CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Midwest Division Provider Update

VOLUME 2 ISSUE6 JULY 2017

When is a Facility Required to Provide Notice to the Ombudsman of a Transfer or Discharge?

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At least 30 days before a facility transfers or discharges a resident, or as soon as practicable when appropriate, the facility must notify the resident and resident representative(s) of the transfer or discharge and the reasons for the move, in writing and in a language and manner they understand. The facility is also required to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman so that residents are afforded an added protection against inappropriate discharges. 42 CFR § 483.15(c).

On May 12, 2017, CMS published S&C Memo 17-27-NH to provide additional guidance on when and how it is necessary to provide notice to the Ombudsman. The memo states that a facility must provide notice to the resident, resident representative, and the Ombudsman, for all "facility-initiated" transfers and discharges, including emergency transfers to the hospital. Facility-initiated transfers and discharges include all moves in which the resident's medical record does not clearly document the resident's or resident representative's verbal or written notice of intent to leave the facility. While notice to the Ombudsman is required for all facility-initiated transfers and discharges, the time frame in which the facility is required provide notice can vary depending on the circumstances.

If a facility ***transfers*** a resident to a hospital on an emergency basis ***with the intent to re-admit the resident after treatment***, the facility must provide the resident and resident representative with a notice of transfer that contains all of the elements listed under 42 CFR § 483.15(c)(5). If the transfer is truly an emergency, the facility may provide notice of the transfer to the resident and resident's representative as soon as practicable. For this transfer, and other similarly situated transfers, the facility can group notices and send them to the Ombudsman on a monthly basis.

On the other hand, a facility may transfer a resident to a hospital with the intent to re-admit the resident, but subsequently decide to refuse to readmit the resident. When the facility makes the determination not to readmit the resident, what was originally intended as a facility-initiated ***transfer*** becomes a facility initiated ***discharge***. At this time, the facility is required to comply with all of the regulations at 42 CFR § 483.15, including providing an appropriate notice at least 30 days before discharge or as soon as practicable when appropriate. In this scenario, while the notice of the original ***transfer*** may be grouped with others and provided to the Ombudsman on a monthly basis, the facility must notify the Ombudsman of the ***discharge*** at the same time notice is required to

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S&C 17-29-ALL dated June 2, 2017 continues the focus on the new Emergency Preparedness requirements with the rollout of the SOM Appendix Z. Everyone is reminded that compliance should already be underway but survey to the new requirements does not begin until November 15th. You can begin to peruse the appendix and the draft E-tags at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf

There is a revision to the June 2, 2017, S&C, that addresses Legionella risk in healthcare facilities. The June 6th **S&C 17-30-Hospitals/CAHs/NHs** was expanded to include potentially impacted facilities and is now directed to Hospitals, CAHs, and Nursing Homes. Consider reviewing the memo to gain insight regarding the recent outbreaks and the aerosolization risks such as water reservoirs that feed shower areas or cooling systems. Facilities should include surveillance and risk mitigation strategies as part of their normal operating procedures to ensure health and safety of beneficiaries, staff and visitors. The revised memo is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-30.pdf

S&C 17-31-ESRD, with a revision date of June 6, 2017 informs of a new effective date of July 2nd, and advises of CMS expectations regarding infection control practices, including the use of multi-dose vials and flush syringes. Preparation of saline syringes for injection should not occur in the dialysis treatment areas, nor should staff prepare flush syringes from saline bags in the treatment areas. CDC's guidance regarding parenteral medication preparation advises that these activities should be conducted in clean areas, away from treatment areas and with aseptic techniques. The revised memo can be retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-31.pdf

ESRD providers are not required to incorporate routine screening for HCV into their processes. ALT results are sufficient to identify the presence of the HCV antibody. **S&C 17-33-ESRD**, dated June 16, 2017 advises ESRD surveyors not to cite providers solely for a failure to routinely screen for HCV. The memo is retrievable at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-33.pdf

Relaxed formatting for submission of Plans of Correction is discussed in **S&C 17-34-ALL**. The June 16, 2017 memo advises that providers may submit plans and attachments as a separate document, rather than on the right side of the CMS 2567. The memo is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-34.pdf

Reasonable Assurance periods will also apply to providers that seek re-admission to the Medicare program following voluntary termination in lieu of involuntary termination. The Reasonable Assurance period is designed to assure that the provider is in sustainable compliance with CoPs/CfCs, the conditions that led to the adverse actions are no longer present, and the agency is "reasonably assured" that recurrence is unlikely. **S&C 17-35-ALL** dated June 16, 2017 is available for review at

CMS UPDATES

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-17-35.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

S&C 17-36-NH, dated June 30, 2017, provides the SOM Appendix P, Phase 2 rollout for the new Long Term Care requirements. Also available are the F-Tag revisions and crosswalks to provide readers a path to follow from the old to the new. Clear some time on your calendar so you can digest the new information, and become familiar with the new locations for the regulations. You may recall that phase 2 also includes a new survey process. Training on the new process will continue through October for providers, state and federal staff as well as the public. All of this—and more, is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf

Federal Register

A June 8, 2017 Federal Register publication announces a delay in the implementation of the New HHA COP. The rollout is delayed until January 13, 2018 to allow providers more time to meet the new requirements. For more information, goto

https://www.federalregister.gov/documents/2017/07/10/2017-14347/medicare-and-medicaid-programs-conditions-of-participation-for-home-health-agencies-delay-of

On June 5th, CMS Media Relations office announced a proposed update to the October 2016 rule regarding Long Term Care binding arbitration agreements, in advance of an actual disagreement. The Federal Register posting can be reviewed at

https://www.federalregister.gov/documents/2017/06/08/2017-11883/medicare-and-medicaid-programs-revision-of-requirements-for-long-term-care-facilities-arbitration

CMS proposes to remove the prohibition of the advance agreement, but includes full disclosure requirements to ensure residents or their representatives are fully informed, in a manner of their understanding, of an arbitration agreement. Providers cannot discourage communication with state or federal representatives and must prominently post a notice regarding the binding arbitration policy, if used.

In an ongoing effort to improve efficiencies and reduce paper clutter, the MWD will be submitting notices electronically. Please ensure Regions V and/or VII has your current fax number for secure transmission of your notices.

These notices are to be considered your

official CMS correspondence.

Transfer/Discharge Notification Cont'd

be given to the resident and resident representative under the regulation.

A third scenario to consider is one in which a resident has an advanced directive to receive emergency treatment, and a facility transfers the resident to a hospital in accordance with the directive. In this scenario, the existence of the advance directive does not qualify the transfer as a "resident-initiated transfer" as described in S&C memo 17-27-NH. The facility is still required to follow the notification requirements and must also provide a copy to the Ombudsman. However, if the facility intends to take the resident back, then the notice can be grouped with others and sent to the Ombudsman on a monthly basis.

It is also important to note that while the regulations require that discharge notices for residents with intellectual disabilities, developmental disabilities, mental illness, and other related disabilities include the name, mailing address, email address, and phone number of the State Protection and Advocacy Agency, it is not necessary to provide the State Protection and Advocacy Agency with copies of transfer and discharge notices.

More detailed information on the regulations can be found in the revised Interpretive Guidance that was released with S&C Memo 17-36-NH on June 30, 2017. The revised Interpretive Guidance will be effective November 28, 2017. B. Karpiak, RO V

Fire Alarm Inspection, Testing and Maintenance (ITM)

All devices connected to your fire alarm system need to have evidence that each individual device was tested. That means you also need an accurate inventory of every device, complete with a description as to where it is located. The test report needs to list each and every individual device (individually itemized), a description of where it is located, and whether it passed or failed its test.

Get those fire alarm interface relays included in the fire alarm testing process and document each one individually, with a "Pass" or a "Fail" notation. Here is a list of the most common interface relays used in healthcare fire alarm systems:

- Magnetic hold-open devices
- Air handler shutdown
- Kitchen hood suppression system
- Elevator recall
- Magnetic locks
- Fire pump
- Smoke dampers
- Clean agent suppression systems
- Sprinkler dry pipe/pre-action systems

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Fired Up Cont'd

Overhead rolling fire doors
If the company that completes the fire alarm ITM is different than the range hood and sprinkler company vendors, then provide a copy of that report to the fire alarm company and they can write in the comments section that these devices were tested by 'vendor' on 'date', and pass/fail.

Don't forget to keep a disposition of the devices that failed or had a comment regarding how the system is not to code with your semi-annual inspection and testing. That way we know corrections were made and you don't have to search for paperwork during a survey.

A note about dampers: Electric fire and smoke dampers must be tested annually with the fire alarm system. Fusible link dampers are required to be exercised and lubricated once every four years in LTC/once every six years in hospitals. Electric fire/smoke dampers are required to be tested annually with the fire alarm.

References: NFPA 72 National Fire Alarm and Signaling Code Katharine Achor, RO VII

FDA Recalls: Did You Know...?

A voluntary recall of Advanced Pharma (Avella of Houston) Nitroglycerine in 5% Dextrose was announced for products processed March 3-May 31st. The medication was found to not reach potency levels. For more detail, go to https://www.fda.gov/Safety/Recalls/ucm563380.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery

Also recalled by Avella of Houston are certain lots of Potassium Phosphate and Succinlycoline due to sterility concerns. Information related to that recall can be found at https://www.fda.gov/Safety/Recalls/ucm564300.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery

A Hospira recall also included Sodium Bicarbonate injection, Succinlycholine and Potassium Chloride by for sterility concerns. For more information goto https://www.fda.gov/Safety/Recalls/ucm563383.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery

Lastly, the Hospira sterility concerns has prompted a voluntary recall by PharmMEDium Services, also of certain lots of Potassium Phosphate and Succinlycholine Chloride for sterility concerns. https://www.fda.gov/Safety/Recalls/ucm564845.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery