August 23, 2016 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat will feature focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff

Recent media reports have highlighted occurrences of nursing home staff taking unauthorized photographs or video recordings of nursing home residents, sometimes in compromised positions. The photographs are then posted on social media networks or sent through multimedia messages.

Nursing homes must establish an environment that is as homelike as possible and includes a culture and environment that treats each resident with respect and dignity. Treating a nursing home resident in any manner that does not uphold a resident’s sense of self-worth and individuality dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive attitude towards the resident(s). Federal nursing home regulations require that each nursing home provides care and services in a person-centered environment in which all individuals are treated as human beings.

In federal Survey and Certification Letter 16-33 to state survey agency directors, the Centers for Medicare & Medicaid Services shared that surveyors will request and review nursing homes’ policies and procedures to prevent staff from taking and distributing photos or videos that “demean or humiliate a resident.” The reviews will begin with the next standard survey 30 days after the memo’s release (On or around September 5, 2016), CMS said.

“Each nursing home must establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation,” the memo reads. “The nursing home management must assure that all staff are aware of reporting responsibilities, including how to identify possible abuse and how to report any allegations of abuse.”

It is also important to note that, for purposes of this S&C, federal CMS defines nursing home staff to include employees, consultants, contractors, volunteers and other care givers who provide care and services to residents on behalf of the facility.

A nursing home resident has the right to personal privacy of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care. Taking photographs or recordings of a resident and/or his/her private space without the resident’s, or designated representative’s, written consent is a violation of the resident’s right to privacy and confidentiality. Examples include, but are not limited to, staff taking unauthorized photographs of a resident’s room or furnishings (which may or may not include the resident), or a resident eating in the dining room, or a resident participating in an activity in the common area.

If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident(s), regardless of whether the resident provided consent and regardless of the resident’s cognitive status, the surveyor must
investigate federal requirements related to abuse at F223 and F226. This would include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, toileting, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part without the resident’s face whether it is the chest, limbs, or back, labeling resident’s pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language and showing the resident in a compromised position.

Each nursing home must develop and implement written policies and procedures that prohibit all forms of abuse, including mental abuse. Each nursing home must review and/or revise their written abuse prevention policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones and other electronic devices) to take, keep or distribute photographs and recordings on social media.

Each nursing home must provide training on abuse prohibition policies for all staff who provide care and services to residents, including prohibiting staff from using any type of equipment (e.g., cameras, smart phones and other electronic devices) to take, keep or distribute photographs and recordings of residents that are demeaning or humiliating.

The provision of in-service education on abuse prohibition alone does not relieve the nursing home of its responsibility to assure the implementation of these policies and procedures. The nursing home must provide ongoing oversight and supervision of staff in order to assure that these policies are implemented as written.

Each nursing home must be managed and operated to ensure that staff implement policies and procedures that promote and maintain each resident’s individuality, self-worth, dignity and respect. The facility must report all allegations of abuse, provide protections for any resident involved in the allegations, conduct a thorough investigation, implement corrective actions to prohibit further abuse and report the findings as required.

Anytime that the nursing home receives an allegation of abuse, including those involving the posting of an unauthorized photograph or recording of a resident on social media, the facility must not only report the alleged violation to the Administrator and other officials, but must also initiate an immediate investigation and prevent further potential abuse. Examples of steps that the facility may put in place immediately to prevent further potential abuse include, but are not limited to, staffing changes, increased supervision, protection from retaliation and follow-up counseling for the resident(s). Based on the investigation findings, the facility must implement corrective actions to prevent recurrence.

Surveyors are expected to take the following actions 30 days after the release of this memorandum. During the next standard survey, whether a Traditional or Quality Indicator Survey (QIS) survey, the survey team must request and review nursing home policies and procedures related to prohibiting nursing home staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones and other electronic devices) to take, keep, or distribute photographs and recordings on social media. Survey teams should begin this review for standard surveys, effective immediately and implement this policy until each nursing home has been surveyed for the inclusion and implementation of such policies. During any survey, the survey team may request to see such written policies, as necessary based upon identified concerns and/or complaints.

AHCA has developed Social Media Guidance for Nursing Care Centers and Assisted Living Communities to provide resources on how to effectively manage social media, review social media policies, conduct social media training, and investigate social media abuses. The guidance provides specific examples and suggested center responses to ensure residents’ rights are protected. It is available on the AHCA/NCAL website under Legal Resources. Please note you must log in to view the document. Please contact Sara Rudow with any questions.

Final CMS Rule Issued on Long Term Care Ombudsman Programs
A final rule governing Long Term Care Ombudsman Programs became effective July 1 and the Administration for Community Living now plans to review states’ progress toward implementing the rule.
The final rule addresses responsibilities of the office, criteria for resolving complaints on behalf of residents, role in resolving abuse complaints and conflict of interest. ACL offers a frequently asked questions resource on the LTCOP rule as well as other information.

The Administration on Aging (AoA) of the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS) is issuing this final rule in order to implement provisions of the Older Americans Act (the Act) regarding states' Long Term Care Ombudsman programs (Ombudsman programs). Since its creation in the 1970s, the functions of the Nursing Home Ombudsman program (later, changed to Long Term Care Ombudsman program) have been delineated in the Act; however, regulations have not been promulgated specifically focused on states' implementation of this program. In the absence of regulation, there has been significant variation in the interpretation and implementation of these provisions among states. HHS expects that a number of states may need to update their statutes, regulations, policies, procedures and/or practices in order to operate the Ombudsman program consistent with federal law and this final rule.

The Long Term Care Ombudsman Program’s final rule now can be found online in the Federal Register. A culmination of several years of collaborative work with states and other partners, this rule guides implementation of the portions of the Older Americans Act governing grants to states for operation of Long Term Care (LTC) Ombudsman programs. Since their establishment in the 1970s, LTC Ombudsman programs have:

- Employed person-centered approaches to resolve problems with and for individuals who live in nursing facilities, assisted living, board and care and other similar adult care facilities;
- Represented consumer interests by recommending improvements in public policy;
- Worked to support survivors of abuse, neglect and financial exploitation; and
- Engaged thousands of volunteers each year.

Unfortunately, without the foundation of federal regulations focused on LTC Ombudsman program operations, there has been significant inconsistency among states in the quality of ombudsman services provided to residents. This rule will help bring the needed consistency and strengthen LTC Ombudsman programs and the effectiveness of their services to individuals living in long term care facilities.

The rule addresses:

- Responsibilities of key figures in the system, including the Ombudsman and representatives of the Office of the Ombudsman;
- Responsibilities of the entities in which LTC Ombudsman programs are housed;
- Criteria for establishing consistent, person-centered approaches to resolving complaints on behalf of residents;
- Appropriate role of LTC Ombudsman programs in resolving abuse complaints; and
- Conflicts of interest: processes for identifying and remedying conflicts so that residents have access to effective, credible ombudsman services.

We know some programs will need to make changes to address conflicts of interest and other issues that will be identified as states evaluate their compliance with the new rule. The rule became effective on July 1, 2016.

ACL can help. They are available to states, long term care ombudsman programs and all other stakeholders for training, technical assistance, and support as we work together to implement the rule.

They set up a dedicated email account—LTCOmbudsman.Rule@acl.hhs.gov—to help manage and respond to questions and requests for assistance. That account will be monitored by multiple staff to enable fastest response. Of course, their regional offices and Long Term Care Ombudsman program staff also are standing by. Click here to view a list of resources.

The Administration on Aging (AoA) recently published a final rule intended to create more national consistency for the State Long Term Care Ombudsman Program.

The rule, effective July 1, 2016, implements provisions of the Older Americans Act (OAA) and focuses on 5 key areas:

- Responsibilities the Ombudsman and representatives of the Office of the Ombudsman.
• Responsibilities of the entities in which LTC Ombudsman programs are housed.
• Criteria for establishing consistent, person-centered approaches to resolving complaints on behalf of residents.
• The role of LTC Ombudsman programs in resolving abuse complaints.
• Conflicts of interest.

The AoA establishes:
• A grievance process to give individuals served by the program a clear process for filing a grievance and receiving a response.
• A minimum qualification for the State Long Term Care Ombudsman.

Ombudsman Authority
The rule does not grant "significant" additional authority or require additional functions of the Ombudsman, but is intended to clarify the responsibilities contained in the OAA.
Based on these requirements, HHS and the AoA hope to foster consistency and/or eliminate the variation across states in implementation of the ombudsman program.

The AoA rule:
• Clarifies that the ombudsman has sole authority for designating and de-designating representatives of the Office.
• Establishes a grievance process within the Ombudsman program, "giving individuals served by the program a clear process for filing a grievance, having their concern investigated, and receiving a response."

The ombudsman must meet minimum qualifications:
• Experience in long term services and supports or other direct services for older persons or individuals with disabilities.
• Consumer-oriented public policy advocacy.
• Leadership and program management skills.
• Negotiation and problem resolution skills.

Policies and procedures that must be established related to program administration include:
• Monitoring the performance of local Ombudsman entities.
• Standards assuring prompt response to complaints, prioritizing abuse, neglect, exploitation and time-sensitive complaints; and which consider severity of risk, imminence of the threat of harm and opportunity for mitigating harm.
• Procedures for timely access to facilities, residents and appropriate records
• Prohibition of disclosure of identifying information of any complainant unless the complainant communicates informed consent; or the disclosure is court ordered;
• Organizational and individual conflicts of interest.
• Designation/removal of designation of local ombudsman entities/representatives of the office.
• A grievance process for the receipt and review of grievances regarding the determinations or actions;
• Training for certification and continuing education of the representatives of the office, based on model standards established by the director of the Office of LTC Ombudsman Programs in consultation with residents, resident representatives, citizen organizations, long term care providers and the state agency. [In the Preamble AoA indicates future plans to develop standardized training requirements.]

Key Definitions
Immediate family: A member of the household or a relative with whom there is a close personal or significant financial relationship.
Office of the State Long Term Care Ombudsman: The organizational unit in a state or territory headed by a state long term care ombudsman.

Representatives of the Office of the State Long Term Care Ombudsman: Employees or volunteers designated by the ombudsman to fulfill the duties set forth.
Resident representative: Any of the following:
- An individual chosen by the resident to act on [his/her] behalf...to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications.
- A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications.
- Legal representative, or the court-appointed guardian or conservator of a resident.
- AoA uses "resident representative" throughout and intends it to be “consistent with the person-centered approaches to Ombudsman program services.”
  - The "resident representative" is authorized to provide permission for a representative of the office to perform the certain tasks when a resident is unable to communicate informed consent or prefers to have a representative act on his/her behalf, i.e., access to resident records; disclosure of the resident identifying information; initiation, coordination and resolution of complaints.

State Long Term Care Ombudsman/Ombudsman: The individual who heads the office and is responsible to personally, or through representatives of the office, to fulfill the functions, responsibilities and duties.

State Long Term Care Ombudsman program, Ombudsman program: The program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the office headed by the ombudsman, and the representatives of the office.

Willful interference: Actions or inactions taken by an individual in an attempt to intentionally prevent, interfere with or attempt to impede the ombudsman/representative from performing

AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 8 of 13

This is part of a series featuring one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of Clinical Foundation: Diagnostic Quality

Key Takeaways: Diagnostic Quality

- Accurate diagnosis is key to assist all disciplines in caring effectively for an individual.
- Diagnostic error frequently leads to unsafe care, waste of resources and unsatisfactory experience for the resident/patient.
- Improving diagnostic quality is a key factor to improve patient safety.
Visit the AHCA Clinical Practice [website](#) to learn more about the element of “Clinical Foundation: “First of All, Do No Harm” Thinking Built Into Practice” and answers to these key questions:

<table>
<thead>
<tr>
<th>Probing Questions for Team Reflection and Discussion:</th>
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<tbody>
<tr>
<td>1. What steps can we take to help avoid cognitive error?</td>
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<tr>
<td>2. How do we know if we have obtained and provided adequate information before seeking treatment or intervention?</td>
</tr>
<tr>
<td>3. How do we engage all staff in contributing to diagnostic quality?</td>
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</tbody>
</table>

What does this mean? Why is this important? What are some examples? What is my part (as an individual employee, manager or practitioner)? What can my organization do?

Start somewhere, pick one element and work through it with your team.

Enjoy the journey through the framework!

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**Trending Statistics**

*Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.*

**AHCA Analysis of New Five-Star Data**

The American Health Care Association (AHCA) has analyzed the new CMS Five-Star data published on Nursing Home Compare on Wednesday, August 10. The data reflects new metrics and methodological changes that expand the Quality Measure (QM) component of the system. As a result of these changes, the QM and Overall Five-Star ratings for some skilled nursing care centers changed. A snapshot of the impact on skilled nursing care centers nationwide is as follow:

**Overall rating change between June and July 2016:**
- 7 percent net decrease in distribution of ratings
- 79 percent or 12,299 did not change
- 14 percent or 2,103 lost one or more stars
- 8 percent or 1,092 gained one or more stars

**QM rating change between June and July 2016:**
- 16 percent net decrease in distribution of ratings
- 61 percent or 9,385 did not change
- 27 percent or 4,238 lost one or two stars
- 12 percent or 1,833 gained one or two stars

Click [here](#) for a detailed breakdown of the above snapshot.

Over the next couple of days, we will be updating [LTC Trend Tracker](#) with the new data which will allow members to run reports that capture the latest Five-Star and QM rates.

In the meantime, we encourage members to go to the Five-Star achancaLED website [here](#) to access the recorded AHCA Five-Star webinar from July 28, 2016, and download the following resources:
- CMS Technical Users' Guide
- Q&As from July 28 Five-Star Webinar
- Member center toolkit for communicating change in ratings to different groups:
  - Suggested talking points
  - Template media statement
  - Template letter to families
  - Sample letter to payors
State Affiliates can access tools and resources here.

**Table 1. Overall Five Star Rating Changes, June to July 2016 – Illinois Members**

<table>
<thead>
<tr>
<th>Illinois Members’ Changes (June to July)</th>
<th>Centers</th>
<th>-4 Stars</th>
<th>-3 Stars</th>
<th>-2 Stars</th>
<th>-1 Stars</th>
<th>Same</th>
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<td>June OVERALL</td>
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<td>16</td>
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<tr>
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**Table 2. Overall Five Star Rating Changes, June to July 2016 – Illinois All SNFs**

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**Table 3. Overall Five Star Rating Changes, June to July 2016 – All AHCA Members in Nation**

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<th>All AHCA Members’ Changes (June to July)</th>
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<td><strong>Count of Centers</strong></td>
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<td>116</td>
<td>11</td>
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<tr>
<td>June 2-Star</td>
<td>1,981</td>
<td></td>
<td></td>
<td>342</td>
<td>1,460</td>
<td>158</td>
<td>21</td>
<td></td>
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<tr>
<td>June 3-Star</td>
<td>1,849</td>
<td></td>
<td></td>
<td>22</td>
<td>280</td>
<td>1,373</td>
<td>164</td>
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<tr>
<td>June 4-Star</td>
<td>2,227</td>
<td></td>
<td></td>
<td>327</td>
<td>1,678</td>
<td>190</td>
<td></td>
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<tr>
<td>June 5-Star</td>
<td>2,194</td>
<td></td>
<td></td>
<td>16</td>
<td>323</td>
<td>1,851</td>
<td></td>
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<td></td>
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<tr>
<td><strong>Percent of Centers</strong></td>
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<tr>
<td>June OVERALL</td>
<td>9,738</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>13%</td>
<td>79%</td>
<td>6%</td>
<td>0%</td>
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<tr>
<td>June 1-Star</td>
<td>1,487</td>
<td></td>
<td></td>
<td></td>
<td>91%</td>
<td>8%</td>
<td>1%</td>
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<tr>
<td>June 2-Star</td>
<td>1,981</td>
<td></td>
<td></td>
<td></td>
<td>17%</td>
<td>74%</td>
<td>8%</td>
<td></td>
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</tr>
<tr>
<td>June 3-Star</td>
<td>1,849</td>
<td>1%</td>
<td>15%</td>
<td>74%</td>
<td>9%</td>
<td>1%</td>
<td></td>
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</tr>
<tr>
<td>June 4-Star</td>
<td>2,227</td>
<td>0%</td>
<td>1%</td>
<td>15%</td>
<td>75%</td>
<td>9%</td>
<td></td>
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<tr>
<td>June 5-Star</td>
<td>2,194</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>15%</td>
<td>84%</td>
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Important Regulations, Notices & News Items of Interest

1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-33 – NH** - Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff. See Lead Article. Freedom from Abuse: Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). **Facility and State Agency Responsibilities:** This memorandum discusses the facility and state responsibilities related to the protection of residents. Specifically, at the time of the next standard survey for both the Traditional survey and QIS, the survey team will request and review facility policies and procedures that prohibit staff from taking, keeping and/or distributing photographs and recordings that demean or humiliate a resident(s).

- **S&C 16-34 – ICF/IDD** - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Appendix J and Exhibit 355: Removal of Website Links. (No actual S&C Letter, just this notice). **Appendix J – Interpretive Guidelines (IGs)/Exhibit 355:** CMS has revised the ICF/IID Interpretive Guidelines (IGs) and Exhibit 355 within the State Operations Manual (SOM) to remove all references to website links that are now inaccessible or may become so in the future.

2) Federal HHS/CMS released the following notices/announcements:

- CMS Midwest Division has distributed their monthly provider update newsletter. This edition includes updates on the Addiction and Recovery Act and other CMS Updates.

- CMS has an upcoming National Partnership to Improve Dementia Care and QAPI MLN Connects® National Provider Call scheduled for Thursday, September 15 from 12:30 to 2:00 pm CT. Click here for details. This call focuses on effective care transitions between long term and acute care settings, highlighting transitions that involve residents with dementia. This is critical for residents with dementia, as care transitions can cause heightened anxiety and aggression. Communication should be optimized, as care transitions are high-risk periods for nursing home residents. Additionally, CMS experts share updates on other related issues also allowing for question and answer time.
CMS is conducting an IMPACT Act; Data Elements and Measure Development Call on August 31 from 12:30 to 2:00 pm CT. To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early. During this call, CMS experts discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

CMS released Post-Acute Provider Training videos on Section GG. Check out the You Tube videos by going to this link... https://www.youtube.com/watch?v=pNgQ3OSaxYg

The Notice of Observation, Treatment and Implication for Care Eligibility (NOTICE) Act will go into effect in October, instead of this month, according to a final rule released by CMS. Basically, this new Medicare law requires hospitals to notify patients that they may incur huge out-of-pocket costs if they stay more than 24 hours without being formally admitted and that the patients can expect to start receiving the warnings in January. In other words, hospitals will be required to notify a patient when admitted verses just being ‘observed.’

CMS has made the ICD-10 GEMS for 2017 Available. The 2017 General Equivalence Mappings (GEMs) are available, along with the ICD-10-CM and ICD-10-PCS code updates:
- Diagnosis: 2017 ICD-10-CM and GEMs webpage
- Procedures: 2017 ICD-10-PCS and GEMs webpage

CMS finally published the new Five-Star rankings on its Nursing Home Compare (NHC) website. The ratings reflect new metrics and methodological changes that expand the quality measure component of the system. The AHCA/NCAL Quality Initiative website here has information and tools to help members achieve the measurable goals aligned with Five-Star. AHCA has also kicked off its new 8-part webcast series designed to assist members with using the Quality Initiative to achieve success. For more information, click here. And be sure to use AHCA’s members-only LTC Trend Tracker here to run reports that capture your Five-Star and Quality Measure (QM) rates. See also Trending Statistics in this issue of Regulatory Beat.

3) The Illinois Department of Healthcare and Family Services (HFS) posted the following notice:

- HFS posted a new provider notice regarding 180 Day Time Limit for Claim Submittal. You may view the provider notice here.

4) The Illinois Department of Public Health (IDPH) remaining 2016 IDPH Town Hall regional meeting dates are below. They are very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words “Town Hall Reservation” in the subject line.
   - 8/31 – Memorial Education Building – O’Fallon – 1-3 pm
   - 9/14 – Alden Estates of Shorewood – Shorewood – 1-3 pm
   - 10/19 – Brookens Building – Champaign – 1-3 pm
   - 11/15 - Friendship Village – Schaumburg – 10-12 noon

5) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

6) MedlinePlus reports that “Underweight Seniors May Have Added Alzheimer’s Risk.” Having a lower weight may increase older adults’ risk of the memory-robbing disorder Alzheimer’s disease, new research suggests. The study included 280 healthy people aged 62 to 90 with normal mental function. The participants underwent physical exams, genetic testing and brain scans. According to the researchers from Brigham and Women's Hospital and Massachusetts General Hospital in Boston, there was a link between lower body weight and more extensive deposits of Alzheimer's-related beta-amyloid protein in the brain.
7) **Medical News Today** reports that “Feeling Full Hormone Increase in Seniors May Explain Anorexia of Aging.” Elderly adults often experience loss of appetite, resulting in weight loss and undernutrition. Now, researchers suggest this may be down to increased production of a hormone called peptide YY, which tells humans when they are feeling full. Termed “anorexia of aging,” loss of appetite is common among elderly adults, with around 15-20 percent of seniors experiencing unintentional weight loss as a result. While loss of appetite in seniors can be driven by emotional issues, such as depression or grief, in many cases, no underlying cause can be found.

8) **HealthDay** reports “Rx for Seniors' Health: Upbeat View, Less Stress.” A small study published online in the Journal of Gerontology: Psychological Sciences examining 43 people aged 60 to 96 by researchers at North Carolina State University suggests that “a positive attitude about aging can help seniors cope with stress.” Study participants were asked by researchers “how they felt about aging and then completed a daily questionnaire for eight straight days” that included questions on levels of stress, fear, irritability or distress.

9) **Provider Magazine** reports “More People Choosing Five-Star Rated Facilities Since CMS Debuted Ratings, Study Suggests.” People are increasingly more likely to choose a skilled nursing center that has a five-star rating from the Centers for Medicare & Medicaid Services, according to a new study. Health Services Research conducted the study and found that admissions at four-star and five-star rated facilities increased, while admissions at one-star facilities decreased, in 2009 after CMS debuted the ratings system at the end of 2008. The article mentions that the American Health Care Association found that skilled nursing centers that employ registered nurses that have been “certified by the American Nurses Credentialing Center (ANCC) in gerontological nursing are twice as likely to” be rated five stars by CMS.

10) The **AP** reports “Assisted Living Centers Growing In Popularity As Population Ages”. Assisted-living centers, including those that offer care for residents with dementia, are growing in popularity across the US as the population ages and more seniors need the services offered by assisted living centers and nursing homes. The article mentions that assisted living centers “tend to attract older seniors, often those 85 and older, according to the National Center for Assisted Living.” **Illinois has 402 licensed Assisted Living facilities (61 of these are Shared Housing) with 18,209 living units.**

11) Articles from **Kaiser Health News:**

   - **“Elderly Getting Too Many Prescriptions For Chronic Illnesses, Raising Chance of Serious Side Effects, Study Suggests.”** A recent study shows a growing number of elderly patients are being prescribed too many medications to treat chronic illnesses, “raising their chances of dangerous drug interactions and serious side effects.” Furthermore, the piece points out that different drugs are often prescribed by different physicians, “who don’t communicate with each other,” further complicating the situation. Data from the Institute of Medicine show that in 2006, “at least 400,000 preventable ‘adverse drug events’ occur[ed]... in American hospitals.” Similarly, a 2013 study found that nearly 20 percent of patients discharged from hospitals “had prescription-related medical complications during their first 45 days at home.”

   - **“Elderly Patients May Leave Hospital More Disabled Than Before They Arrived.”** Research indicates one third of adults over 70 who go to the hospital return from their visit more disabled than before the arrival. For adults over 85 years of age, the risk of increased disability following a hospitalization is more than 50 percent. Ken Covinsky of UC San Francisco explains, “The older you are, the worse the hospital is for you. A lot of the stuff we do in medicine does more harm than good. And sometimes with the care of older people, less is more.” The piece highlights an innovative approach to the problem, in which elderly patients are treated in a special ward called “Acute Care for Elders (ACE)” and get accommodations appropriate for their age and unique needs.

12) **Modern Healthcare** reports “Observation Stay Notices Will Cost Hospitals $23 Million Every Year.” A new requirement for hospitals to notify Medicare patients when they are receiving observation care but have not been admitted will cost the industry $23 million every year, according to the CMS. The agency estimates that 1.4 million beneficiaries will receive annual notices. The Notice of Observation Treatment and Implication for Care Eligibility Act requires hospitals to notify beneficiaries receiving observation services for more than 24 hours. The document must be provided no later than 36 hours after observation services are initiated.
13) *Medscape* reports “*Striking Link Between Sleep Disturbances and Stroke.*” Sleep-disordered breathing (SDB) and sleep-wake disturbances (SWD) may increase the risk for a first or secondary stroke and decrease stroke recovery, a large literature review shows.

14) *McKnight’s* reports:

- “*Value-Based Purchasing Demo Had Little Impact on Medicare Spending, Quality: Study.*” CMS’ Nursing Home Value-Based Purchasing demonstration had little effect on participating facilities’ Medicare spending or quality, a new study has found. The study analyzed administrative and qualitative data from nursing homes in Arizona, New York and Wisconsin, where the demonstration was conducted. Researchers used data from 2008 (before the demonstration began) and from the demonstration period lasting from 2009 to 2012. Results, which were published earlier this month, showed that Medicare savings were realized in Arizona only over the first year and in Wisconsin only over the first two years. New York facilities, meanwhile, reported no savings. Those reported savings were likely a “regression toward the mean,” researchers concluded, reflecting higher baseline spending in Arizona and Wisconsin facilities that moved closer to the average upon later measurements.

- “*Medicaid Expansion Improved Care For Chronic Conditions, Study Finds.*” Low-income adults in two states experienced significant improvements in care after Medicaid services were expanded as part of the Affordable Care Act, according to a recent analysis. Researchers found that Medicaid expansions in Arkansas and Kentucky resulted in better primary care access and lower out-of-pocket costs for low-income adults. This is in comparison to similar patients in Texas, where coverage has remained the same. Improvements in Arkansas and Kentucky also were made in care for chronic conditions within the states where the expansions occurred, according to the study. The results were compiled from the survey responses of nearly 9,000 low-income adults in the three states. The surveys were conducted for two years, ending in December 2015.

- “*Fair Warning: New Medicaid ‘Pass-Through Payments’ For SNFs May Be Blocked.*” So-called “pass-through” Medicaid payments may soon find themselves in the crosshairs of federal regulators, according to a recent bulletin from CMS. Pass-through payments, additional payments given to providers by managed care plans, are “inconsistent” with the goals laid out for Medicaid in the massive final rule for the program released in April, Center for Medicaid and CHIP Services Director Vikki Wachino wrote in the July 29 bulletin. The final rule included plans to phase out pass-through payments through “transition periods” for different providers. Payments to nursing facilities would be phased out over five years, compared to 10 years for hospitals. The rule also put limits on such payments as the Medicaid program transitions to value-based payments, which aren’t compatible with the pass-through system.

- “*20% Leave Hospital With Unstable Vital Signs, Posing Problem for Providers.*” Nearly one in five adult hospital patients are discharged with at least one unstable vital sign, a new study from University of Texas researchers has found. Those instabilities have become a growing concern over the past three decades as hospital stays have shortened dramatically, researchers said. Of the 32,835 patients included in the study, almost 20 percent had one of more vital sign “abnormality” upon discharge. Elevated heart rate was the most common, affecting 10 percent of all patients. Those unstable vitals, which also include abnormalities with temperature, blood pressure, respiratory rate and oxygen saturation, increase patients’ risk of hospital readmission and death, researchers noted. Thirteen percent of the patients were readmitted or died in the 30 days following hospital discharge. Post-acute care facilities were found to be a “frequent” post-discharge care setting for those with unstable vital signs. Those patients were still found to have high rates of readmission and death, leading researchers to suggest than another post-discharge setting may have been better “for a significant subset of these individuals,” researchers said.

- “*Updated Five-Star Doesn’t Fix Accuracy Issues, Senator Says.*” New quality measures added to the Five-Star Quality Rating System this week are unlikely to improve the accuracy of the ratings, according to one lawmaker. While the updated measures give prospective nursing home residents and their families more information when choosing a facility, they do little to “impact the accuracy and reliability of the measures reported,” Sen. Robert Casey (D-PA) told *Bloomberg BNA* on Wednesday.
• “Dementia Care Added to Medicare Advantage Insurance Model.” A value-based, clinically-focused insurance model will add benefits tailored for people with dementia in its second year, CMS announced recently. The Medicare Advantage Value-Based Insurance Design, set to kick off tests in 2017, offers “clinically-nuanced benefit designs” for enrollees that have certain clinical conditions such as diabetes, congestive heart failure or past strokes. The model will add dementia, as well as rheumatoid arthritis, to its covered conditions beginning in 2018, CMS said.

• “CMS Proposes First PACE Update in 10 Years.” The Programs of All-Inclusive Care for the Elderly would get its first major update in a decade under a proposal recently announced by CMS. The PACE program, last overhauled in 2006, provides coordinated, community-based services to Medicare and Medicaid beneficiaries who qualify for skilled nursing care. The new proposal would allow for “a more flexible approach” to coordinating participants’ care teams than the current structure, which only allows team members to fill one role on a care team. Non-physician primary caregivers such as nurse practitioners would also be allowed to provide some services instead of primary care physicians.

• “Common Painkiller May Help Reverse Alzheimer’s-Related Memory Loss.” An anti-inflammatory drug commonly used to treat pain associated from menstrual cramps may be able to reverse memory loss linked to Alzheimer’s disease, new research shows. Researchers with the University of Manchester in England gave mefenamic acid, which is used to reduce mild pain, to a group of 10 mice genetically modified to develop Alzheimer's over the course of one month. Another group of mice received a placebo. After the month was over, researchers found the memory levels of mice treated with mefenamic acid returned to normal, mirroring mice that were Alzheimer’s-free.

15) Interesting Fact: An average American weighs at least 15 pounds more than 20 years ago a CDC study reports.