February 27, 2019 Edition

Feature Focus

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

Medication Pass - Surveyor Observation
Several LTC facilities have contacted IHCA in regard to the medication pass and surveyor observation during an annual survey. The nurses that do medication passes are often nervous and sometimes intimidated about having a surveyor look over their shoulder when doing a medication pass observation.

The federal Requirements of Participation (RoPs) require surveyors to make random medication observations of several staff over different shifts and units, multiple routes of administration (oral, intravenous (IV), intramuscular (IM), subcutaneous (SQ), topical, ophthalmic) with a minimum of 25 medication opportunities. The surveyors are told not to preselect residents for observation. The surveyors are to observe and document all of the resident’s medications for each observed medication administration. Additionally, if possible, the surveyors are to observe medications for a sampled resident whose medication regimen is being reviewed. Otherwise, the surveyor is to observe medications for any resident to whom the facility nurse is ready to administer medications.

It is also important to note that the surveyor is supposed to intervene before the facility nurse makes a potential medication error. If the surveyor intervenes to prevent a medication error from occurring, each potential medication error would be counted toward the facility’s medication error rate.

Helpful tips for nurses passing medication in LTC facilities:

- Facility nurses passing medications should use the same routine every time medications are administered. Start the pass at the same time and administer medications to residents or rooms in the same order. This will help keep the medication pass process organized.

- Surveyors will look for omissions, unauthorized medications, wrong doses, etc. The surveyors will also look for failure to confirm placement of a feeding tube, which must occur before any medication or flush is administered. Failure to do this is a medication administration error. Facility nurses must follow manufacturer’s specifications or accepted professional standards for administration. Simple things such as failure to shake well could become a cited error.

- Crushing or combining medications that should not be crushed or combined is also a problem. Have your pharmacy assist you with a list of the drugs that cannot be crushed or combined.
Flushing the feeding tube between medications is also a required standard of practice, but a facility nurse is not required to flush between each medication if the physician order specifies a different schedule because the resident has a fluid restriction.

The physician’s order must state the amount of water to be used for flushing between crushed medications and administration of medications. Many citations are being given for this item.

The facility nurse should wash their hands and always lock the medication cart.

Do not leave the MAR open so that others can read it when they walk by the medication cart. This could be seen as a HIPAA violation.

Do not hesitate or be afraid to seek out answers to questions or seek advice or guidance from the facility’s pharmacist.

If possible, do a peer review of each nurse that performs medication passes for the nurse to get use to someone looking over their shoulder and correcting any issues prior to a survey.

The CMS Critical Element Pathways have a section on Medication Administration Observation that can be used to help guide the facility’s medication nurses (click here). This is the tool the surveyors will use to conduct the medication pass observation.

In addition to the above, the surveyors will select an additional five (5) residents for a full Unnecessary Medication Review. This Unnecessary Medication Review will be based on information entered by the surveyor during interviews, observations, record review and information from the MDS. The selection process considers all psychotropic medications, insulin, anticoagulants, opioids, diuretics and antibiotics, as well as some adverse consequences, including falls, weight loss and sedation. There are exclusions; for example, a resident would be excluded if he/she had a diagnosis of Huntington’s or Schizophrenia and was receiving an antipsychotic. The residents selected for the full medication review will include insulin, an anticoagulant and an antipsychotic with Alzheimer’s or dementia, if available.

**What Nursing Homes Can Learn From a ‘Troubling’ Court Decision on Sexual Consent**

Navigating the nuances of nursing home resident sexual encounters has to be an extremely difficult proposition for administrators, and things just got a little thornier after a recent court ruling.

The case in question relates to the Neighbors Rehabilitation Center in Byron, IL, which had a policy of intervening between residents with dementia, but only when there were “outward signs” of non-consent. Federal officials decided this wasn’t enough to protect Neighbors’ residents, fining the facility more than $83,000. Earlier this month, an appeals court upheld the decision, noting there was “substantial evidence” to back up CMS’ assertion that the policy was misguided and left residents in danger of victimization, McNight’s reported.

One longtime industry expert stated that he was deeply “troubled” by the ruling, and especially the fact that it was labeled as “Immediate Jeopardy,” with there being no outward signs of serious injury, harm or impairment in the incident. He’s worried that it could have a negative influence on how SNF leaders regulate sexual activity going forward.

“This court decision will have a very chilling effect on nursing homes’ efforts to move to a more enlightened and balanced approach to dealing with intimacy,” said Daniel Reingold, CEO of RiverSpring Health, a Bronx-based provider that established one of the nation’s first sexuality and intimacy policies in a long-term care facility in the 1990s.

Neighbors’ policy stipulated that it would intervene only when there were outward signs of non-consent, and the judge deemed that was insufficient. Reingold believes that’s “a very difficult standard in the me-too world that we live in.”

“We rely frequently on reactions of residents to determine whether they want or don’t want something. That is a typical standard by nursing staff,” he told me. For instance, if residents are unable to voice displeasure with a meal and
a CNA is feeding them something they don’t want. Some may get agitated and push the food away. “That’s telling us, ‘I don’t want this,’ and we make those kinds of decisions every day, in multiple ways to determine the preference or lack of a preference on the part of a resident with dementia.”

Reingold hopes this doesn’t lead to administrators creating blanket declarations that any physical interaction between residents with cognitive impairment must immediately be stopped, regardless of what occurs leading up to the incident. What if they’ve been holding hands for days and showing signs of outward affection beforehand?

“To decide unilaterally and across the board, ‘Break ‘em up, they’ve got Alzheimer’s, they’re having sex, that’s a no-go,’ would be a shame,” Reingold said. “We allow people with Alzheimer’s and dementia to make decisions all day long. Do you want the peas or the carrots? Do you want to play bingo or go to the art program? Do you want salt or no salt? And we honor those kinds of things. Just because someone has short-term memory impairment doesn’t mean that they can’t make a decision in the moment. We know that.”

The case involves Neighbors’ handling of three residents who were battling some form of dementia or Alzheimer’s. In one instance, an 80-year-old man suffering from dementia and behavioral disturbances was observed touching the genitals of a 65-year-old man who suffered from Alzheimer’s, dementia and behavioral disturbances. The two lived in separate rooms, connected by a shared bathroom. Coming across the encounter in one man’s bed, a nursing assistant did not see the 65-year-old objecting and did not intervene or investigate further. In another case, that same 65-year-old man was witnessed fondling a 77-year-old female resident suffering from Alzheimer’s, low cognitive functioning and severe impairment. An aide witnessed that incident and separated them because of the woman’s auditory challenges, but did not intervene further.

“I didn’t think it was unreasonable for a nursing staff member to look at it and say that it’s basically consensual,” Reingold said referencing the interaction between the two men. “It’s tricky. It’s a tricky balance to make, but I’m a little disheartened that the court felt this way.”

Reingold — who also holds a law degree and reviewed the court’s decision — believes this could possibly be the highest court ruling related to sexual behavior between residents of nursing homes who have dementia. He said it will “absolutely” be used to establish precedent, and is concerned that it will be used by plaintiffs’ attorneys to file further lawsuits against SNFs.

For nursing homes, Reingold offered three steps leaders can take following this precedent-setting court decision:
1. Make sure that you have very carefully drafted policies and procedures.
2. Be sure that nursing staff are well trained in exactly how to deal with cases where there is sexual interaction between residents, particularly those who have experienced cognitive decline.
3. Document specific interventions in the chart. In this case, it appeared that records didn’t necessarily support the reasonable efforts made by nursing home staff.

For its part, in a statement sent to McKnight’s after our initial story ran, a Neighbors spokeswoman emphasized that the fine was related to an interaction between two consenting adults.

“While the facility accepts the court’s ruling,” the company said in a statement, “we respectfully disagree and continue to advocate that all residents have the right to privacy in their interactions with their peers and loved ones.”

Article reprinted out of McKnight’s.

Focus F-Tag – F567 Protection/Management of Personal Funds

This Regulatory Beat’s Focus F-Tag is F567 Protection/Management of Personal Funds. The core of this F-Tag is that the resident has the right to manage his or her financial affairs. Included in this regulation is the facility’s responsibility for informing the resident of what charges may be imposed against their personal funds.
Personal Funds
A facility cannot require a resident to deposit their personal funds with the facility. If, however, the resident chooses to deposit their personal funds with the facility, upon written authorization of the resident, the facility has a fiduciary responsibility to “hold, safeguard, manage and account for” the deposited personal funds. All personal funds in excess of $100 must be deposited in an interest-bearing account(s) that is not co-mingled with the facility’s operating account. All interest earned on the resident’s funds must be credited to his or her account. If the facility pools the residents’ funds into a single account, they must have a system for separate accounting for each resident’s share.

Medicaid
The regulation also addresses those residents whose care is funded by Medicaid. All personal funds in excess of $50 must be deposited in an interest-bearing account(s) that is not co-mingled with the facility’s operating account. All interest earned on the resident’s funds must be credited to his or her account. If the facility pools the residents’ funds into a single account, they must have a system for separate accounting for each resident’s share. The facility is also responsible for maintaining personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account or petty cash fund for these residents.

Reporting & Requests
Facilities must report quarterly on the status of resident funds to all residents who maintain a personal fund account with the facility. Don’t forget those quarterly statements. Facilities must also ensure that cash requested by a resident ($100 or for Medicaid residents $50) is provided within a reasonable period. The IG notes that requests for less than $100 ($50 for Medicaid residents) should be honored within the same day of the request. The IG also notes that requests for $100 ($50 for Medicaid residents) or more should be honored within three banking days. You are responsible for maintaining amounts of petty cash on hand to meet resident requests for funds. Most facilities have a reasonable idea of the amount of cash to have on hand on a routine basis. A system needs to be in place so that residents can have access to their funds on an ongoing basis as well as arrange for access to larger cash amounts in their account.

Residents should also be able to request that the facility temporarily hold their funds in a safe place without the facility being authorized to manage those funds. There should be a system in place to document the date, time, amount of funds received from and who the funds were released to.

A resident cannot be charged a fee by the facility for management of their personal funds. All fund transactions should include the resident receiving a receipt for the transaction and the facility maintaining a copy for its records.

On survey, residents will be questioned regarding such things as if they get a quarterly statement that indicates any interest earned, if they have a problem accessing their funds (especially outside of routine business hours) or if limited are placed on the amount of money that can be withdrawn from their accounts. Lastly, there is a cross-reference to compliance with F583 – Personal Privacy / Confidentiality of Records. Do some interviews of your own and see what your residents know and understand about the management of their personal funds.

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Trending Statistics

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

**Where Should You Live as a Senior Citizen? A List of the Best and Worst States to Grow Old In.**

More than 50 million Americans today are 65 years of age or older. This figure is expected to **roughly double** over the next four decades. At that rate, older Americans will make up about 25 percent of the U.S. population by 2060, up from 15.6 percent in 2017.
The quality of life for elderly Americans often depends on the facilities, businesses, government spending and living conditions in their home state. As is the case for Americans of any age, senior citizens are more likely to be happy and healthy if they are financially secure and living in a safe area.

Other factors, including access to public transportation, medical treatment facilities, and social venues, often are far more important for elderly Americans than for other age groups.

As these and other social and environmental factors vary by region, so, too, does the quality of life of elderly Americans.

24/7 Wall St. created an index of over a dozen measures related to income, health, environment, education and access to amenities to identify the best (and worst) states in which to grow old.

While the best states for the elderly span the country, the worst states are almost exclusively in the South.

24. Illinois
- Pct. of pop. age 65+: 15.2 percent (12th lowest)
- 65 and older poverty rate: 8.6 percent (24th highest)
- 65 and older bachelor's deg. attainment: 27.1 percent (24th lowest)
- Healthy life expectancy after 65: 13.5 years (16th lowest)

The full report can be found here.

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Important Regulations, Notices & News Items of Interest

1) No new CMS Quality, Safety and Oversight Letters (QSO) - (formerly known as Survey and Certification (S&C) Letters) were released since the last issue of Regulatory Beat.

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

- **CMS: Beyond the Policy — New Podcast.** On February 19, CMS launched CMS: Beyond the Policy, a new podcast highlighting updates and changes to policies and programs in an easily accessible and conversational format. “The new Beyond the Policy podcast demonstrates our commitment to transparency and outreach by presenting CMS-related policies, updates, and innovations on as many platforms as possible,” said CMS Administrator Seema Verma. “This program is a direct response to stakeholders’ suggestions that a podcast would be a modern, user-friendly way to stay informed about CMS.” The first episode focuses on evaluation and management coding. New episodes of the podcast will be released periodically. See the full text of this excerpted CMS Press Release (issued February 19).

- **SNF Provider Preview Reports: Review Your Data by March 4.** Skilled Nursing Facility (SNF) Provider Preview Reports are available. Review your performance data by March 4, prior to public display on Nursing Home Compare in April 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe your data is inaccurate. For more information:
  - SNF Quality Public Reporting webpage
  - Access Instructions

- **SNF PPS Patient Driven Payment Model: Updated Resources.** On October 1, 2019, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). Based on stakeholder feedback, CMS revised resources on the PDPM webpage to help you prepare for implementation, including:
- MDS 3.0 QM User’s Manual Version 12.0 Now Available. The MDS 3.0 QM User’s Manual Version 12.0 has been posted. The MDS 3.0 QM User’s Manual V12.0 contains detailed specifications for the MDS 3.0 quality measures. The MDS 3.0 QM User’s Manual V12.0 can be found in the Downloads section of this page and the MDS 3.0 QM User’s Manual V11.0 has been moved to the Quality Measures Archive page. Two files related to the MDS 3.0 QM User’s Manual have been posted:
  - MDS 3.0 QM User’s Manual V12.0 contains detailed specification for the MDS 3.0 quality measures. MDS 3.0 QM User’s Manual V12.0 is available under the Downloads section of this page.
  - Quality Measure Identification Number by CMS Reporting Module Table V1.7 documents CMS quality measures calculated using MDS 3.0 data and reported in a CMS reporting module. A unique CMS identification number is specified for each QM. The table is available under the Downloads section of this page.

- Hospice Compare Quarterly Refresh Available. The February 2019 quarterly Hospice Compare refresh of quality data is now available. It is based on Hospice Item Set (HIS) quality measure results from data collected Q2 2017 – Q1 2018 and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® results reported Q2 2016 – Q1 2018. We invite you to visit Hospice Compare to view the data. For more information, view the CMS Hospice Quality Public Reporting webpage.

- Promoting Interoperability Program: 2019 Resources. CMS has Medicare Promoting Interoperability Program resources for the 2019 program year:
  - Promoting Interoperability Programs website: Overview and important deadlines
  - 2019 Program Requirements for Medicare webpage: Reporting requirements
  - FY 2019 IPPS and Medicare Promoting Interoperability Program Overview Fact Sheet: Changes finalized in the Inpatient Prospective Payment System (IPPS) final rule

- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model. This MLN Matters Article (click here) is for SNFs billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

- New Medicare Card: 0 not O. The Medicare Beneficiary Identifier (MBI) uses numbers 0-9 and all uppercase letters except for S, L, O, I, B and Z. They exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”). Read MLN Matters® Article New MBI Get It, Use It for other helpful information, such as what to do if an MBI changes.

- Home Health Compare Refresh. The January 2019 Home Health Compare refresh is available, including new quality measure results. Visit Home Health Compare to view the data. For more information, visit the Home Health Quality Reporting Program webpage.

- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier. Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:
  - Centers for Disease Control and Prevention (CDC) – approved National Diabetes Prevention Program curriculum
  - Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:
Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; see the Supplier Fact Sheet and CDC website for more information.

Prepare for Medicare enrollment; see the Enrollment Fact Sheet and Checklist.

Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll).

Furnish MDPP services; see the Session Journey Map.

Submit claims to Medicare; see the Billing and Claims Fact Sheet and Billing and Payment Quick Reference Guide.

For More Information:
- MDPP Expanded Model Booklet
- Materials from Medicare Learning Network call on June 20
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact the MDPP Help Desk at mdpp@cms.hhs.gov

Influenza Activity Continues: Are Your Patients Protected? People over 65 are at a greater risk of serious complications from seasonal influenza. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. It is not too late to get vaccinated— to help protect your patients, your staff and yourself. Medicare Part B covers the influenza virus vaccine once per influenza season. Medicare covers additional influenza vaccines if medically necessary. You may also want to recommend the pneumococcal vaccine during the same visit. Medicare covers:
  - An initial pneumococcal vaccine for Medicare beneficiaries who never received the vaccine under Medicare Part B
  - A different, second pneumococcal vaccine 1 year after the first vaccine was administered

For More Information:
- Preventive Services Educational Tool
- Influenza Resources for Health Care Professionals MLN Matters Article
- Influenza Vaccine Payment Allowances MLN Matters Article
- CDC Influenza website
- CDC Information for Health Professionals webpage
- CDC Tools to Prepare Your Practice for Flu Season webpage
- CDC Make a Strong Flu Vaccine Recommendation webpage

CMS Special Open Door Forum: Medicare Documentation Requirement Lookup Service – Thursday, February 28, 2019, 1 to 2 pm CST. CMS, Center for Program Integrity will host a series of Special Open Door Forum (SODF) calls to educate the public about a new initiative underway to develop a Medicare Fee for Service (FFS) Documentation Requirement Lookup Service prototype. Also, to allow physicians, suppliers, IT and Electronic Health Record (EHR) Developers and Vendors, and/or all other interested parties to provide feedback to CMS and inform how interested parties can get involved or track the progress of this initiative.

Dementia Care & Psychotropic Medication Tracking Tool Call — National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement – Tuesday, March 12, 12:30 to 2 pm CST. Register for Medicare Learning Network events. During this call, gain insight on the Dementia Care & Psychotropic Medication Tracking Tool, a free, publicly available electronic tool that facilitates a structured approach to tracking preference-based care and psychotropic medication use among residents living with dementia. Also, learn about a recently released Nursing Home Staff Competency Assessment toolkit. Additionally, CMS provides updates on the Phase 3 Requirements for Participation from the Reform of Requirements for Long Term Care Facilities final rule and the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question and answer session follows the presentations.
• NF Value-Based Purchasing Program: Phase One Review and Corrections Call — Wednesday, March 20, 12:30 to 2 pm CST. Register for Medicare Learning Network events. During this call, participants learn about the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program Review and Corrections process and get answers to frequently asked questions about Phase One of the process. During the Review and Corrections period, SNFs have an opportunity to review and submit correction requests to quality measure information. Deadline for correction submission is April 1, 2019. For more information: visit the SNF VBP Program webpage. A question and answer session follows the presentation; however attendees may email questions in advance to SNFVBPInquiries@cms.hhs.gov with “SNF VBP Mar 20 NPC” in the subject line. These questions may be addressed during the call or used for other materials following the call.

• New HHAs Placed in a Provisional Period of Enhanced Oversight MLN Matters Article — New. A new MLN Matters Article SE19005 on What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight is available. Learn how new HHAs are affected by the provisional period of enhanced oversight authority.

• Appeals Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the February 5 call on the New Electronic System for Provider Reimbursement Review Board Appeals. Learn how to use the new Office of Hearings Case and Document Management System to submit new appeals, transfer issues, file position papers and manage your appeals.

• LCDs MLN Matters Article — Revised. A revised MLN Matters Article MM10901 on Local Coverage Determinations (LCDs) is available. Learn about updates to the Medicare Program Integrity Manual.

• How to Use the Medicare National Correct Coding Initiative Tools Booklet — Revised. A revised How to Use the Medicare National Correct Coding Initiative (NCCI) Tools Booklet is available. Learn about:
  o Website navigation
  o Medicare code pair edits
  o Medically unlikely edits
  o Coding and billing errors

• How to Use the Medicare Coverage Database Booklet — Revised. A revised How to Use The Medicare Coverage Database Booklet is available. Learn about:
  o Navigating the database
  o Searching indexes
  o Downloading reports

• Advance Care Planning Fact Sheet — Reminder. The Advance Care Planning Fact Sheet is available. Learn about:
  o Provider and patient eligibility information
  o How to code and bill services

• Home Health PDGM MLN Matters Article — New. A new MLN Matters Article MM11081 on Home Health Patient-Driven Groupings Model (PDGM) – Split Implementation is available. Learn about the payment reform requirements.

• ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New. A new MLN Matters Article MM11134 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) is available. Learn about coding changes.

• Medicare Physician Fee Schedule Database: April 2019 Update MLN Matters Article — New. A new MLN Matters Article MM11163 on Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2019 Update is available. Learn about the new HCPCS codes.
• **Advance Beneficiary Notice of Noncoverage Interactive Tutorial — Revised.** A revised [Advance Beneficiary Notice of Noncoverage Interactive Tutorial](https://go.usa.gov/xEEdw) is available. Learn:
  o How to complete the form
  o When to issue a notice
  o Common reasons for Medicare to deny an item or service

• **Long Term Care Hospital Prospective Payment System — Revised.** A revised [Long-Term Care Hospital Prospective Payment System](https://go.usa.gov/xEEdG) Booklet is available. Learn about:
  o Certification elements
  o Patient classification
  o Policy payment adjustments

• **Medicare Advance Written Notices of Noncoverage Booklet — Revised.** A revised [Medicare Advance Written Notices of Noncoverage](https://go.usa.gov/xEEdw) Booklet is available. Learn about:
  o Financial liability
  o How to issue and complete the forms
  o Guidelines for collecting beneficiary payment

• **Medicare Parts A & B Appeals Process Booklet — Revised.** A revised [Medicare Parts A & B Appeals Process](https://go.usa.gov/xEEdG) Booklet is available. Learn about:
  o Tips for filing
  o The five levels of appeals
  o Appointing a representative

3) The federal HHS Office of the Inspector General (OIG) posted the following report: **CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met.** According to Federal law, to be eligible for coverage of post-hospital extended care services, a Medicare beneficiary must be an inpatient in a hospital for not less than 3 consecutive calendar days (3-day rule) before being discharged from the hospital. CMS improperly paid 65 of the 99 skilled nursing facility (SNF) claims we sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled $481,034. On the basis of our sample results, we estimated that CMS improperly paid $84 million for SNF services that did not meet the 3-day rule during 2013 through 2015.

  - Read the Full Summary [https://go.usa.gov/xEEdw](https://go.usa.gov/xEEdw)
  - Read the Report [https://go.usa.gov/xEEdG](https://go.usa.gov/xEEdG)

4) The federal Centers for Disease Control and Prevention (CDC) provides updates on the 2018-2019 Flu Season:

  • [Weekly U.S. Influenza Surveillance Report](https://go.usa.gov/xEEdG)

5) The federal Agency for Healthcare Research and Quality (AHRQ) reports that **Treatments After Hospital Discharge Prevent MRSA Infections.** A new AHRQ-funded study shows that methicillin-resistant *Staphylococcus aureus* (MRSA) infections and hospitalizations after hospital discharge dropped by 30 percent in patients known to carry the bacteria on their bodies by a treatment that cleansed the bacteria from their skin or in their noses. The study in the *New England Journal of Medicine* included more than 2,000 patients with MRSA discharged from Southern California hospitals between 2011 and 2014. One group in the study received educational materials while a second group received the same educational materials plus took steps over six months to remove MRSA from their skin and noses with chlorhexidine antiseptic for bathing, chlorhexidine mouthwash and the nasal antibiotic ointment mupirocin. Participants who followed the treatment completely had a 44 percent reduction in MRSA infections and a 40 percent reduction in all infections. Access the article [abstract](https://go.usa.gov/xEEdG) and the [AHRQ news release](https://go.usa.gov/xEEdG).

6) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of *Regulatory Beat*:
HFS posted a new Provider Notice regarding Reminder Regarding Hospital Use of Modifier 90 for Reference (Outside) Laboratory Services. You may view the notice here.

HFS posted a new Provider Notice regarding HFS 2270, Physician Certification Statement for Non-Emergency Transportation. You may view the notice here.

HFS posted a new Provider Notice regarding An Overview of the Preadmission and Conversion Screenings Process for Potential Supportive Living Program Participants. You may view the new notice here.

7) The Illinois Department of Public Health (IDPH) reports:

- ePOC FAQ #3. The third ePOC Frequently Asked Question document can be seen here.

- Post-Survey Distribution For Flood Mapping Tool: The Building Resilience Against Climate Effects (BRACE-Illinois) team at the UIC School of Public Health developed maps to identify healthcare facilities in or near floodplains. A pre-survey was previously sent out and subsequently the actual mapping tool with an instructional video on how to navigate the map. For those who participated in the baseline survey, thank you. In order to obtain a follow-up understanding of what tools and resources emergency preparedness professionals currently use for planning for flood disasters, please complete the survey here.

Participation in the online survey will take about 5 minutes to complete, is voluntary and answers will be confidential. As of September 4, 2018, the University of Illinois at Chicago’s Office for the Protection of Research Subjects granted the “Flood preparedness among Illinois healthcare facilities” research project exempt from the federal regulations for the protection of human subjects. However, our project will adhere to the ethical conduct of research and protection of participants’ information.

Building Resilience Against Climate Effects (BRACE-Illinois) is a CDC-funded project at the University of Illinois at Chicago (UIC). A goal of BRACE is to improve preparedness for the health effects of climate change and extreme weather events. More information about BRACE-Illinois can be found here: https://braceillinois.uic.edu/. BRACE-Illinois works directly with and on behalf of the Illinois Department of Public Health (IDPH).

If you have any questions, please feel free to reach out to Elena Grossman at egross5@uic.edu or 312-996-2085.

- The February 27, 2019 LTC Advisory Board was cancelled due to a quorum issue.

8) The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) report on:

- 2019 National Skilled Nursing Care Week (NSNCW) Planning Guide and Product Catalog is Now Available. The 2019 National Skilled Nursing Care Week (NSNCW) Planning Guide and Product Catalog is now available online here. Start planning now! Browse through the guide to get ideas about NSNCW events and activities and check out the great selection of Live Soulfully themed products available this year. Promotional graphics and the new guide are available now for download at ahcancal.org/NSNCW. Additional tools including a proclamation and template press release will be available in early April. Use social media to share your great ideas for NSNCW and to see what other centers are planning for this special week. Use the hashtag #NSNCW and like us on the NSNCW Facebook page here.

- AHCA shares some responses to commonly asked PBJ questions that they received:
  - If a nurse is working 8 hours and the center reports 7.5 hours (due to the 30-minute meal time exclusion) will the provider be penalized for not having an RN on staff for 8 hours?
    - CMS auditors are aware of this situation and as long as the facility can provide proof that the RN was onsite for 8 consecutive hours, reporting time for 7.5 is not going to be an issue.
Do meal times need to be excluded even if the staff eats with the residents or works through lunch?

- Per the PBJ Policy Manual, facilities must deduct the time allotted for meals from each employee's daily hours. A 30-minute meal break must be deducted from an employee's shift whether or not the employee actually takes a meal break. We realize that this policy is frustrating for members and AHCA continues to advocate for changes to be made to it. However, until such time that a policy change is made providers must exclude meal times to avoid being penalized.

- Providers may consider having two separate timekeeping systems to comply with both CMS’s PBJ requirements and the Department of Labor's (DOL) Fair Labor Standard Act. Manually editing the data to reflect the needs for both PBJ reporting and payroll runs the risk of human error and documentation challenges during an audit by either CMS or DOL. If separate timekeeping systems is not possible, as a best practice, providers should have a system that preserves the original record before any edits are made.

Which residents do we need to report hours for?

- Hours should be reported for SNF/NF residents, essentially, those that have an MDS assessment submitted for them.

9) Provider Magazine reports Proposed Rule Indicates CMS Getting Serious About Data Interoperability. Provider Magazine reports on the recently released proposed rule from CMS aiming "to support its MyHealthEData initiative to improve patient access and promote electronic data exchange and care coordination." The Interoperability and Patient Access Proposed Rule was issued alongside "two Requests for Information to get feedback on interoperability and health information technology (health IT) adoption in post-acute care settings, and the role of patient matching in interoperability and improved patient care." Health IT expert Steven Chies said, "The CMS administrator [Seema Verma] has continued her pursuit of expanding access to health information by directing the Office of the National Coordinator [ONC] to propose a series of new requirements on providers, payers, and state Medicaid agencies intended to enhance interoperability and access to health care information by the patient."

10) WKRC Cincinnati reported, Study: To Reduce Memory, Thinking Problems, Eat Plenty of Fruits and Vegetables. This study in the journal Neurology says if you want to boost your brain, stock up on fruits and vegetables. The study found those who ate about five-and-a-half servings of fruits and vegetables a day were 34 percent less likely to report memory and thinking problems compared to those who ate just one-and-a-half. This appears to be especially true for men.

11) The Washington Post reports on a New Approach to Dementia Care Focuses on Openness, Positivity. The Washington Post reports that "a growing camp of people" is "determined to approach dementia care differently, coming at it with a sense of openness, playfulness and even wonder." This new approach involves a lot of flexibility and willingness to expand one’s ideas of how things are supposed to be – even, crazy though it might sound, to see Alzheimer’s as a kind of gift." This positive approach to Alzheimer’s is intended to help both patients and caretakers, and the article discusses some organizations and people who are putting it into practice.

12) McKnight’s reports:

- CMS Changes PDPM Website, Says New RAI Manual to be Delivered Early. After receiving a barrage of feedback, CMS is updating its new website for the Patient-Driven Payment Model, and touting a quick release for a much-anticipated regulatory/training manual.

- EPA Rule Change Draws Concern from AHCA. McKnight’s Long Term Care News reported on the EPA’s law change prohibiting "long-term care facilities from disposing down the toilet or drain pharmaceuticals considered to be hazardous waste." AHCA associate VP of Quality and Clinical Affairs Holly Harmon said, "We are concerned with the short timeframe of six months when the final rule becomes effective due to the operational changes that nursing centers face to comply with these new regulations."
Data Expert Discusses How Expectations of PDPM Differ From Reality. McKnight’s Long Term Care News reported that during the final day of the National Investment Center for Seniors Housing & Care’s spring meeting in San Diego, California, "data expert" Steven Littlehale discussed the challenges of Patient-Driven Payment Model implementation. He observed that while the model is "the biggest overhaul of nursing home reimbursement in at least a generation...it is only a temporary fix," according to the article. He told the audience that PDPM "is indeed a stepping stone to something else" and that it "will morph into" a unified post-acute care payment system (U-PAC) as outlined in the IMPACT ACT.

13) **Interesting Fact:** Pet ownership is higher than it has ever been, with almost 60 percent of American households having at least one.