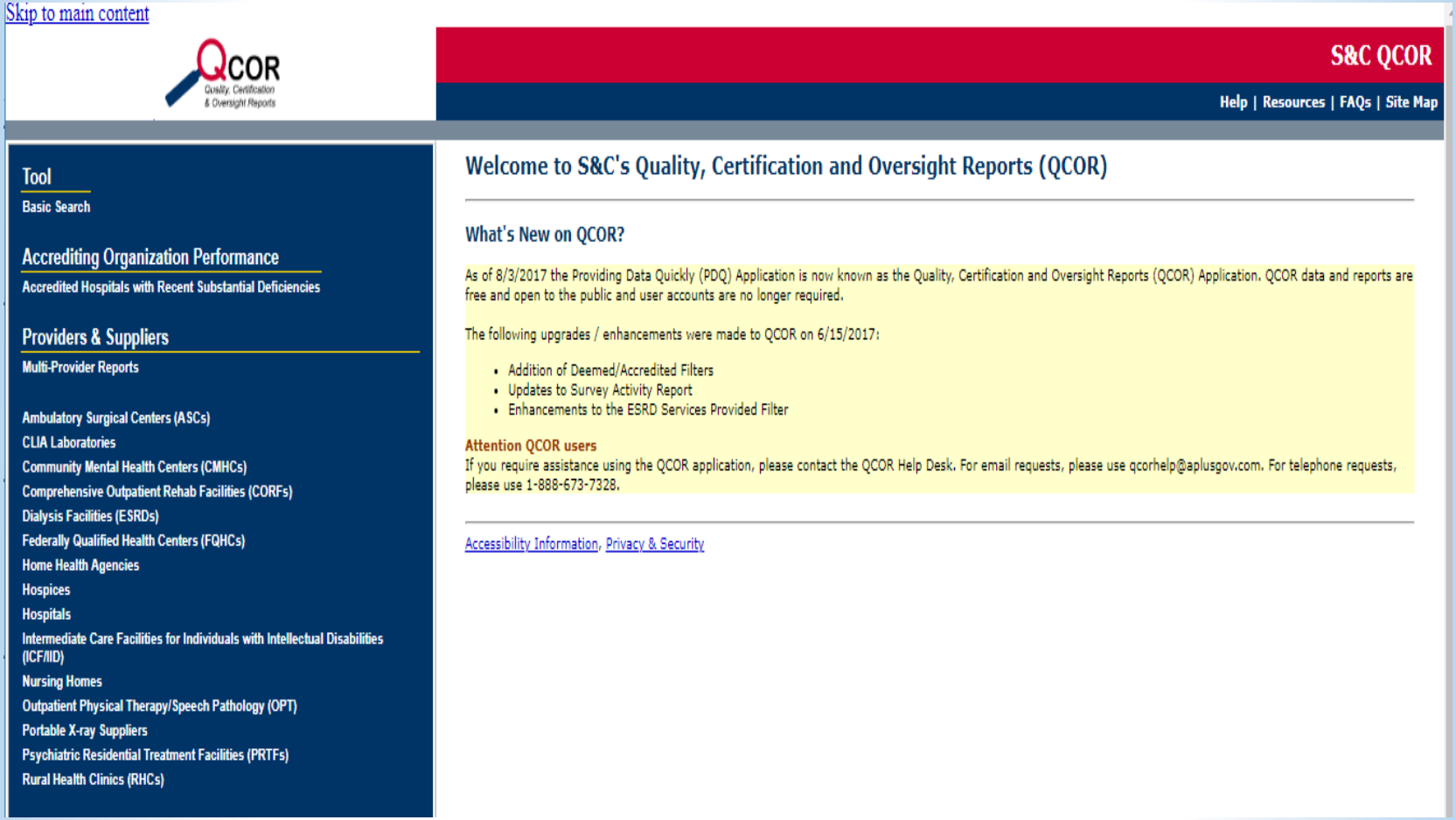


CMS Federal Reports

Quality, Certification and Oversight Reports (QCOR)

https://qcor.cms.gov

Quality, Certification and Oversight Reports (QCOR)



QCOR Reports

QCOR Quality, Certification & Oversight Reports

S&C QCOR

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Search

Provider Reports
Active Provider and Supplier Counts
New Provider and Supplier Counts
Terminated Provider Counts

Survey Reports
Overdue Recertification Surveys
Recertification Survey Counts
Survey Activity Report
Frequency of Data Entry (F4)

Deficiency Reports
Deficiency Count
Average Number of Deficiencies
Citation Frequency
Double G Citations Report

Enforcement Reports
Enforcement Actions
Civil Money Penalty (CMP)
CMP Tool

Abuse Reports
Abuse Citation Rates

Nursing Home Provider Reports

Deficiency Count

Displays number and percent of citations at each scope and severity level.

Sample:

Region	Deficiencies by Scope & Severity										
	B	C	D	E	F	G	H	I	J	K	L	Total
(I) Boston	37	50	574	152	29	81	5	0	5	0	0	933
Connecticut	0	3	86	13	3	21	0	0	0	0	0	126
Maine	25	27	92	43	8	5	0	0	2	0	0	202
Massachusetts	8	9	268	65	7	36	0	0	0	0	0	393
New Hampshire	3	7	82	19	8	10	0	0	3	0	0	132
Rhode Island	1	1	16	6	3	2	1	0	0	0	0	30
Vermont	0	3	30	6	0	7	4	0	0	0	0	50
(II) New York	88	36	712	265	56	33	5	0	12	5	0	1,212

The data in these reports, including provider and supplier counts and percentages, are valid for the subset of providers or suppliers for which there are survey records in CASPER.
For More Information

Source: CASPER (01/21/2019)

Accessibility Information, Privacy & Security

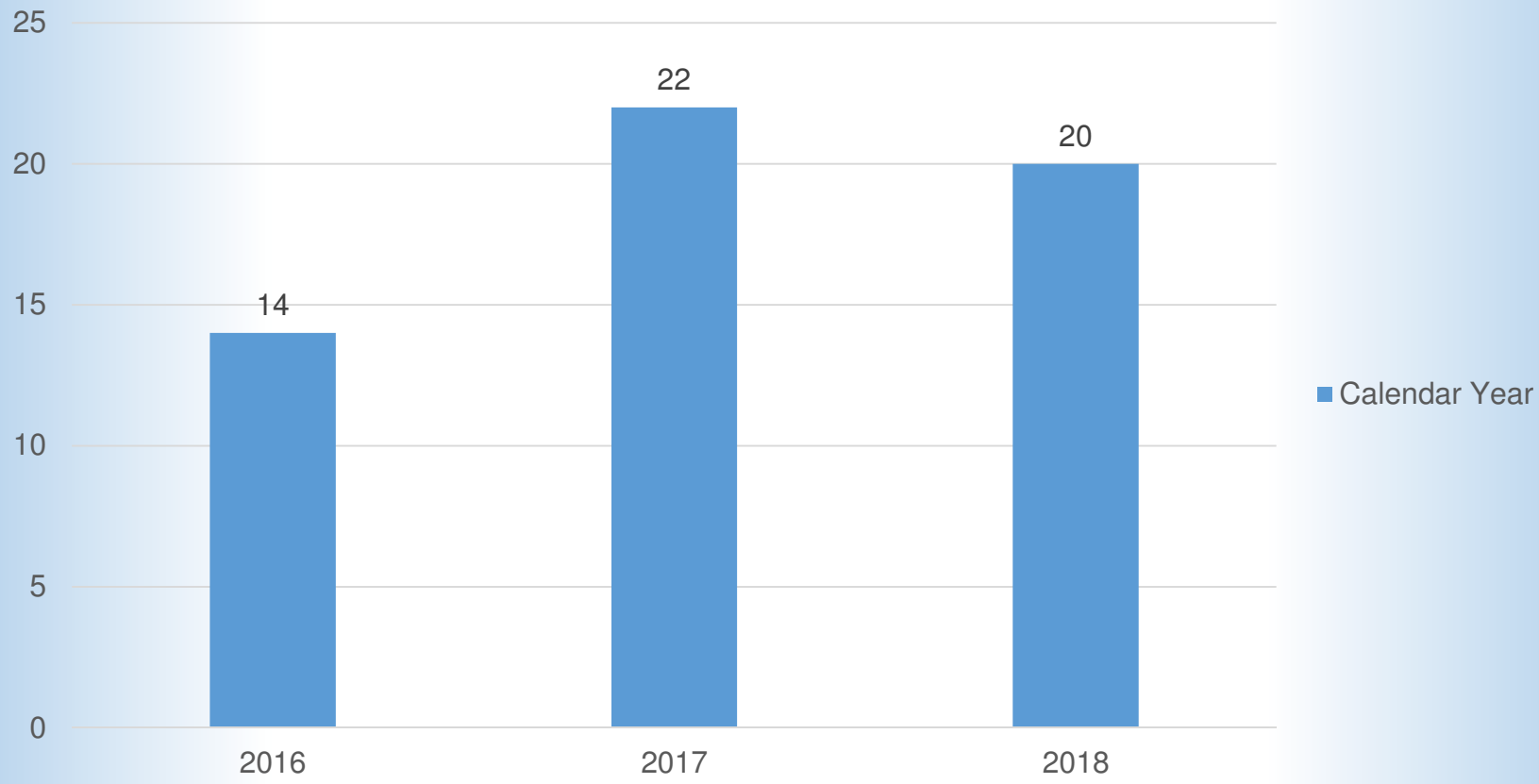
FFY 2018
Top 10 LTC Deficiencies

Year Type: Fiscal Year ▼ **Year:** 2018 ▼ **Quarter:** Full Year ▼

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Connecticut Active Providers=223		Total Number of Surveys=464
F0689	Free of Accident Hazards/Supervision/Devices	143	43.9%	30.8%
F0684	Quality of Care	138	42.6%	29.7%
F0880	Infection Prevention & Control	72	29.6%	15.5%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	71	22.9%	15.3%
F0692	Nutrition/Hydration Status Maintenance	63	21.1%	13.6%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	56	22.0%	12.1%
F0842	Resident Records - Identifiable Information	55	19.7%	11.9%
F0656	Develop/Implement Comprehensive Care Plan	54	18.4%	11.6%
F0550	Resident Rights/Exercise of Rights	52	20.6%	11.2%
F0609	Reporting of Alleged Violations	46	14.3%	9.9%

Immediate Jeopardy



Immediate Jeopardy 2018

- Accidents
- Glucometers (5)
- Elopements (4)
- Choking (2)
- Sprinklers
- CPR not initiated/delay (2)
- Neglect (wounds)
- Medication Error/availability of medications
- No action when change in condition

The Survey an Certification Group (SCG) Website

- Providers and Suppliers should refer to the resources on the CMS website for assistance in developing emergency preparedness plans.
- The website also provides important links to additional resources and organizations who can assist.
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

S+C 18-04

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-04-NH

DATE: **November 24, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to *Nursing Home Compare*

Memorandum Summary

- **Temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements:** CMS will provide an 18 month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18 month period will be used to educate facilities about specific new Phase 2 standards.
- **Freeze Health Inspection Star Ratings:** Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health

S+C 18-08

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 18-08-NH

DATE: **December 22, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations

Memorandum Summary

- **Federal regulations allow facilities to initiate discharges of residents only in specific instances.** Despite these protections, discharges which violate Federal regulations continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs.

- **The Centers for Medicare & Medicaid Services (CMS) has begun an initiative to examine and mitigate facility-initiated discharges that violate federal regulations.** CMS is examining State survey agency's intake and triage practices for these type of discharge complaints, developing examples of inappropriate and appropriate discharges

S+C 18-15

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO 18-15-NH

DATE: **March 16, 2018**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group *(formerly Survey and Certification Group)*

SUBJECT: Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) are collaborating on the development of a free on-line training course in infection prevention and control for nursing home staff in the long-term care setting.

Background

Healthcare-associated infection (HAIs) can result in considerable harm or death for residents in Long Term Care (LTC) facilities, as well as increased costs for the healthcare system. The

S+C 18-17

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety and Oversight Group

Ref: QSO-18-17-NH

DATE: **April 06, 2018**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety and Oversight Group (*formerly Survey & Certification Group*)

SUBJECT: Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five Star Quality Rating System

Memorandum Summary

- **Transition to Payroll-Based Journal (PBJ) Data** – Starting in April, 2018, CMS will use PBJ data to determine each facility's staffing measure on the *Nursing Home* Compare tool on Medicare.gov website, and calculate the staffing rating used in the *Nursing Home Five Star Quality Rating System.*
- **Staffing data audits -** We are providing lessons-learned from audits conducted, and guidance to facilities for improving their accuracy. Nursing homes whose audit identifies significant inaccuracies between the hours reported and the hours verified, or facilities who fail to submit any data by the required deadline will be presumed to have low levels of staff. This will result in a one-star rating in the staffing domain, which will drop their

S+C 19-02 and State Agency Requirements

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO 19-02-NH

DATE: **November 30, 2018**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Payroll Based Journal (PBJ) Policy Manual Updates, Notification to States and New Minimum Data Set (MDS) Census Reports

Memorandum Summary

- **Notification to States** – The Centers for Medicare & Medicaid Services (CMS) will provide CMS Regional Offices (ROs) and State Survey Agencies with a list of facilities with potential staffing issues to support survey activities for evaluating sufficient staffing and improving resident health and safety.
- **Updates in the PBJ Policy Manual and Frequently Asked Questions (FAQs)** – We are expanding the guidance on the meal breaks policy to ensure consistency. In addition, we are adding guidance regarding reporting hours for "Universal Care Workers."
- **Additional Technical Support for Facilities** – New MDS-based census reports in the

S+C 18-18

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/ Quality, Safety & Oversight Group

Ref: QSO 18-18-NH

DATE: **June 15, 2018**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Final Revised Policies Regarding the Immediate Imposition of Federal Remedies

Memorandum Summary

- **This memo replaces the following Survey & Certification (S&C) Memos: 16-31-NH released July 22, 2016 and revised on July 29, 2016, and S&C: 18-01-NH, released in draft on October 27, 2017.** The October 2017 memo solicited comments on a proposed directive requiring, for certain situations, immediate imposition of federal remedies on Medicare and Medicaid participating skilled nursing facilities. After reviewing comments, CMS is issuing a final version of the directive. Substantive revisions to the prior Immediate Imposition of Federal Remedies guidance include:
  - When the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regional Offices may determine the most appropriate remedy;

October 2018

Anticipated 1150B Delegation of Authority- Proposed Rule

- Requirements for reporting crimes against nursing home residents to fully enforce Section 1150B CMS proposing a regulation that will allow Civil Money Penalties (CMPs) up to $200,000 against covered individuals. *(staff, volunteers, etc.) who fail to report reasonable suspicion of crimes.*

Reporting Requirements for Crime

Definition and Citation

- Abuse
- Neglect
- Exploitation
- Misappropriation / Mistreatment
- Injuries of unknown source

Reporting Requirements for Crime cont'd

Freedom from abuse, neglect, and exploitation (§483.12)

1. Phase 1- Reporting requirements- implemented on November 26, 2016
2. Phase 2- Reporting crimes/1105B- implemented on November 28, 2017
3. Phase 3- Coordination with QAPI plan- to be implemented November 27, 2019.

§483.12(c)(1) has been revised to require that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

Reporting Requirements for Crime cont'd

Timeline

All allegations of abuse, with or without injury, require immediate reporting. It is imprudent to delay reporting of any abuse. The 2 hour and 24 hour time frames represent maximum; most reports should occur more quickly.

In all cases, prompt action to protect individuals and address concerns is expected. Delay's in reporting, even within the allowable timeframes, must be reasonable and not be related to attempts to obscure events or evade responsibility. The results of all investigations must be reported to the Administrator or his/her designated representative.

Reporting Requirements for Crime cont'd

- Facilities must not employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of residents' property.
- Facilities must develop and implement written policies and procedures that prohibit and prevent abuse, neglect in exploitation of residents' property.
- Facilities must establish policies and procedures to investigate allegations of abuse, neglect in exploitation of residents' property.
- Facilities are required to establish policies and procedures to ensure reporting of crimes in accordance with Section 1150B of the Social Security Act.

Definitions

"**Abuse**" is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

"**Alleged violation**" is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

Definitions

"**Exploitation**" as defined at §483.5, means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"**Immediately**" means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

Definitions

"**Injuries of unknown source**" An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

Definitions

"**Misappropriation of resident property**" as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"**Mistreatment**" as defined at §483.5, is "inappropriate treatment or exploitation of a resident." "Neglect," as defined at §483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

"**Sexual abuse**" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

Reporting Requirements for Crime cont'd

483.12 Freedom from abuse, neglect, and exploitation

(F600, 602, 603, 604, 605, 606, 607, 608, 609, 610)

Phase 1

- Strengthens existing protection, in addition P/P
- Additional language related to resident (right to free from neglect and exploitation)

Phase 2

- Regulatory inclusion 1150B requirements (reporting reasonable suspicion of a crime). Currently an existing requirement under statute.

Phase 3

- QAPI must be involved in review of allegation/incidences of abuse, neglect, and exploitation.

Recap Phase 2 Requirements

- Reporting of crimes
- Communications with other healthcare
- Baseline care plan
- Staff competencies and skills
- Behavioral health services
- Pharmacist review of medical record
- Psychotropic drugs
- Denture/Dental policies
- Facility Assessment
- Smoking policies

Phase 3 Implementation Requirements

Phase 1

- Existing requirements, those requirements relatively straightforward to implement, and require minor changes to survey process (11-28-16)

Phase 2

- Requirements that providers need more time to develop, foundational elements, new survey process can assess compliance (11-28-17)

Phase 3

- Requirements that need more time to implement (personnel hiring and training, implementation of system approaches to quality) (11-28-19)

Phase 3 Requirements

483.12 Freedom from Abuse, Neglect, and Exploitation(F600, 602, 603, 604, 605, 606, 607, 608, 609, 610)

Phase I:
Strengthens existing protection, in addition to receive of policies and procedures
Additional language related to resident (ie: “right to be free from neglect and exploitation”)
Phase 2:
Regulatory inclusion 1150 B requirements (Reporting reasonable suspicion of a crime). Currently an existing requirement under the Statute.
Phase 3:
QAPI must be involved in review of allegation/incidences of abuse, neglect, and exploitation.

Phase 3 Requirements

483.12(b)(4) Establish coordination with the QAPI program required under 483.75

483.12(b)(4) will be implemented beginning November 28,2019 (Phase 3)

Phase 3 Requirements

483.21 Comprehensive Resident Centered Care Plans (F655, 656, 657, 658, 659, 660, 661)

F655- Baseline care plan
Implemented in Phase II

(b)(3)(iii) Trauma informed care
Implemented in Phase III

Phase 3 Requirements

F659
§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(iii) Be culturally-competent and trauma–informed. [§483.21(b)(iii) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

- **483.25 Quality of Care**
- F699 –Trauma Informed Care (Phase III)

- §483.25(m) Trauma-informed care. The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. [§483.25(m) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

483.40 Behavioral Health Services

-Most in Phase II
-Comprehensive Assessment and medically-related social services implemented in Phase I

-Resident with hx of trauma/ PTSD will be implemented in Phase III

Phase 3 Requirements

F740 483.40 Behavioral Health Services

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

Phase 3 Requirements

483.75 Quality Assurance and Performance Improvement (QAPI)

F865- QAPI Program/Plan, Disclosure/Good Faith Attempt
F866- QAPI/QAA Data Collection and Monitoring (Phase III)
F867- QAPI/QAA Improvement Activities
F868-QAA Committee

Phase 3 Requirements

483.75 Quality Assurance and Performance Improvement (QAPI)

Phase I: Participation in QAA Committee and maintain existing QAA requirements

Phase II- AQPI Plan- as required by Affordable Care Act

Phase III- Full Implementation of QAPI and integration of Infection Preventionist

Phase 3 Requirements

483.80 Infection Control

F880- Infection Prevention & Control

F881- Antibiotic Stewardship Program

F882- Infection Preventionist Qualifications/Role- Phase III

F883- Influenza and Pneumococcal Immunizations

Phase 3 Requirements

F837 §483.*70*(d) Governing body. §483.*70*(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
§483.*70*(d)(2) The governing body appoints the administrator who is—
(i) Licensed by the State, where licensing is required;
(ii) Responsible for management of the facility; *and*

(iii) Reports to and is accountable to the governing body.
§483.*70*(d)*(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). [§483.70(d)(3) Governing body responsibility of QAPI program will be implemented beginning November 28, 2019 (Phase 3).]*

Phase 3 Requirements

F865

§483.75(a) Quality assurance and performance improvement (QAPI) program. [§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified] Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;
§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)]

Phase 3 Requirements

F866

§483.75(c) Program feedback, data systems and monitoring. (§483.75(c) will be implemented during Phase 3) A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

Phase 3 Requirements

F867

§483.75(d) Program systematic analysis and systemic action. (§483.75(d) will be implemented during Phase 3)

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities. (§483.75(e) will be implemented during Phase 3)

Phase 3 Requirements

F868

§483.75(g) Quality assessment and assurance.
§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:
(i) The director of nursing services;
(ii) The Medical Director or his/her designee;

(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and
(iv) The infection preventionist. [**483.75(g)(1)(iv) Implemented beginning November 28, 2019(Phase 3)]**

Phase 3 Requirements

F882
§483.80(b) Infection preventionist [§483.80(b) and all subparts will be implemented beginning **November 28, 2019 (Phase 3)]**
The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:

Phase 3 Requirements

F895- Compliance and Ethics Program

§483.85 Compliance and ethics program.
[§483.85 and all subparts will be implemented beginning November 28, 2019 (Phase 3)]
§483.85(a) Definitions. For purposes of this section, the following definitions apply:
Compliance and ethics program means, with respect to a facility, a program of the operating organization that—
§483.85(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and
§483.85(2) Includes, at a minimum, the required components specified in paragraph (c) of this section.

Phase 3 Requirements

§483.85 (e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care. [§483.85 and all subparts will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F919
§483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area –
§483.90(g)(1) Each resident's bedside; and
[483.90(g)(1) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F940

§483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to— [§483.95 will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F941

§483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. [§483.95(a) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F942

§483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.
[§483.95(b) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F944

§483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. [§483.95(d) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F945

§483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). [§483.95(e) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F946

§483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85—§483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

§483.95(f)(2) Annual training if the operating organization operates five or more facilities. [§483.95(f), (f)(1) and (f)(2) will be implemented beginning November 28, 2019 (Phase 3)]

Phase 3 Requirements

F949
§483.95(i) Behavioral health.

A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). [§483.95(i) will be implemented beginning November 28, 2019 (Phase 3)]

SOAR Reports

Soar reports are the Survey Outcome Activity Reports for the new LTCSP (Long Term Care Survey Process)

The State Agency receives them monthly and display cumulative data.
The data provides an overview of a states performance and compares data at the National, State and Regional level.

Soar Reports

Overview - State, Regional and National Averages: 01/2018 - 12/2018 Connecticut

				Initial Pool Size		Sample Size			Survey Time (hrs)							
	# of Surveys	Census	Team Size	Projected	Actual	Target	Actual	% of Offsite Residents	Pre	Onsite	Post	Total	Onsite time per surveyor	# of Investigations per Surveyor	# of Investigations per Survey	% of Investigations Cited
National	13407	83.6	4.9	25.0	24.6	18.4	19.1	72%	4.4	122.7	22.4	149.5	26.0	11.4	52.8	14%
Boston (Reg. 1)	752	91.1	5.4	26.4	27.1	19.6	19.9	73%	4.1	117.3	14.6	136.0	23.7	12.1	59.3	12%
Connecticut	201	100.4	7.4	27.5	27.7	20.7	21.2	64%	3.8	123.6	5.7	133.2	17.2	6.6	47.8	14%
Quarter 3 2018																
National	3611	83.0	4.8	24.8	23.0	18.3	19.0	75%	4.1	116.6	20.9	141.6	25.6	11.2	51.1	14%
Boston (Reg. 1)	196	90.2	5.2	26.2	24.9	19.6	19.7	77%	4.3	117.0	14.7	136.0	24.7	12.3	56.9	12%
Connecticut	46	101.0	7.1	27.3	27.2	21.2	21.6	69%	4.0	133.3	5.7	143.1	19.2	6.4	44.7	15%
Quarter 2 2018																
National	3506	82.4	4.9	24.7	22.0	18.2	19.0	70%	4.4	122.4	22.4	149.1	26.0	11.4	53.0	14%
Boston (Reg. 1)	196	84.5	5.2	25.6	22.8	18.7	18.9	70%	4.1	112.4	13.7	130.2	23.7	12.3	55.9	13%
Connecticut	53	98.5	7.6	27.5	25.9	20.5	20.8	62%	4.1	126.9	6.5	137.5	17.0	6.6	49.5	15%

SOAR Reports

Table 4. Frequency of Scope/Severity of Deficiencies Cited on New Process and Previous Surveys

Scope/Severity	New Survey Process		Previous Survey Process	
	Number of Citations	Percent of Citations	Number of Citations	Percent of Citations
B	1,684	2.0	1643.0	1.8
C	1,580	1.8	2092.0	2.3
D	51,947	60.8	49980.0	55.6
E	22,229	26.0	26087.0	29.0
F	5,855	6.8	7329.0	8.2
G	1,475	1.7	1695.0	1.9
H	110	0.1	175.0	0.2
I	6	0.0	1.0	0.0
J	298	0.3	418.0	0.5
K	227	0.3	353.0	0.4
L	75	0.1	110.0	0.1
Total	**85,486**	**100.0**	**89,883**	**100.0**

SOAR Reports

Table 2. Average Number of Deficiencies Cited on New Process and Previous Surveys, by State (Standard Surveys only)

State	Number of Deficiencies Cited (includes deficiency-free)								Number of Deficiencies Cited (excludes deficiency-free)							
	New Survey Process				Previous Survey Process				New Survey Process				Previous Survey Process			
	# Srvy	Mean	25th %ile	75th %ile	# Srvy	Mean	25th %ile	75th %ile	# Srvy	Mean	25th %ile	75th %ile	# Srvy	Mean	25th %ile	75th %ile
Nation	**13131**	**6.5**	**3**	**9**	**15476**	**5.8**	**2**	**8**	**11905**	**7.2**	**3**	**10**	**13908**	**6.5**	**3**	**9**
Alabama	217	3.2	1	4	227	4.1	2	6	194	3.6	2	5	211	4.4	2	6
Alaska	17	12.6	9	17	18	9.6	6	13	17	12.6	9	17	18	9.6	6	13
Arizona	99	6.2	3	8	146	3.6	0	5	93	6.6	3	8	107	4.9	2	6
Arkansas	217	5.9	3	8	230	4.5	2	6	209	6.1	3	8	212	4.9	3	6
California	999	9.7	6	13	1195	9.6	5	13	980	9.9	6	13	1170	9.8	5	13
Colorado	149	6	2	9	227	7	3	10	127	7	3	10	205	7.8	4	10
Connecticut	191	6.5	3	9	223	5.4	3	7	189	6.6	4	9	217	5.5	3	7
D.C.	15	13.7	8	21	18	10.9	6	15	15	13.7	8	21	18	10.9	6	15
Delaware	37	10.6	5	15	45	8.9	6	12	34	11.5	5	16	44	9.1	6	12
Florida	596	5.3	3	7	688	4.6	2	7	537	5.8	3	8	622	5.1	3	7
Georgia	352	3.2	1	5	359	3	0	4	267	4.2	2	6	252	4.3	2	5
Guam	0	0	0	0	1	11	11	11	0	0	0	0	1	11	11	11
Hawaii	44	8.2	4	10	45	7.9	4	11	43	8.3	4	10	43	8.3	5	11
Idaho	54	9	6	12	77	7.9	3	11	49	10	7	12	72	8.4	5	11
Illinois	679	7	4	9	728	6.2	3	8	656	7.2	4	10	701	6.4	3	8
Indiana	511	6.8	3	9	549	5.8	3	8	474	7.4	4	10	504	6.3	3	8
Iowa	315	3.8	1	5	437	2.9	1	4	268	4.5	2	6	344	3.7	2	5
Kansas	280	6.4	2	9	333	7.7	4	10	240	7.4	4	10	312	8.2	4	11
Kentucky	244	3.6	1	5	282	3.4	1	5	201	4.4	2	6	225	4.3	2	6
Louisiana	266	3.6	1	6	276	2.6	1	4	217	4.5	2	6	212	3.4	2	4
Maine	84	4.2	2	5	95	2.9	1	4	78	4.5	2	6	88	3.1	1	4
Maryland	149	12.3	6	17	226	8.6	4	12	142	12.9	7	17	220	8.9	5	12
Massachusetts	268	8	3	11	389	5	2	7	248	8.7	4	11	346	5.6	3	7
Michigan	387	9.3	5	12	440	8.8	5	12	378	9.5	5	12	431	8.9	6	12
Minnesota	337	6.7	3	9	375	5.8	3	8	323	7	3	9	353	6.2	3	8
Mississippi	104	3.2	1	4	204	3.4	2	5	89	3.7	2	5	181	3.8	2	5
Missouri	481	7.5	3	10	514	6.2	3	9	452	8	4	11	482	6.6	3	9
Montana	62	9.2	6	12	73	7.8	4	11	58	9.9	7	12	72	7.9	4	11
Nebraska	180	7.3	2	10	210	6	2	9	168	7.8	3	11	191	6.6	3	9
Nevada	57	12.2	7	17	61	6.9	4	9	56	12.5	7	17	58	7.2	5	10
New Hampshire	68	2.1	0	3	74	2.8	0	5	40	3.6	2	5	55	3.7	2	5
New Jersey	308	4	2	6	360	3.7	2	5	274	4.4	2	6	319	4.1	2	5
New Mexico	65	12.6	7	17	74	9.5	4	14	64	12.8	7	17	68	10.3	6	14
New York	356	4.8	1	7	618	4.2	1	6	306	5.6	3	7	522	5	2	7
North Carolina	405	4.9	1	7	426	4.2	1	6	343	5.7	3	7	348	5.1	2	7
North Dakota	79	5.7	4	7	80	6.2	3	8	76	5.9	4	7	78	6.3	3	8
Ohio	841	6.1	2	9	960	4.6	1	6	753	6.8	3	9	814	5.4	2	7

Hemodialysis in a Nursing Home

- Hot topic past few years but no direction on how to administer hemodialysis in LTC until guidance was released
- Peritoneal dialysis has been administered for years by LTC staff in collaboration with the Medicare certified dialysis facility.

CMS released/updated the following as guidance for the administration of hemodialysis in a nursing home:

- CMS Memo dated August 10, 2018
- Revised State Operations Manual Chapter Two (2)
- CMS Memo dated August 17, 2018
- CMS Memo dated August 27, 2018
- F-698

On August 10, 2018, CMS released a memo (QSO 18-22-ESRD) that provided guidance for dialysis services provided in a nursing home

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-22-ESRD.pdf

- The memo identified that there were revisions made to the State Operations Manual, Chapter 2, for the End Stage Renal Disease Program

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf

SOM, Chapter 2, section 2271A:

All chronic dialysis patients receiving dialysis services must be under the care of certified ESRD provider to have outpatient care and treatment reimbursed by Medicare

Residents in a SNF may receive chronic dialysis treatment through two options:

- Transport to and from an off-site certified ESRD facility for treatment, OR
- Transport to a location within or proximate to the SNF building which is separately certified as ESRD facility

SOM Chapter 2

The current model is that the resident receives hemodialysis at the ESRD facility

For hemodialysis to be performed at the nursing home, a written agreement must be signed by authorized representatives of the Medicare-certified ESRD dialysis facility and the nursing home prior to the provision of dialysis care at the nursing home. This agreement must be readily available for review.

Hemodialysis in LTC

CMS released a memo dated August 17, 2018 (QSO-18-24-ESRD) that provided guidance for the "Survey Process for Reviewing Home Dialysis Services in a Long Term Care Facility"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-24-ESRD.pdf

- This guidance will be utilized by the ESRD surveyor during the ESRD survey. The CORE survey process was updated to include the evaluation of home hemodialysis provided in the nursing home.

- Currently CT has 50 outpatient ESRD facilities
- Survey every 2 years for licensure and average of every 3 years for recertification.
- We have three ESRD certified nurse consultants that conduct these surveys

- Medicare participating ESRD facilities must comply with the Conditions for Coverage at 42 CFR Part 494. Under this provision, Medicare-approved ESRD facilities **may provide dialysis services to LTC residents in a LTC facility with an approved Home Training and Support modality**.

- If the ESRD facility has a contract with a nursing home for the provision of home hemodialysis, we will conduct the onsite visits at the SNF

- ESRD facilities that provide home hemodialysis or peritoneal dialysis services to LTC residents must maintain compliance with these requirements, including the requirements set forth at §494.100: **Care at home.**

- There are approximately 20 V tags surveyed for the home program, this includes PD and home hemodialysis patients

- It is the responsibility of the dialysis facility to provide all necessary equipment and supplies for the provision of the dialysis treatments, including maintenance and repair as needed, testing/monitoring water and dialysate quality for the dialysis treatment, and for the training of individuals providing the HHD/PD.

Onsite visit at the SNF:

- The ESRD surveyor will ask for Administration and explain that the purpose for the visit is to review residents receiving hemodialysis by the ESRD provider.
- Surveyor tasks include, **in part,**
- Observations: Set-up; Initiation of treatment; Vascular access check; and Discontinuation of treatment
- Infection control observations (common area of noncompliance)

- Ensure that the access site, dialysis blood lines, and the patient's face visible at all times. Can result in IJ or condition level non-compliance
- Interviews with residents and staff
- Medical record review
- Equipment checks
- Review of water checks if applicable

Nursing Home Regulations were updated to reflect this change

- F-698 responsibilities for the provision of services
- Just to reiterate, the ESRD surveyor will review care & services for the SNF residents receiving home hemodialysis provided by the ESRD facility, not the LTC surveyor

F-698

- The nursing home remains responsible for the overall quality of care the resident receives, this includes the ongoing provision of assessment, care planning and provision of care.
- The dialysis facility is responsible for the medical management for the end stage renal disease including dialysis treatments, performed offsite or onsite.

- Both the ESRD facility and the nursing home are responsible for ensuring the collaboration necessary to provide dialysis care coordination to each nursing home resident receiving dialysis treatments. The resident must be on the nursing home census and not from another facility.
- At a minimum, the ESRD facility, in collaboration with the nursing home, must develop and implement protocols for the delivery of ESRD services that are equivalent to the standards of care provided to dialysis patients receiving treatments in a dialysis facility.

- The protocols should include in part, procedures for infection control, patient assessment, patient plans of care, and care of the dialysis patient at home.
- Policies and procedures must be reviewed and updated as necessary to be consistent with the most current standards of practice.

Shared Responsibilities of the ESRD Facility and Skilled Nursing Facility

The ESRD provider and the LTC facility should:

- Providing a safe and sanitary environment for dialysis treatments
- Ensuring ongoing infection control practices (prevent cross contamination)
- Monitoring and mitigating hazards
- Prohibiting unauthorized intrusions into the dialysis environment during treatments

Shared Responsibilities of the ESRD Facility and Skilled Nursing Facility

- Written communication between the nursing home and ESRD facility including, but not limited to, dialysis treatment orders, medication orders, patient assessment and any changes in patient condition
- Review of each resident's ESRD and LTC plans of care, and collaborative revisions to each plan of care in order to ensure that the needs of the resident are met and their goals are attained
  - Complete, timely and accurate documentation of all assessments, care provided and interventions by both facilities;

Food for Thought

Home hemodialysis in the SNF is a new concept, what will the administration of hemodialysis in the SNF look like?

- Where will the treatment be administered, bedside or designated room (den)
- PHC 19-13-D8t requirements for space will need to be maintained unless eligible for a waiver, work with BFSI

Food for thought

- Accommodations for patient who requires isolation (use of ESRD facility if needed?)
- Where will the equipment and supplies be stored?
- ESRD facility would determine which machines are used

Dialysis facility with separate water room

Baby K dialysis machine, portable water system, common at home

Nx stage machine, small and portable system

Food for thought

- Will need a system for ongoing communication
- Licensed staff handoff beginning and end of treatment?
- Provision of emergency care, code status, ESRD staff oriented to facility P&P
- Change in condition, MD & responsible party notified by whom?

Food for thought

- Use of EMR, paper record?
- Staffing requirements based on patient acuity, V-tag regulation, and dialysis PHC

In conclusion:

If interested in this concept, collaborate with a certified ESRD provider to start the discussion.

DPH is available to listen to any proposal, just keep in mind the guidance mentioned in this talk.

Questions

DPH FLIS UPDATES

Connecticut Department of Public Health

Facility Licensing and Investigations Section

February 2019

ePOC Updates

- Attachments/Letters through ePOC website
  - ePOC Federal Deficiency Letter
  - CT Violation Letter
- State Plan of Correction (POC)
  - State POC should be written in the violation letter after each violation in the space provided in the letter.

  - If size is too large to attach try scanning and attaching it otherwise email as an attachment to the Supervising Nurse Consultant.
  - Please submit the State POC with the Federal POC.
- Follow-up Survey/ePOC posting
  - Follow up Survey along with letters will be posted in ePOC website.
- ePOC Instructions(Training, Enrollment & Assistance)
  - https://portal.ct.gov/epoc

DPH FLIS Events

❖Reportable Events Information Page

https://portal.ct.gov/DPH/Facility-Licensing--Investigations/Facility-Licensing--Investigations-Section-FLIS/Reportable-Events

❖DPH FLIS Events Webpage

https://dphflisevents.ct.gov

❖Reportable Events Facility Administrators To-Do List

- Manage your authorized facility user accounts.
- Make sure you have more than one facility administrator(backup).
- Make sure Events and Summary are submitted on time.
- No limits on user accounts for each facility.
- Make sure the Event Description contains enough details for the duty officer while initiating an event.
- Request for more information email – Messages will appear in the message box for the corresponding event(Seq#).

DPH FLIS Events

❖Event Types – Upcoming/Work In Progress

Classification A Event Types:

- Choking
- Missing Resident
- Unanticipated Death
- Life Threatening Event
- Threat of harm to staff, residents, visitors

Classification B Event Types:

- Injury of unknown origin
- Resident to resident abuse with injury
- Resident to resident abuse without injury
- Staff to resident Abuse
- Visitor to resident abuse
- Sexual Assault
- Neglect
- Misappropriation
- Outbreak
- Other

DPH FLIS Events

Classification C Event Types:

- Fire and Smoke
- Fire alarm impairment
- Sprinkler impairment
- Gas Odor
- Lateral or external evacuation of one or more residents
- Loss of electrical or generator power
- Loss of heat
- Loss of telephone service
- Loss of Water
- Loss of all elevator service
- Event causing facility damage
- Threat of harm to facility
- Equipment failure affecting in dietary, laundry
- Call light failure
- Other

Classification D Event Types:

- Event resulting in serious injury or significant change in condition
- Medication error of clinical significance

DPH FLIS Events- Workplace Violence

Workplace Violence Online Submission Link:

- Web link for yearly workplace violence submissions - https://dphflisevents.ct.gov/
- No login needed for submission of yearly workplace violence.
- Click " Yearly Report Submission to DPH-FLIS"
- Fill out the facility demographic information and attach the document if necessary.
- Check the "Affidavit of Submitter" before submitting the report.

Questions?

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