CMS Issues New Guidance for F-tag 309 on End of Life Care

Over a month ago, the Centers for Medicare and Medicaid Services (CMS) issued new OBRA guidance to surveyors (and consequently providers) for F-155 on Advance Directives and F-309 on End of Life Care. Last week’s newsletter covered the changes to the interpretive guidance for F-155 on Advance Directives. This week, we cover the changes for the interpretive guidelines for F-309 regarding End of Life Care. The new survey standards will be effective November 30, 2012.

The Illinois Council on Long Term Care is scheduling training, co-sponsored with the Illinois Department of Public Health, on the new guidance for Advance Directives in F-tag 155 and End of Life Care in F-tag 309 Quality of Care:

- Wednesday afternoon, February 27, 2013 at the Oak Lawn Hilton
- Thursday morning, February 28, 2013 at the Skokie Holiday Inn

The brochure and registration form will be out shortly.

In addition, the Illinois Health Care Association will be doing a Nursing Academy Web seminar on this same topic on:

- Tuesday morning, November 27, 2012 from 10:00 – 11:30 a.m.

For the seminar brochure and registration, click here. To register online, click here.

As has been the trend for the past six years, any new certification guidance to surveyors is vastly more detailed in order to encourage a consistent standard of practice among both surveyors and providers. The new guidance on F-309 regarding End of Life Care covers the following:

- **A Best-Practices Overview**, including, in the case of F-309, assessment of the resident approaching end of life; management of care at end of life; care planning for the resident approaching end of life; monitoring the resident who is approaching end of life; election of a hospice benefit; and a coordinated plan of care.
- **Investigative Protocols** for surveyors, including what to observe, whom to interview, and what to look for in the record review.
- **Criteria for Compliance**, for F-309, include six areas:
  1. **Assessed the resident’s clinical condition, risk factors, and preferences** and identified the resident’s prognosis and its basis;
  2. **Initiated discussions regarding advance care planning and resident choices** to clarify resident’s goals and preferences regarding treatment at the end of life;
  3. **Recognized and advised the resident and/or the resident’s legal representative that the resident was approaching end of life** and, if the resident was not already...
receiving palliative care, advised that care could potentially be shifted to a palliative focus;

4. **Defined and implemented resident-directed care, treatment and interventions, services, and support**; consistent with the resident’s choices, rights, goals, comprehensive assessment, care plan and the recognized standards of practice. Compliance with this criteria is done in the attempt to manage pain and other physical and psychosocial symptoms and meet the resident’s physical, mental, psychosocial and spiritual needs;

5. **Communicated the resident’s goals and preferences to the facility’s interdisciplinary team**, as well as the hospice, emergency department, hospital or home health team in the event of a transfer; and

6. **Monitored and evaluated the impact of the interventions provided** to address the resident’s end of life condition and revised the approaches as appropriate.

- Guidance to surveyors on the criteria for **level of deficiency, with examples**, if problems are found (see the rest of this newsletter).

The clinical and documentation requirements for nurses under F-309 are covered in detail in this week’s **nursing newsletter Clinical Capsule**. Correspondingly (for management and administrators), this newsletter will identify **enforcement consequences – and examples** – provided by CMS to guide surveyors in considering the level of severity. The prudent facility will incorporate these examples into its quality assurance reviews prior to November 30, 2012.

**Severity Level 4 Considerations: Immediate Jeopardy to resident health or safety for a resident at or approaching end of life.**

Immediate Jeopardy is a situation in which the facility’s noncompliance with one or more requirements of participation:

- Has allowed, caused, or resulted in (or is likely to allow, cause, or result in) serious injury, harm, impairment, or death to a resident; and

- Requires immediate correction as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.

**NOTE:** The death or transfer of a resident, who was harmed as a result of facility practices, does not remove a finding of immediate jeopardy. The facility is required to implement specific actions to correct the deficient practices, which allowed or caused the immediate jeopardy.

Examples of avoidable actual or potential resident outcomes that demonstrate severity at Level 4 may include, but are not limited to:

- The facility failed to recognize that the resident was approaching the end of life and continued to implement aggressive medical interventions against the resident’s wishes. As a result, the resident experienced severe physical discomfort and/or psychosocial distress; or

- The resident approaching the end of life experienced prolonged nausea; recurrent vomiting, or daily, prolonged, or repeated moderate to severe pain as a result of the facility’s repeated failure to implement interventions in accordance with the doctor’s orders and care plan.

**NOTE:** If Severity Level 4 (immediate jeopardy) has been ruled out based upon the evidence, then evaluate whether actual harm that is not immediate jeopardy exists at Severity Level 3 or the potential for more than minimal harm at Severity Level 2.

**Severity Level 3 Considerations: Actual Harm that is Not Immediate Jeopardy**
Severity Level 3 indicates noncompliance that resulted in actual harm that is not immediate jeopardy. The negative outcome, can include, but may not be limited to, clinical compromise, decline, or the resident’s inability to maintain and/or reach his/her highest practicable well-being.

Examples of avoidable, actual resident outcomes that demonstrate severity at Level 3 may include, but are not limited to:

- Despite the documented choice to accept partial pain control in order to become more alert, the resident was repeatedly so lethargic or somnolent because of medication used to treat symptoms related to the end of life that he/she was unable to relate to visitors.

NOTE: If Severity Level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate whether Severity Level 2 (no actual harm with the potential for more than minimal harm) exists.

Severity Level 2 Considerations: **No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy**

Severity Level 2 indicates noncompliance that resulted in a resident outcome of no more than minimal discomfort and/or had the potential to compromise the resident’s ability to maintain or reach his or her highest practicable level of well-being. The potential exists for greater harm to occur if interventions are not provided.

An example of avoidable outcomes at Severity Level 2 include, but are not limited to:

- A resident received end of life care from a hospice and there was no evidence in the resident’s record of care coordination between the facility and the hospice, but the resident did not experience adverse consequences.

Severity Level 1: **No Actual Harm with Potential for Minimal Harm**

The facility fails to provide appropriate care and services to a resident who is approaching the end of life is more than minimal harm. Therefore, **Severity Level 1 does not apply for this regulatory requirement.**

The complete guidance can be viewed [here](#).

**Medicaid Payment Update**

The associations received the following confirmation on payment schedules from the Department of Healthcare and Family Services as of November 21, 2012.

- **Nursing Facilities (NFs):** 5/12 services paid into group 2. 5/12 to 8/12 services vouchered. 9/12 services vouchered into group 8.
- **Expedited Nursing Facilities (ENFs):** 9/12 services paid into group 5. Groups 6-10 vouchered.
- **Institutions for Mental Disease (IMDs):** 5/12 services paid into group 2. 5/12 – 8/12 services vouchered. 9/12 services vouchered into group 8.
- **Expedited Institutions for Mental Disease (EIMDs):** 9/12 services paid into group 5. Groups 6-10 vouchered.
- **Facilities for the Developmentally Disabled (DDs):** 2/12 services paid into group 4. 2/12 – 9/12 services vouchered. 10/12 services vouchered into group 1.
• **Supportive Living Facilities (SLFs):** 5/12 services paid. 6/12 – 9/12 services vouchered.
• **Expedited Supportive Living Facilities (ESLFs):** 9/12 services paid.

In response to questions regarding the status of Comptroller payments:

As of October 3, IOC has paid all HFS medical schedules that were set up as FY12 appropriations. Due to cash flow constraints at IOC and their intent to pay remaining FY12 appropriation claims for other agencies by 12/31/12, it is still not known when May and June Non-Exp LTC services will be paid. It is highly likely they will not be paid in November, but the months of December and January are strong revenue months so it is a possibility, not a guarantee, that the remaining non-expedited FY12 services will be paid during that time.

**Question of the Week**

Q: Are we required to delegate a percentage of staff per shift? Also, are we required to have an RN present for each shift?

A: No, there is no provision for percentages of your required staff totals to be delegated by shift in the staffing regulations, nor is there a requirement that an RN be present for each shift.