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Nursing Home: Regulatory Update 2023

Presenters:

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New Mexico Nursing Homes

68 Federally Certified Nursing Homes

- 64 Skilled Nursing/Nursing Facilities
- (2) Nursing Facilities
- (2) Skilled Nursing Only

(1) State Licensed Only Nursing Home

25 Nursing Home Surveyors, including Managers

- 5 vacancies
- 12 SMQT surveyors

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Brief Overview- 2022

Have Met all Nursing Home CMS workload in FY22 (complaints and recertification surveys)

No Nursing Home closures

Contracted with HMS to complete (7) recertifications surveys

- Cited 97 Deficiencies
- Including (4) Immediate Jeopardy and (1) Harm Citations

State	Average # Deficiencies Recert	% Deficiency Free Recerts	% Surveys with Actual Harm Citations	% Surveys with Immediate Jeopardy	Average # Deficiences with Complaints	% Deficiency Free Complaint Surveys	% Complaint Surveys with Actual Harm	% Compliant Surveys with Immediate Jeopardy
National	6.41	6.4%	10.5%	4.1%	1.83	40.7%	9.1%	3.3%
New Mexico	12.54	0.0%	12.3%	7.7%	2.62	35.3%	14.7%	5.9%

2022 Nursing Home Data

- Recertification Surveys 30
- Recerts with Complaints 35
- Complaint Surveys 77
- Complaint Intakes 268
- Total Health Citations 1001
  - Emergency Preparedness 59
  - Life Safety Code 210
  - Reporting NHSN 64
- IJ Citations 16
- Actual Harm Citations 23

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Top Deficiencies

0880 - Infection Prevention & Control	44
0684 - Quality of Care	41
0657 - Care Plan Timing and Revision	33
0761 - Label/Store Drugs and Biologicals	33
0812 - Food Procurement,Store/Prepare/Serve-Sanitary	33
0656 - Develop/Implement Comprehensive Care Plan	31
0658 - Services Provided Meet Professional Standards	31
0677 - ADL Care Provided for Dependent Residents	28
0842 - Resident Records - Identifiable Information	28
0550 - Resident Rights/Exercise of Rights	23
0655 - Baseline Care Plan	22
0756 - Drug Regimen Review, Report Irregular, Act On	21
0600 - Free from Abuse and Neglect	20
0758 - Free from Unnec Psychotropic Meds/PRN Use	20
0689 - Free of Accident Hazards/Supervision/Devices	19

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Actual Harm Deficiencies

F580: Notify of Changes

- Not notifying Physician of s/s of constipation, delayed in starting ordered laxative and results of xray resulting in pain and fecal impaction.
- Not restarting anticoagulant medication resulting in stroke
- Did not notify Physician and POA that resident had fallen. Hospice identified fractured hip 4 days later.

F558: Reasonable Accommodations Needs

- Resident with MS and unable to use call light and was not able to get staff assistance. Unable to trigger call light pad; Alexa was not working to call nurse; Nurse phone didn't have power

F600: Free from Abuse and Neglect

- Resident with MS and unable to use call light and was not able to get staff assistance. Unable to trigger call light pad; Alexa was not working to call nurse; Nurse phone didn't have power
- Nurse did not assess resident following a fall; did not initiate neurochecks. Resident passed away.
- Not monitoring for constipation with start of antidepressant medication and Metamucil; not getting result of xray for 6 days after resident complained of abdominal pain; not starting laxative order for 2 days, not assessing resident to rule out constipation resulting in fecal impaction.

F660: Discharge Planning Process

- Not developing effective discharge plan when postponed discharge to wait for wound vac when resident did not have electricity at home.

F684: Quality of Care

- Delay in treatment for resident experiencing numbness for 10 days, ended up being diagnosed with stroke. Not providing adequate pain relief. Not identifying chronic constipation resulting in fecal impaction.
- Staff pushing resident in wheelchair when foot fell and got twisted. Resident was not assessed and was complaining of pain. Fracture identified 3 days later.
- Resident having pain in shoulder for a couple weeks. Was not assessed or sent out for xray. Resident had Grade 3 AC separation
- Staff not notified of new fractured hip or instructions how to transfer and turn the resident resulting in increased pain during transfers.

F686: Treatment/Services to Prevent Pressure Ulcers

- Not putting on pressure relieving device (boots) resulting in worsening Stage 3 wound.
- Not completing weekly skin assessments; and implementing wound orders for (3) days following discovery of pressure wound resulting in development of facility acquired unstageable pressure wound.
- Did not identify pressure wound upon admission or start any treatment for (5) days resulting in worsening pressure wound that became septic.
- Not measuring and documenting wound progress and not notifying the Physician of wound decline resulting in worsening pressure wound and development of MRSA
- Not monitoring for change in condition of surgical wound for 6 weeks, resulting in requirement for debridement in hospital.

F689: Free of Accidents

- Resident experienced numerous falls and no interventions resulting in injury.
- Staff put resident in wheelchair's feet on bed. Resident fell out of wheelchair resulting in spinal fracture and concussion.
- Hot beverage spilled in resident lap causing severe burns.
- Not transferring resident with 2 people assist as ordered, resulting in fall and fractured arm.

F697: Pain Management

- Facility ran out of pain medication (oxycodone) and was not providing breakthrough pain medications resulting in 10/10 pain for several days.
- Resident did not receive prescribed pain medication from hospital discharge. Received alternative pain meds but was ineffective.
- Not receiving pain medication timely from pharmacy resulting in pain 8/10 for several hours. Not identifying foot fracture from hospital and therapy was having him walk.
- Not providing prescribed pain medication by accessing medication from pyxis in which resident felt only option for relief was to return to the hospital.
- Not providing available prn pain medication and delay in sending resident to hospital following unwitnessed fall for 12 hours despite immediate identification that resident was in pain.

F740: Behavioral Health Services

- Not providing medication or non-pharmacological interventions for a resident experiencing visual hallucinations

F760: Resident are Free of Significant Med Error

- Not restarting anticoagulant medication resulting in stroke

Immediate Jeopardy Citations

F580: Notify of Changes

- Resident began to require O2 more frequently after arriving at facility, neither the residents POA or the residents primary Physician was notified of use. Resident expressed to Physical Therapist that he was feeling dizzy and dopey. It was reported to nursing staff. There were no Physicians orders for O2 use. Resident was found in severe respiratory distress. Resident was placed on 5 L of O2 via nasal cannula. Resident was struggling to breathe resident was placed on a nonrebreather mask at 10L, 911 was called. Resident expired later that night in the hospital.
- Not notifying Physician of medication error or change in condition of the resident.

F600: Free from Abuse and Neglect

- Failure to supervise during medication administration a resident with known hoarding behaviors, resulting in the resident not taking 29 medications prescribed for the resident. This resulted in a hypertensive situation and hospitalization of the resident.
- Failure to provide supervision and intervention of a known physically aggressive resident, resulting in a hip fracture for another resident.
- Failure to recognize a change in resident's condition which likely resulted in a urinary tract infection, sepsis, and death.
- Failed to prevent resident to resident abuse when first started with pushing and adequate supervision was not provided resulting in another altercation in which resident received laceration and fractured arm

F678: Cardiopulmonary Resuscitation

- System for staff to immediately recognize the resident's code status during an emergency. Ensure there was complete and ready to use crash cart equipment available for use in case of an emergency. Provide advanced directive to Emergency Medical Services personal at the time of transfer for a resident, resulting in resuscitation attempts against Residents wishes.

F695: Respiratory/Tracheostomy Care

- Did not have necessary supplies at bedside in the event of life saving emergency and failed to train staff on what to do in an emergency.

F684: Quality of Care

- Resident with uncontrolled diabetes and insulin dependent goes out on leave and is provided by the facility short acting insulin to self-administer but is not provided a glucometer to check blood sugar levels. Resident stated that he would take insulin if he had a glucometer, but without knowing his blood sugar level would be afraid of the health risks. Resident ended up in the Hospital while out on leave due to DKA. Residents that go out to appointments with facility transportation staff do not take insulin or a glucometer during transport and staff are unqualified to give insulin or check blood sugar levels when out on transport.
- Failure to timely recognize a change in condition, failure to notify physician of this change, likely resulting in delay of treatment and death of resident.
- Resident admitted and no medications arrived. Resident had anxiety attack and asked for medication. Medication not provided. Early next morning, O2s was 61% and was receiving oxygen 2L however order was for 5L. Resident passed away.

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F686: Treatment Service to Prevent/Health Pressure Ulcer

- Resident was admitted into the facility wound care for above knee amputation. Wound care was not immediately initiated. Resident was transferred to hospital 2 weeks later with increased exposed bone, necrotic drainage and needed additional amputation.

F689: Free of Accident Hazards/Supervision/Devices

- Failure to provide adequate monitoring and supervision for a resident that was smoking while using oxygen

F726 Competent Nursing Staff

- Staff working in a dementia care unit did not have the necessary training to care for the behavioral needs of the residents, resulting in a fractured hip for one of the residents.
- Staff covered resident trach with plastic bag during shower, resulting in resident losing consciousness.

F760: Residents Free of Significant Med Errors

- Resident administered wrong medications likely resulting in resident's death.

F880: Infection Control

- Repeated antibiotic use for resident with chronic UTI with no change in type pf antibiotic. Resident had 9 infections for 12 months (8 out of 9 same antibiotics used). No culture and sensitivity test performed to ensure infection is cleared after each treatment.
- Poor infection control practices including not using appropriate PPE, not sanitizing hand upon leaving covid positive room. Facility in covid outbreak and several residents were transferred to hospital for covid symptoms.

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Infection Control Compliance

New Mexico Public Health Order 12/19/22
121922-PHO-Omnibus-Order.pdf (nmhealth.org)

- All facilities certified by CMS are instructed to adhere to all COVID-related requirements prescribed by CMS.
- All Assisted Living Facilities and Adult Day Care Settings are required to adhere to all COVID-related requirements to which Nursing Homes are held by CMS

CMS QSO 20-39 NH
QSO-20-39-NH REVISED 09/23/2022 (cms.gov)

- Visitation is allowed for all residents at all times
- Updated guidance for face coverings and masks during visits
- Removed vaccination status from the guidance
- Refer to CDC

Infection Control Citations

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Not removing gowns before exiting resident rooms	Not quarantining unvaccinated/newly admitted residents *	Not isolating covid positive residents; pending results and shared bathrooms	Nasal cannulas/urinary catheter bags/tubing on the floor
Staff re-using same eye protection goggles	Not screening visitors Visitors not wearing masks *	Staff not wearing appropriate PPE for situation	Nebulizer masks left uncovered when not in use
Trash bins for used PPE overflowing	Not disinfecting communal medical equipment; vitals	Not training staff/communicating covid status to staff	Not separating dirty/clean laundry; positive air flow
Staff working with symptoms (minor symptom)/returning to work from quarantine too soon	Not wearing masks correctly; under nose and chin	Not having PPE available outside covid positive rooms for staff; staff walking down hall to dispose of PPE	Not properly disinfecting glucometers

Defensible Citations 2022

Informal Dispute Resolution (IDR)

- 34 Citations disputed
  - (11) Removed during IDR
  - (4) Removed before sending to committee

  56% of IDR citations supported
- IDR Committee provides feedback to surveyors and facilities

CMS Enforcement Review

(30) Surveys for 18 facilities

Resulting in

- (16) IJ Citations
- (23) Harm Citations

29/30 surveys supported with CMP; 96%

- Resulting in approximately $1,785,000 plus imposed CMPs (minus 35% reduction for waiving appeal)
- CMS reviews resulting in Surveyor and Reviewer training

Satisfaction Survey Results

DHI staff:	
Professional/courteous	86% Agree/Strongly Agree
Fair/Unbiased	86% Agree/Strongly Agree
Trained/Knowledgeable	86% Agree/Strongly Agree
Team Leader kept you informed	86% Agree/Strongly Agree

* 135 onsite surveys (not including onsite revisits) and received (15) Nursing Home responses

- [name] was very professional. He made it clear as to what exactly he needed.
- It was a good experience in an unfortunate IJ situation. it was handled professionally and with grace.
- We are always looking for ways to improve so the learning experience is welcomed.
- very organized and tried to make the experience more comfortable and less threatening
- Some interpretations were just that - interpretations not supported by CMS guides