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CMS Issues Draft Revised Survey and Enforcement Guidance On SNF Advance Directives Policies and Implementation

Shorts on Long Term Care December 2010

12.03.2010

Kenneth L. Burgess

In early October, the Centers for Medicare and Medicaid Services (CMS) issued draft revised guidance to surveyors on the responsibility of SNFs to have policies and procedures, and to properly implement and honor advance directives (living wills, health care powers of attorney, the MOST form) of residents. There's good news and bad news in this.

The good news is that the N.C. long term care industry is far ahead of the curve on advance directives information. The N.C. Healthcare Facilities Association, working with our firm, has developed, distributed and trained on policies and procedures governing advance directives in SNFs in the last couple of years. The model policy we developed for the association is consistent with the expectations of CMS regarding end of life care planning and documentation, including advance directives. So, if you have obtained, implemented and are following that policy, you should be in great shape.

The bad news is that this revised guidance seems to signal a heightened focus on advance directives in SNFs. As with all recent CMS survey/enforcement guidance, the CMS October guidance on advance directives not only explains facility obligations regarding end of life care planning and options, but also directs surveyors about what to look for and how to survey for compliance with those obligations. Each facility should obtain this guidance and, in our opinion, train staff on it, paying particular attention to the examples CMS gives surveyors of the various scope and severity levels that should or may be assigned to various failures of the facility to properly educate about, plan for, assist residents with and implement advance directives.

The guidance identifies FTag 155 (entitled Advance Directives) as the primary tag for citations involving advance directives, but also directs surveyors to consider related citations at FTag 154 (right to be fully informed); FTag 242 (self-determination and participation in care); FTag 278 (accuracy of assessments); FTag 279 (care plans); FTag 289 (care plan revision); FTag 282 (care provided by qualified persons in accordance with plans of care); FTag 329 (unnecessary drugs); FTag 285 (physician supervision); FTag 501 (medical director requirements); and FTag 514 (clinical records).

Taken together, the inclusion of these FTags, and their corresponding federal regulations, signals CMS's expectation, as fully described in the October guidance, that end of life care planning and delivery must include:

- Educating residents about their end of life care planning options AND assisting them in implementing an advance directive if they choose;
- Educating staff about advance directives and how to follow them;
- Ensuring that resident care plans are consistent with a resident's advance directives;
- Ensuring that the clinical records are consistent with and reflect existing advance directives;
- Periodically reviewing residents' advance directives to ensure they remain consistent with the wishes of a resident or his or her legal surrogate AND that care plans and clinical records accurately reflect a resident's current wishes;
- Ensuring that treating physicians are involved in these decisions, aware of a resident's choices and directing care consistent with those wishes;
- Ensuring that medical directors have been involved in the development of a facility's policies and procedures governing advance directives;
- Ensuring that facility staff know who is authorized to make care choices for an incompetent resident and that the individual upon whom they rely for those choices is the proper person, under state law, to make such choices; and
- Ensuring that staff are fully aware of a resident's expressed care wishes AND that care is delivered consistent with those wishes.

In directing surveyors on how to select scope and severity classifications for violations of advance directive regulations and FTags, CMS says such violations never qualify as "no actual harm with potential for no more than minimal harm," or severity level 1 in CMS parlance. So, all deficiencies will be scored at either harm level 2, no actual harm with potential for more than minimal harm (levels D, E or F on the grid); actual harm that is no immediate jeopardy (levels G, H or I on the grid); or immediate jeopardy (levels J, K or L on the grid).

Some examples CMS gives of immediate jeopardy deficiencies based on end of life care planning and delivery include:

- A resident is transferred to a hospital after an acute change in condition where a feeding tube is inserted, inconsistent with the resident's documented wishes;
- As a result of the failure of a facility to systematically assess and document the decision-making capacity of residents, the facility excludes residents with cognitive impairment, regardless of level, from participating in their care planning decisions; and
- Continuing care that is inconsistent with a resident's expressed wishes.

Examples of a G level deficiency, or actual harm, include:

- Allowing family members to override the documented wishes of a resident and providing care, based on family member insistence, that is inconsistent with the resident's wishes (such as for life-sustaining care) and/or failing to recognize that one or more family members lack legal standing under state law to make decisions for the resident (you will recall the N.C. statute that creates a hierarchy of individuals who can make decisions for an incompetent resident without an advance directive, and this example highlights the importance of facility staff understanding this hierarchy and honoring it – see the "decision tree" poster Poyner Spruill sent to all SNF and assisted living facilities a few months ago for posting in the facility); and
- Performing CPR on a resident and transferring him to the hospital for further care when that is inconsistent with the resident's documented wishes.

A level 2 harm situation would occur where facility staff are unaware of and/or have failed to document a resident's end of life care planning choices but no care inconsistent with those wishes has yet been delivered, or where a resident has expressed a desire to create an advance directive but has been offered no assistance in doing so and has no advance directive in place.

This guidance underscores the importance of incorporating end of life care planning, and ongoing review and updating of clinical records as residents' preferences change over time, into the normal care planning and care delivery process. The American Health Care Association is submitting comments on this draft surveyor guidance. We'll continue to monitor the progress of the guidance and report to you when it's final, and whether any significant changes are included in the final version.