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*New Series:*  
**The 7 Reasons Why Most F-Tags are Cited  
Part I & Part II**

While it is true that each F-tag has content specific requirements and/or implementation nuances, the underlying reasons why facilities receive survey deficiencies actually transcend F-tag boundaries.

It doesn't matter which F-tag is involved, i.e. F323 Falls, F314 Pressure Sores, F315 Continence Management, F309 Pain, F325 Weight Loss, F-ETC... *The reason your facility got an F323 deficiency may be the same reason your facility received an F324 tag!*

This new series will explore the **7 reasons** why most F-tags are cited AND the **7 corresponding solutions** to prevent survey deficiencies. Let's get started.

**Reason #1: Risk Assessments/The Assessment Process**

Risk Assessments are the foundation for most if not all clinical decision-making. How can you identify change of condition if you don't know the resident's baseline? How can you prevent avoidable negative outcomes if you haven't identified the resident's risk factors? Yet, in many facilities, staff consider risk assessments to be just one more piece in an overwhelming pile of paperwork.

Survey deficiencies related to Risk Assessments or the Assessment Process, *regardless of the F-tag involved*, typically include reference to the following:

- Assessment wasn't done; wasn't done timely; incomplete:
  - This includes clinical areas/issues for which the facility apparently doesn't expect an assessment to be completed or hasn't implemented a process yet, i.e. facility has not initiated implementation of a Pain or Continence assessment, facility does not perform a Side Rail assessment.
  - The facility expects a designated form/documentation to be completed but it wasn't done at all or wasn't done within the designated timeframe, i.e. Fall risk

assessment not updated quarterly, elopement risk assessment not completed upon readmission, etc.

- The designated form/documentation was initiated but not completed, i.e. sections blank, i.e. sections of pain assessment related to non-pharmacological approaches not filled in, continence assessment does not identify type of incontinence, etc.
- Assessment wasn't completed accurately and/or is inconsistent with other documentation in the medical record, i.e. continence assessment indicates resident *is* continent, Braden indicates resident *is not* continent, fall risk assessment indicates resident *is not* continent, nursing monthly summary check-off section indicates resident *is* continent.
- The facility relies upon the risk assessment 'score' to develop care plan interventions, i.e. 10= high risk for falls, 5= high risk for elopement, 13= moderate risk for skin breakdown, etc.
- Despite observed/documented changes in resident condition, abilities, resident compliance issues, occurrence of a negative outcome, etc., the risk assessment tools are not reviewed and risk factors are not re-evaluated, i.e. resident observed to have increasing difficulty ambulating in room but not requesting assistance. Fall, continence, Braden, contracture, etc. risk assessments not re-evaluated.

As indicated by the above, issues with ANY risk assessment/assessment process, *regardless of the clinical area or corresponding F-tag*, can result in a survey deficiency.

Now, let's take a look at **solutions** that can be applied, *regardless of the clinical area or corresponding F-tag*, to **prevent** a survey deficiency:

Solutions related to Risk Assessments or the Assessment Process, *regardless of the F-tag involved*, typically require attention to the following:

Do the Assessment:

- Identify and implement risk assessment tools/processes for all relevant clinical areas. You know the surveyors are going to be looking for them, i.e. falls, skin, pain, continence, psychotropic drug usage, elopement, restraints (as applicable), safety and/or postural devices (documents need and substantiates non-restraining effect), contracture risk, etc etc etc (this is not an exhaustive list)

Do the Assessment timely:

- Complete the high risk clinical area assessments within 2 to 4 hours of admission AND readmission, i.e. falls, skin, elopement, pain, at a minimum.
- Incorporate pre-admission/readmission information, resident/family interview, post-admission observation.
  - Staff will likely observe/learn more about the resident in the days following admission/readmission; update/correct the risk assessments completed on day one to ensure that appropriate care plan interventions are developed.
    - Is the resident really 100% continent?
    - Is the resident really pain-free as they indicated on admission? If so, then why are they requesting Tylenol every evening?
    - The resident is a 'low risk' for falls but insists on attempting to reach the top shelf of the closet.
- Update/review/redo risk assessments:
  - Upon change in condition:
    - Acute/temporary, i.e. acute illness may cause a cognitively intact, continent, independently ambulatory resident to become confused,

incontinent, etc. thereby putting them at risk for skin breakdown, UTI, falls, etc.

- Persistent/permanent: if the resident's change is persistent/likely to be permanent, why wait until the next quarterly interval when the resident requires the appropriate care and services now?
  - Quarterly
  - Following negative outcome (more about that later in the series)

Don't rely on the 'score':

Even when the risk score has been computed accurately, guidance to surveyors point out that reliance on a **risk assessment 'score' is not enough!** A resident whose overall 'score' may place them at low to moderate risk for pressure ulcer development or falls may, in fact, have a high degree of risk in one of the assessment categories. This singular area of high risk could be diluted or obscured when you 'do the math.' Guidance state that, regardless of any resident's total risk score, the facility **SHOULD** review each risk factor and potential cause(s) individually and determine whether targeted interventions need to be implemented.

The benefits of a Risk Assessment Summary:

After the assessment is performed using a validated assessment tool, **add a summary paragraph or section that translates the assessment and any identified risk factors/categories into resident-specific terms.** What is it about the resident's mobility limitations that puts the resident at risk for pressure ulcer development? How does the resident's cognitive impairment affect their potential for falls? Consider additional factors that may not be directly considered by the risk assessment tool such as: other medical conditions/treatments, refusal/resistance to care, and, very importantly, history of the negative outcome. When the resident-specific areas of risk have been translated from a number into resident-specific English, the care plan team can more easily and effectively develop resident-specific interventions.

Make sure it all gets done:

Review the risk assessment documentation and associated processes (any/all clinical areas and/or F-tags) as part of the facility's Quality Assurance program. Audit to answer the following questions:

- Was it done?
- Was it done timely?
- Was it complete?
- Was it accurate?
- Does the information provide a path to resident-specific care plan interventions?

## **The 7 Reasons Why Most F-Tags are Cited Part II**

In the first article in this new series, we discussed that, while it is true that each F-tag has content specific requirements and/or implementation nuances, the underlying reasons why facilities receive survey deficiencies actually transcend F-tag boundaries. It doesn't matter which F-tag is involved, i.e. F323 Falls, F314 Pressure Sores, F315 Continence Management, F309 Pain, F325 Weight Loss, F-ETC... *The reason your facility got an F323 deficiency may be the same reason your facility received an F324 tag!* This series continues to explore the **7 reasons** why most F-tags are cited **AND** the **7 corresponding solutions** to prevent survey deficiencies.

## **Reason #2: The Care Plan:**

The Care Plan is the core document that determines and directs the care, treatment, and services provided to the resident. The Care Plan expresses the decisions of the interdisciplinary team regarding potential/actual risks and conditions identified via the assessment process, which risks will be addressed, how the potential for risk will be prevented or reduced, and how actual risks/conditions will be controlled/managed.

Survey deficiencies related to the Care Plan, *regardless of the F-tag involved*, typically include reference to the following:

- A potential/actual risk factor or condition is not included in the Care Plan.
- Interventions are generic and/or not resident-specific.
- Interventions do not reflect resident's current condition/care needs/care actually provided.
- (The list is longer but additional aspects will be discussed in Part III of this series)

As indicated by the above, issues with the Care Plan, *regardless of the clinical area or corresponding F-tag*, can result in a survey deficiency.

Now, let's take a look at ***solutions*** that can be applied, *regardless of the clinical area or corresponding F-tag*, to ***prevent*** a survey deficiency:

### Solutions:

- All areas of potential or actual risk/conditions must be included in the Care Plan:
  - The resident may currently be independent (no risk/low risk) in a particular care area but requires certain services in order to remain that way and/or ongoing observation by staff to identify subtle changes as quickly as possible. Often, however, if the resident doesn't 'trigger' in an MDS areas, the interdisciplinary care plan team doesn't include the area in the Care Plan. At a minimum it is recommended that all residents have Care Plan interventions addressing the following areas: Falls/Safety, Nutrition, Activities, Continence, Skin, Ambulation/Transfer, ADLs. (*Please note: this is a consultative recommendation – not a regulatory requirement.*) Most elderly are vulnerable to rapid change in these key areas resulting from, i.e. acute illness, life losses, other situational changes, etc.
  - As we discussed in Part I, there may be specific or isolated areas of risk identified via the risk assessment process (falls, pressure ulcers, elopement, etc.) although the resident may not 'score' as a high risk. Make sure these risks are addressed with corresponding interventions.
  - Some times the risk/condition is just missing! Resident is on psychotropic drugs/not mentioned, the resident has history of UTI/not mentioned, the resident has a medical condition for which they are receiving medication/not mentioned.
- Care plan interventions must be SPECIFIC to the individual resident.
  - Interventions are often noted to be 'non-committal' i.e. 1-2 person assist with transfer, manual or mechanical lift, diet as ordered, turn/position in accordance with facility policy, etc. Facilities frequently voice that they are reluctant to 'get specific' in the Care Plan because then they could 'get caught' during a survey when the care isn't provided in accordance with the care plan. In actuality, if the Care Plan is non-committal, how are staff supposed to render care commensurate with the resident's real needs? And then surveyors will cite the facility for care planning AND actual care rendered/not rendered. For those facilities who are reluctant to commit on the Care Plan but commit on a CNA assignment sheet or Care Guide, you

- are just as vulnerable to a deficiency if the CNAs don't perform in accordance with the Care Guide!
- 'Canned' or generic care plan interventions, the ones that typically spew forth from electronic care plan programs, often can be in conflict with resident's actual care needs, i.e. resident on fluid restrictions with intervention 'keep water pitcher readily accessible at all times', 'encourage resident to consume fluids', etc. While 'canned' interventions can save the interdisciplinary team a lot of time from listing the myriad of interventions that may apply to all, it is critical that the team weed out all of the interventions that apply to the specific resident.
  - Care plan interventions must be consistently and *promptly* reviewed/revise in a clear and usable fashion to reflect the resident's current condition/care needs, and current interventions.
    - If the pages of a Care Plan are pristine, appear untouched by human hands, and/or have no handwritten additions/modifications, it is likely that some of the interventions are not current! (or that the Care Plan doesn't commit to resident-specific interventions so therefore there is nothing to update/modify.)
  - Require care plan reviews following unit changes, readmission, acute/temporary illness, etc.
  - Re-evaluate the facility's care planning process, i.e. paper compliance versus actual team discussion?
  - Incorporate unit nurses into the process.
  - Reinservice care plan team members.
  - Have clinical department heads observe the care plan meetings.
  - Review/audit care plans as part of the facility's Quality Assurance process.

*Next Time:* **Reason #3: The Care Plan... Monitoring & Modification**

**About the Author:**

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*For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.*

