Survey process puts bull’s-eye on MDS
Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE

At AANAC’s 2014 annual convention, officials from the Centers for Medicare & Medicaid Services (CMS) announced by phone that they are currently developing a new MDS Focused Survey process. In the course of a general overview that offered few details, they informed attendees that they are beginning a demonstration project in multiple states to test the new survey process. As a director of nursing, nurse assessment coordinator, or other professional in long-term care, you know the importance of the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) processes for achieving quality care outcomes, Quality Measures accuracy, payment integrity, and minimal survey deficiencies.

As we in the provider community learn more about this new survey process over the coming months, we should continue to evaluate our current RAI/MDS processes to ensure that our facility staff are doing all they can to have strong systems, accurate coding, and quality assurance and performance improvement (QAPI) where needed. To that effect, let’s take a look at the current survey landscape in relation to MDS-referenced citations.

According to CMS’ Survey & Certification Compliance Division’s Full Statement of Deficiencies for March 2014 (CMS, 2014), from September 1 through December 31, 2013, there were over 28,000 deficiencies issued to facilities in the United States. That is 229 citations a day. The MDS was referenced in nearly 9,500 of the citations, or over 33%. No wonder CMS is attempting to be more intentional and methodical about MDS system integrity and accuracy.

Keep OBRA assessments on track with these tips
Caralyn Davis, BA, Staff Writer

Over the past few years, the PPS assessment schedule has taken center stage thanks to the explosion of off-cycle PPS assessments, such as the change-of-therapy Other Medicare Required Assessment (COT OMRA) and the end-of-therapy OMRA (EOT OMRA). “The OBRA assessments sometimes take a back seat just because providers are so worried about COTs and EOTs that they get sidetracked,” says Jane Belt, RN, MS, RAC-MT, principal of the Clinical Group at Plante Moran PLLC in Columbus, Ohio. “Obviously PPS assessments are very important, but so are the OBRA assessments.”

AANAC master teachers offer the following suggestions for keeping OBRA assessments on track:

Don’t forget to apply basic rules.
The assessment reference date (ARD) of a quarterly MDS must be no more than 92 calendar days after the ARD of the previous OBRA assessment, according to Chapter 2 of the RAI User’s Manual for the MDS 3.0. “So if no other OBRA assessments have been completed in the interim, that means there should be no more than 92 days ARD to ARD from the previous quarterly to the current quarterly,” says Belt. “Sometimes new MDS coordinators forget to apply this rule when a long-term patient has been picked up on Medicare Part A and also now follows a PPS assessment schedule.”

The timing rules for annuals are slightly more complicated: The ARD for an annual MDS must be no more than 366 days following the ARD of the previous OBRA assessment, according to Chapter 2 of the RAI User’s Manual for the MDS 3.0. “So if no other OBRA assessments have been completed in the interim, that means there should be no more than 92 days ARD to ARD from the previous quarterly to the current quarterly,” says Belt. “Sometimes new MDS coordinators forget to apply this rule when a long-term patient has been picked up on Medicare Part A and also now follows a PPS assessment schedule.”

The timing rules for annuals are slightly more complicated: The ARD for an annual MDS must be no later than 366 days following the ARD of the previous OBRA comprehensive assessment (often the previous annual) and no later than 92 days following the ARD of the previous OBRA quarterly or significant correction to the prior OBRA quarterly. “In some case-mix states, providers are doing early quarterlies or extra quarterlies in order to obtain appropriate payment for their residents,” says Belt. “That’s fine, but a common side effect is that they are so focused on quarterlies, they either miss the annual completely or exceed the 366-day time frame.”
These deficiencies for inaccurate MDS assessments included errors such as not placing a functional range of motion, restraint, fall, or other item on the MDS when warranted. immediate jeopardy) and 21% were cited at a level E (pattern with no actual harm, with potential for more than minimal harm that is not immediate jeopardy). These deficiencies for inaccurate MDS assessments included errors such as not placing a functional range of motion, restraint, fall, or other item on the MDS when warranted.

Take, for example, how the MDS was used in a citation at a facility in Tennessee. The surveyor reported that in his review of the MDS for the Brief Interview for Mental Status, he found that it was documented at a score of 15 out of 15, indicating the resident was cognitively intact. Upon further review of the MDS, he discovered that it was also documented that “it is very important” for the resident to do her favorite activities (section F). During an interview, the resident confirmed that she smokes. Asked if she received assistance to go outside during smoking times, she stated, “They [staff] take me out to smoke, but you can only go at certain times. If you don’t get up when it is time to go, you miss your time.” The facility was cited for violating the resident’s rights.

An overview of the CMS State Operations Manual (2011), Appendix PP, indicates that the RAI/MDS is currently referenced in the text of almost all F-Tags. Following is a summary of the instructions to surveyors from some of the most-cited deficiencies across the country as well as the deficiencies directly related to the RAI/MDS process:

- **F222: Restraints**—Do facility staff use the Care Area Assessments (CAAs) to evaluate the appropriateness of restraint use?
- **F250: Social Services**—Review the appropriate sections of the MDS.
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Use available leeway.

Since most OBRA assessments have more liberal timing requirements than PPS assessments, facilities have a golden opportunity to adjust the OBRA assessment schedule to account for interdisciplinary team (IDT) workload, says Deb Myhre, RN, C-NE, RAC-MT, a consultant with Ankeny, Iowa-based Continuum Health Care Services.

“Facilities can move assessments within the OBRA assessment schedule while still maintaining timeline compliance, so they need to monitor the schedule for those times when a week may be very heavy with assessments. Moving assessments to an earlier week may lighten the load for a heavy week.”

Myhre offers this example: If a facility has a week with 12 OBRA assessments due (seven quarterlies, three annuals, and two new admissions), the facility may want to move several quarterlies or annuals to an earlier week to lighten the load for the IDT. “Similarly, even though the PPS assessment schedule is more fluid, providers also can move OBRA assessments back to help compensate for a week with a heavy Medicare workload,” she notes.

Give your IDT plenty of time.

One common scheduling problem involves the time period that facilities allow for assessment and MDS completion, says Myhre. “Facilities often fail to give the IDT sufficient time between when the ARD is set and when the MDS sections need to be completed. For example, if the ARD for quarterlies and annuals is set on Monday, the facility will only give the IDT Tuesday and Wednesday to complete and sign off on their MDS sections because the care plan conference has been scheduled for Thursday.”

However, such a tight timeline isn’t a requirement. “With the exception of the admission assessment, facilities actually have 14 days from the ARD to complete an MDS assessment,” explains Myhre. (For details, see the chart “RAI OBRA-Required Assessment Summary,” on pages 2-15 – 2-16 of the RAI Manual.)

“A better timeline would be to set the ARD one week and allow the IDT at least a full week or more to complete their assessments /MDS sections before the next week’s care plan conference date,” she suggests. “Going back to the original example, if the facility set the ARD on Monday for quarterlies and annuals and the MDS completion date was the following Wednesday, that allows the IDT Tuesday through the following Wednesday—or seven regular business days—to complete their assessments, MDS sections, and CAAs (care area assessments) if needed. Then the facility can still hold its care plan conference on a Thursday if that’s preferred.”

Note: Resident interviews continue to follow RAI guidelines.

The same type of time management problem crops up when providers set the ARD for the admission assessment on the 14th day after admission, notes Myhre. “Although not prohibited by the RAI Manual, this practice is highly discouraged as it does not allow the IDT enough time to complete an accurate assessment.”

The 14-day time frame for completing most MDSs is nothing new, so why do some providers give their IDTs such an abbreviated time period to wrap up OBRA assessments? The most common reason appears to be habit. “What I often hear is, ‘This is the way it has always been done,’” says Myhre. “People just have the mindset that an MDS has to be completed and transmitted within a week. Similarly, people think care plan conferences always have to be done on a certain day of the week.”

Providers need to be less rigid with the OBRA assessment schedule, recommends Myhre. “MDS coordinators often complain about IDT members who are habitually late completing their sections of the MDS. Learning to be more flexible with the process can do a lot to improve IDT timeliness, as well as the accuracy of the MDS coding. You need to allow staff as much time as you can because there are always roadblocks cropping up, such as surveyors walking in on a complaint, staff illness, weather related emergencies, or residents with critical health issues.”

Pay attention to the Final Validation Report.

Most providers investigate fatal errors on Final Validation Reports because fatal errors mean that an MDS record hasn’t been accepted into the QIES database. “Providers often aren’t as vigilant about warning messages, but they need to read each one to make sure they haven’t missed a break-down in the process or timing requirements for their OBRA assessments,” says Belt. (Need help interpreting warning messages? See Section 5 of the MDS 3.0 Provider User’s Guide.)

Don’t forget SCSAs.

Providers still can miss recognizing the criteria for a significant change in status assessment (SCSA), says Belt. (Need a refresher on the criteria? See pages 2-20 – 2-25 of the RAI Manual) “Most often, providers miss significant changes in patients who slowly decline. Surveyors tend to pick up those significant changes because they compare assessment to assessment,” she explains. “So it’s an absolute must for providers also to look for significant change criteria by comparing the previous MDS to the current one before they close that MDS.”

Have a fully trained backup for the MDS coordinator.

Like the PPS assessment schedule, the OBRA assessment schedule most often falls apart when the MDS coordinator goes on vacation or has an unplanned absence, for example, due to accident or illness, notes Belt. “Providers have to train a backup. There must be someone other than the MDS coordinator who can complete MDSs, submit MDSs, and track MDSs to ensure the schedule is being followed timely. Smaller facilities are especially likely to run into trouble because they don’t have a trained backup.”
FOSTERING A JUST CULTURE ENVIRONMENT

How does your facility address errors made by staff members? Is the focus on determining who is to blame and providing punishment when a mistake is made? If discipline is the primary method used to correct errors, has it succeeded in improving quality and reducing turnover? Dr. Lucian Leape, member of the Quality Health Care in America Committee at the Institute of Medicine and professor at Harvard School of Public Health, testified before Congress on improving the quality of health care. He proposed to those in attendance that the single greatest impediment to error prevention in the medical industry is that “we punish people for making mistakes.” Dr. Leape recommends adopting principles that establish an environment known as a “just culture,” for which the following six major changes are needed:

- Stop looking at errors as individual failures and realize that they are caused by system failures.
- Move from a punitive environment to a just culture.
- Move from secrecy to transparency.
- Shift from a provider focus to a patient/resident focus.
- Stop using models of care that rely on individual performance excellence, and adopt a system of collaborative inter-professional teamwork.
- Realize that accountability should be universal and reciprocal, not top-down.

People are human; we make errors. In most settings the standard procedure is to place blame on the people involved. When we apply root cause analysis, however, we often learn that the problem is not the fault of the individual but rather the fault of the system. David Marx, JD, in a presentation titled “Just Culture Community,” shared three types of behaviors we can expect to occur. They are:

- Human error—inadvertently doing other than what should have been done; a mistake
- At-risk behavior—a choice that increases risk where risk is not recognized or is mistakenly believed to be justified
- Reckless behavior—choosing to consciously disregard a substantial and unjustifiable risk

The principle of accountability requires that something be done to address the above behaviors when they result in negative outcomes. When human error is the behavior, we can manage through changes in processes, procedures, training, and system redesign. We can console the person who made the error as we discuss solutions. If the person’s actions involved at-risk behavior, we can manage by removing incentives for at-risk behavior, creating incentives for healthy behavior, and increasing situational awareness through coaching. Finally, if the individual is determined to have performed in a reckless manner, intentionally disregarding the obvious risk, we should manage through remedial and punitive actions. Dr. Marx makes it clear that there is a time when discipline is the correct path to take, but only if the person took actions that intentionally disregarded the risk.

In his book Just Culture: Balancing Safety and Accountability, Sidney Dekker explains that the reason behind errors is not solely individuals or systems, but individuals in systems. He states that a blame-free environment does not mean accountability-free. He believes that accountability is best achieved not by blaming individuals, but by getting them actively involved in the creation of a better system within which they will work. He proposes that accountability in most cases is only backward-looking, and is the kind of accountability that is seen in lawsuits, terminations, demotions, and suspensions. Instead, accountability should be forward-looking, bringing areas that need improvement into the open so that changes can be made.

So how should a facility team get started with creating a just culture initiative that ensures all staff members feel free to report errors? Barbara Brun of Health Leaders Media recommends that administration support the concepts of a just culture and encourage staff to feel safe in reporting errors, fostering an atmosphere of mindfulness in their workers. She explains that mindfulness consists of five components, as defined by Weick and Sutcliffe:

- A constant concern about the possibility of failure, even in the most successful endeavors
- Deference to expertise, regardless of rank or status
- An ability to adapt when the unexpected occurs (commitment to resilience)
- An ability to concentrate on a specific task, while having a sense of a bigger picture (sensitivity to operations)
- An ability to alter and flatten the hierarchy as best fits each situation

The Joint Commission (formerly JCAHO) suggests developing an organization-wide policy of transparency that sheds light on adverse events and

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Q + A

**DON** ADL Documentation by CNAs

We just went to electronic health records and I am finding quite a few errors with ADL charting. We plan on doing some education this month, hands on, trying to act out specific scenarios according to our residents as well as where we see the errors. Does anyone have suggestions on educating the CNAs on ADL charting? We have used lecture, power points, handouts, and examples, but it doesn’t seem to sink in. Any suggestions would be helpful.

Lesley responded: When I worked as MDS Coordinator at a facility that made the conversion requiring GNAs to do electronic ADL charting, the Director of Nursing required attendance at the class I taught. Passing the test given at the end of the class had to be completed prior to the implementation date. Anyone who didn’t comply was taken off the work schedule. There were one or two people who tested her resolve, but they did manage to learn the information and pass the test without missing any time. Then as we got further into the process, it became pretty clear who needed additional training by reviewing the coding as I completed the MDS. With the DON’s support through counseling the employees who were having difficulty, and then working with them 1:1, we were able see improvement. But it was necessary to do continual education and encourage the GNA’s to ask questions and seek clarification.

**DON** Psychotropic Care Plans

Recently I’ve been reading some audit results from OMIG. They have been finding a lot of facilities lacking in care plans. Since one of their main areas of focus is the use of antipsychotics, I have instructed all of the head nurses in our facility to initiate a separate care plan for psychotropic drugs, which is the #17 CAA trigger. I have some head nurses suggesting to just add it as an approach in the Mood State care plan and not have a separate care plan for that trigger. My main concern is that the surveyor may say that we don’t have a specific care plan for a specific CAA trigger, and we can get a deficiency. We had this problem before when one head nurse added that the resident was on hospice in all of her care plan approaches, but we got a deficiency because there was NO specific, stand-alone care plan just for hospice. Should we code this cream being applied to arm as chemotherapy in O0100A?

Here are the instructions for coding Chemotherapy in O0100A from page O-2 in chapter 3 of the *RAI User’s Manual*:

“Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment.”

Rena R. Shephard, MHA, RN, RAC-MT, C-NE (RRS2000@aol.com)

**OBRA Assessments while on Medicare**

I have a resident who was on Medicare A from 11/6/13 to 11/22/13, when he had EOT and went to private pay. Did he need a 30 day done, or does he just cycle into the quarterly which should be in Feb? I am hoping I did not miss some assessment.

If his last Medicare A day was 11/22 (day 17 of the stay, then no 30-day was needed). Looks like you’d have a 5-day, 14-day and any required unscheduled assessments (i.e. EOT). The OBRA schedule continues during and after a Medicare A stay. When a resident goes on/off Medicare, evaluate for Significant Change of Status Assessment and complete if necessary or continue with the next OBRA assessment.

Judi Kulus, NHA, RN, MA, RAC-MT, C-NE (jkulus@aanac.org)
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- F327: Hydration—Consider whether the MDS assessment triggers CAAs and whether facility staff have assessed the causal factors for decline, potential for decline, or lack of improvement.
- F328: Special Needs—Refer to the appropriate sections of the MDS to determine whether the facility staff ensure that residents receive proper treatment and care for the following special services: parenteral and enteral fluids; colostomy, urostomy, or ileostomy care; tracheostomy care; respiratory care; foot care; and prostheses.
- F329: Unnecessary Drugs—Refer to the MDS and CAAs to determine whether, during the quarterly MDS review, facility staff evaluate mood, function, behavior, and other domains that may be affected by medications. Evaluate whether facility staff are using the results to maintain or improve the individual’s mental, physical, and psychosocial well-being (as reflected on the MDS or other assessment tools).
- F385: Physician Services—Facility staff should share MDS and other assessment data with the physician.
- F406: Provision of Services—Refer to appropriate sections of the MDS as applicable. Observe for unmet needs for rehabilitative services.

While we wait for more information about the MDS Focused Survey process, use this list of current regulations to conduct QAPI reviews of your RAI/MDS system. You may find broken systems that will take months to fix. Why not begin now, so that when the surveyors arrive at your door, your MDS assessment process will be working flawlessly?

REFERENCES

Fostering a just culture environment, continued from page 4
patient safety issues, thereby creating an environment where staff members are safe to discuss real and potential vulnerabilities and to support each other in reporting issues without fear of reprisal. Ask not who is to blame, but what is to blame. Include regular monitoring and analysis of adverse events, promote open discussion of risks and barriers to safety, and ensure that caregivers involved in the adverse outcomes receive attention that is respectful, supportive, and timely. An organization that has adopted a just culture will not merely wait until there is harm that requires a reaction, it will assess risk and work toward ensuring maximum reliability to prevent adverse events from occurring. This can be accomplished by instilling in all team members a commitment to values, creating a learning culture, focusing on safe system design, and ensuring the effective management of behavioral choices. A just culture provides the foundation for improvement by empowering all staff to speak freely in the effort to balance accountability and safety. It creates an environment with a focus on each resident receiving the highest attainable quality of care.

All the articles in this LTC Leader can also be found on the AANAC.org website.