LONG-TERM CARE SURVEY READINESS

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About the author:

Cheri Benander brings over 30 years of experience in various healthcare settings including hospitals, home health, hospice, assisted living, and long-term care. Benander has served in a variety of leadership roles including Vice President of Resident Care Services, Nursing Home Administrator, Interim Chief Nursing Officer, Director of Home Health and Hospice, Privacy Officer, and Compliance Officer. Benander received her basic nursing education from Fort Scott Community College and a Bachelor’s Degree and Master’s Degree in Nursing from the University of Phoenix. Benander is a Certified Healthcare Compliance professional through the HealthCare Compliance Association and received a certification in Nursing and Healthcare Education from the University of Phoenix. She is licensed as a Registered Nurse in Wyoming, Kansas and Missouri and a licensed Nursing Home Administrator in Wyoming. Benander is also a member of the Healthcare Compliance Association (HCCA) and the American Association of Nurse Assessment Coordination (AANAC).

About HealthTechS3:

HealthTechS3 is an award-winning healthcare consulting, executive recruiting, interim executive placement and hospital management firm based in Brentwood, Tennessee with clients across the United States.
Enacted in 1935, The Social Security Act provided a system of “old-age benefits” to those who were 65 or older. The Act made federal money available to the states so that they could assist the elderly but prohibited payments to public institutions.¹ This fueled the development and growth of the private nursing home industry and in 1950, amendments to the act provided for payments to be made directly to nursing homes as opposed to the beneficiaries. In order to receive these payments, the states were required to license the nursing homes. Nursing home utilization increased without a focus on the quality of care provided. Both the Commission on Chronic Illness and the Council of State Governments began reporting concerns over poor quality of care and the use of untrained staff.²

Previous amendments had not provided for minimum licensing standards or procedures and had not put any type of enforcement monitoring system in place.³ Concerns over the quality of care and safety conditions in nursing homes led the chronic disease program from Public Health Service to begin working to develop federal guidelines.⁴ In 1963, the guidelines were published in a document called the Nursing Home Standards Guide.

During this same timeframe, Senator Frank Moss began to hold hearings regarding the variations in state standards and their enforcement. The final report from these hearings described the reasons for these variations:

1. Enforcement meant the closure of facilities, already in short supply, with no place to put the dispossessed patients.

2. States have few weapons other than the threat of licensure revocation to bring a home into compliance.

3. The license revocation itself was of very little use because of protracted administrative or legal procedures required.

³ Idem.
⁴ Ibid. Ref # 2
4. Even if the revocation procedure was implemented, judges were reluctant to close a facility when the operator claimed that the deficiencies were being corrected.

5. Nursing home inspections were geared to surveying the physical plan rather than assessing the quality of care.  

The “Moss Amendments” were passed in 1968 standardizing regulations for Medicare and Medicaid providers and setting in motion the development of comprehensive nursing home regulations. Amid pressure following two incidents in which poor standards led to the deaths of 32 residents in Ohio and 36 in Maryland, pressure began to mount over the number of nursing homes in violation of standards. President Nixon made a speech in 1971 condemning the conditions in nursing homes and vowed that substandard facilities would no longer receive federal payments. He followed up with a second speech a couple of months later outlining an eight-point plan to improve nursing home regulations. However, it would not be until 1987 that President Ronald Reagan would sign into law the first major revision of the federal standards in the Omnibus Budget Reconciliation Act (OBRA) of 1987.

OBRA requires nursing homes to provide services enabling each resident “to attain and maintain the highest practicable physical, mental, and psychosocial well-being”. The Act established a set of minimum standards of care to be delivered through an established set of protocols. These standards were considered the “minimum” requirements with which a facility should build upon in order to allow each resident to be happy, feel fulfilled, and ensure their well-being. According to Turnham (n.d.), some of the most important resident provision in OBRA includes:

- Emphasis on a resident’s quality of life as well as the quality of care;

- New expectations that each resident’s ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons;

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5 Ibid. Ref # 2 Appendix A para 10
6 Ibid. Ref # 1
7 Ibid. Ref # 2
8 Ibid. Ref # 2
10 Idem.
11 Ibid. Ref # 9
• A resident assessment process leading to development of an individualized care plan 75 hours of training and testing of paraprofessional staff;

• Rights to remain in the nursing home absent non-payment, dangerous resident behaviors, or significant changes in a resident’s medical conditions;

• New opportunities for potential and current residents with mental retardation or mental illnesses for services inside and outside a nursing home;

• A right to safely maintain or bank personal funds with the nursing home; Rights to return to the nursing home after a hospital stay or an overnight visit with family and friends. The right to choose a personal physician and to access medical records;

• The right to organize and participate in a resident or family council;

• The right to be free of unnecessary and inappropriate physical and chemical restraints;

• Uniform certification standards for Medicare and Medicaid homes;

• Prohibitions on turning to family members to pay for Medicare and Medicaid services; and

• New remedies to be applied to certified nursing homes that fail to meet minimum federal standards. 12

These provisions were included in the final regulations posted in the Federal Register on February 2, 1989 (54 FR 5316). The rules were comprehensively reviewed and revised due to additional legislation and comments received by the public in 1991 (56 FR 48826).

**CURRENT REGULATIONS**

Over the past 25 years, substantial changes have been seen in the both the theory and services delivery of care in long-term care facilities. Although there have been revisions to the long-term

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12 Ibid. Ref # 9 pg. 2
care standards along the way, there had not been a comprehensive review performed of the rules since 1991.

The Centers for Medicare and Medicaid Services, (formally known as HCFA) announced in 2015 that major changes were being made to the LTC standards in order to improve the quality of care and safety for residents. These improvements would be accomplished by reducing unnecessary hospital readmissions and infections, increase the quality of care, and strengthen safety. CMS indicated that they believed “...these changes are needed to ensure that LTC residents receive care that maintains or enhances quality of life and attains or maintains the resident’s highest practicable physical, mental, and psychosocial wellbeing.” The final rule implementing the changes proposed by CMS was subsequently published in the federal register (81 FR 68688) on October 4, 2016.

The central themes of the changes centered around six areas; person-centered care, quality, facility assessment, competency-based approach, alignment with Health and Human Service priorities, comprehensive review and modernization and the implementation of legislation. These changes implemented across 24 sections of the rules, including four new sections. Those new sections are Comprehensive Person-Centered Care Planning; Laboratory, Radiology, and other Diagnostic Services; Compliance and Ethics Program; and Training Requirements.

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14 Idem.
**Survey Readiness**

An important element in consistently providing quality care and performing well during licensure and certification surveys is to be prepared. This can be done maintaining a constant state of survey readiness through documentation preparation and mock surveys.

Develop a binder that will contain information and documentation that surveyors typically ask for when they arrive. Include the following in your survey binder information from CMS-20045:

- Facility Census
- Alphabetical Resident Census List (including room or unit numbers)
- Lists of New Admissions in the Last 30 Days (Admission Date, Date of Birth, Room Number)
- Facility Floor Plan
- Staffing Schedules (licensed and registered nursing staff)
- List of Key Personnel and their location
- Name of Resident Council President
- Schedule of Meal Times and Location of the Dining Room
- Schedule of Medication Administration Times
- Paid Feeding Assistants and evidence of their training
- A list of residents who smoke, designated smoking times, and smoking locations
- Influenza/Pneumococcal Immunization Policy and Procedures
- List of Rooms with less than the required square footage, more than four residents, below ground level, do not contain a window, or have no direct access to an exit corridor
- Quality Assessment and Improvement Performance (QAPI) Committee Information
• Abuse Policies and Procedures

• Complaints and Grievance Information

• List of Medicare Beneficiaries who requested a demand bill in the past six months

• Facility Emergency Water Source

Consider performing a mock survey, either internally or externally a few months before your annual survey is due. External surveyors provide an impartial review but, if this is not an option, ensure that you develop a process where the individual can remain objective. Mock Surveys will allow you time to identify potential risk areas, give your staff more experience and prepare them to do well when the actual surveyors arrive.

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