Office of Health Care Facilities Licensure and Certification,
South Dakota Department of Health

Partnership News & Best Practice

Partnership News February 2018

Biannual Nursing Facility Regulation Report

On January 9, 2018, our office sent out the first Biannual Nursing Facility Regulation Report. As stated on the report, the purpose is to provide statistics and information regarding the regulation of South Dakota nursing facilities. The deficiency data includes all Long-Term Care health surveys (both standard and complaint). The report will be updated on a biannual basis, and will be distributed on our Listserv and posted on our website.

The information provided on the report is a snapshot which includes data regarding the number of deficiencies cited compared to recent years, the number and type of surveys conducted, IDRs conducted, and CMPs collected.

As always, I welcome calls or emails from Administrators with comments and suggestions.

My phone is (605)773-3356 and email address is chris.qualm@state.sd.us.

Inside this issue:

SD Department of Health
615 East 4th Street
Pierre, SD
57501

Phone: 605-773-3356

FDA announced antibiotic tool

Did you know on December 13, 2017, FDA announced a new approach to get critical updates regarding antibiotics and antifungal drugs to health care professionals as part of an overall effort to combat antimicrobial resistance.

The agency created a website that will provide direct and timely access to information about when bacterial or fungal infections are likely to respond to a specific drug.

This approach is intended to aid health care professionals in making more informed prescribing decisions that will both benefit their patients and prevent the spread of resistant bacteria.

"Antimicrobial resistance remains one of our most pressing public health challenges. While we're continuing our policy efforts to encourage the development of new drugs and limit the use of antibiotics in livestock, we also need to take new steps to encourage more appropriate use of these treatments in patient care," said FDA Commissioner Scott Gottlieb, M.D.

"When you're treating critically ill patients, you want as much information as possible about the pathogen your patient is fighting and the susceptibility of that pathogen to various treatments. Prescribing a drug that's only going to be met with resistance from the bacteria or fungus it's intended to treat doesn't help that patient, and it has broader public health consequences that cannot be ignored.

Read more at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm588836.htm.

Critical Access Hospital (CAH) Reclassification Verification Requirement

The Office of Inspector General (OIG) report entitled, "Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-enroll in Medicare," was released August 19, 2013. The OIG report recommended the Centers for Medicare and Medicaid Services (CMS) periodically reassess and maintain evidence of CAHs' compliance with status and location requirements at 42 CFR 485.610.

"Section 1820(c)(2)(B) of the Social Security Act (the Act) requires CAHs to be located in a rural area (as defined in section 1886(d)(2)(D)) or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E); more than a 35-mile drive (15 miles in areas with only secondary roads or mountainous terrain) from a hospital (as defined at Section 1861(e) of the Act); or another facility as described in subsection 1820(c) of the Act."

Annually State Survey Agencies provide Regional Office with a list of deemed and non-deemed CAHs which are expected to undergo a recertification survey over the next twelve months. The Regional Office utilizes the CAH Recertification Checklist: Rural and Distance or Necessary Provider Verification Checklist when evaluating, determining, and documenting compliance with the CAH location-related Conditions of Participation.

Once Regional Office has made a determination of the CAH compliance or non-compliance with the rural status and/or distance requirement, the State Survey Agency or the Accreditation Organization will be notified. CAHs found non-compliant with the rural status and/or distance requirements will not receive a recertification survey.

CAHs found non-compliant with the rural status and/or distance requirements will have four options:

1) Provide the State Survey Agency with a copy of the Rural Reclassification Approval letter received from the Division of Financial Management and Fee for Service Operations. You will only have this letter if the facility participated in a reclassification action after the CAH initial designation.
2) Submit documentation for approval to the Division of Financial Management and Fee for Service Operation attesting the CAH meets the rural status and/or distance requirements.
3) Convert the CAH to hospital status to prevent termination of its Medicare provider agreement.
4) Terminate the CAH Medicare provider agreement and close the hospital.

Prior to sending termination notifications to the CAH, Regional Office will notify the State Survey Agency of any CAH not meeting the rural and/or distance requirements. The South Dakota Department of Health Office of Licensure and Certification will work closely with any facility to collect documentation for submission to the Division of Financial Management and Fee for Service Operation attesting compliance with the rural status and/or distance requirements.

The information in this article is a brief summary of Survey and Certification Memo 16-08-CAH dated February 12, 2016. The full document may be located at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-08.pdf.

If you have any questions regarding this matter, please contact Patricia Brinkley at (605) 367-5375 or email patricia.brinkley@state.sd.us.

doh.sd.gov/providers/licensure/

Providers interested in joining the listserv can subscribe at https://listserv.sd.gov/scripts/wa.exe?A0=SDOLC .

Click on the ***Subscribe*** function found on the right side of the page.

Receive newsletters as well as updates and information on licensing, survey, certification, rules, and regulations.

What the Assisted Living Center is Required to Provide

Within **44:70 Assisted Living Center regulations** there are specific requirements the ALC must furnish or provide for safe resident care and to ensure the needs of the resident are met. We recommend the administrator and all key personnel conduct a periodic review of those regulations to ensure the intent and ability to meet all regulations. The provider at a minimum must provide or furnish:

- The availability of linen equal to two times the licensed capacity.
- A bed, a bedside table or stand, and a chair.
- A sufficient number of qualified personnel to provide safe and effective care.
- An orientation and an ongoing staff training program to meet the needs of your residents and the optional services approved for. The staff training should be documented. For example:
  - Acceptance of diabetic residents with physician orders to monitor the resident's blood sugars twice daily. Have the staff trained to assist with the testing and education related to diabetes.
  - If approved to provide two person assist, it would be the expectation of the facility to train the staff to use a mechanical lift with two individuals. The mechanical lift should be furnished/ purchased by the facility, not purchased by a family member.
  - Additional education based on the facility's identified needs.
- Provision of linens, equipment, and supplies for personal care and other activities of daily living to meet the resident's individualized care.
  - For example, shampoo, incontinence products, toilet paper, or adaptive eating utensils.
- Activity supplies and equipment according to the individualized resident's interests.

If you have any questions, feel free to contact Deb Carlson at Deb.carlson@state.sd.us.

Emergency Preparedness

Need help with planning? Need to know how to connect with a HealthCare Coalition in SD?
Go to http://doh.sd.gov/providers/preparedness/hospital-preparedness/system/

The **South Dakota Hospital Preparedness Program (HPP)** works with hospitals and other medical facilities to ensure that South Dakota's medical community is as prepared as we can be! For additional information about HPP go to http://doh.sd.gov/providers/Preparedness/Hospital-Preparedness/ or contact the HPP at 605-773-4412.

Use this link to find your **local Emergency Manager:** https://dps.sd.gov/emergency-services/emergency-management

CMS Emergency Preparedness Site:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

The Assistant Secretary for Preparedness and Response (ASPR) **Technical Resources Assistance Center and Information Exchange (TRACIE)** is a resource for developing emergency plans and can be found at https://www.asprtracie.hhs.gov.

Enhancing Quality Using the Inspection Program (EQUIP)

A quality mammography exam is the primary goal of the Mammography Quality Standards Act (MQSA). A quality exam is necessary for an accurate interpretation by the radiologist.

Beginning January 1, 2018, inspectors will start reviewing the ***EQUIP*** regulations as part of the survey. The inspector will be reviewing the provider's policies and procedures to ensure an ***EQUIP*** program has been put in place. The following will be reviewed:

- **Clinical Image Quality**

  System to ensure that clinical images continue to comply with the image quality standards established by the facility's accreditation body. This must include a mechanism for annual reviews of image quality attributes for a sample of mammograms from each active registered technologist and each active interpreting physician. There must be documentation that these reviews were done since the last inspection. One accepted image from each technologist and each interpreting physician must be reviewed at least annually.

- **Clinical Image Corrective Action**

  There must be a system for corrective action when images are of poor quality. This includes a mechanism for providing ongoing interpreting physician feedback on image quality. There also needs to be a mechanism for documenting any needed corrective action and the effectiveness of that corrective action.

- **Quality Assurance/Quality Control (QA/QC)**

  There must be a system for the lead interpreting physician's oversight of the QA/QC records and appropriate corrective action is taken when needed. This oversight must include, at a minimum, an annual review of the quality assurance program to ensure frequency of QA testing and any corrective actions have been performed according to manufacturer's recommendations.

If you have any questions, feel free to contact Gary Kaus at gary.kaus@state.sd.us or John Priest at john.priest@state.sd.us.

Submitting Acceptable Plans of Correction (POC)

Our office has noticed many POCs are received up to five days earlier than required. Some are received the day after being emailed to the provider. Emailing POCs has improved the turn-around time of sending and receiving them compared to using USPS mail.

However, there continues to be a considerable delay in getting acceptable POCs from providers. That is due to two things: 1) some of the required information had not been included or 2) the POC had been submitted in the wrong document type.

It is the providers' responsibility to submit their POC in the appropriate format with all required information. Failing to do so slows down the process of having the POC accepted. When that happens for nursing homes or other providers who had Denial of Payment or other sanctions levied due to findings found during survey, it can delay the removal of those sanctions. The removal of sanctions depends upon when the citations are corrected. The longer it takes to submit an acceptable POC, the longer it takes to correct the citations tied to sanctions. Such a delay may result in a financial loss or a loss of services. Below are tips to consider when submitting a POC:

Tips for submitting an acceptable POC within the required timeframe:

1) Do use an Adobe read/write program such as Adobe Acrobat DC Pro. If that isn't available, use an Adobe read only program.

2) Do start working with the report in the first day or two it is received. That might determine early on what issues may come up when

Submitting Acceptable POCs *(continued)*

entering POC text. This office could then be contacted for assistance. Doing so would help prevent last minute scrambling, stress, and frustration.

3) Do make sure the POC contains all the required information. Review each citation's POC against the POC guideline form to help ensure that information is present. That would help prevent requests for more information. It could also prevent delay of getting the POC accepted.

4) Do not wait until the second -to-last or last day to start putting your POC text on the survey report form.

Provider actions that automatically prevent a POC from being accepted (outside of missing required information):

1) Using Word to open the survey report and enter the POC, and saving it as a Word document. When that occurs, pages of the POC end up being printed partly on one page and the rest on the next.

2) Saving the POC to Adobe Cloud and attach that to the email you send to the dohpoc@state.sd.us address.

If you have issues or concerns with entering POC text or using an appropriate document format, contact Connie Richards at (605) 773-3694 or connie.richards@state.sd.us.

Activities

Nursing homes, assisted living facilities, and other elderly care homes find it essential to engage residents in activities that make them feel active and stimulated. Activities should meet the needs of all residents, including those in wheelchairs or with debilitating physical or mental conditions. Staff, community members, and volunteers can help carry out programs and activities. Below are a few links we have found that may spark a new idea or add a new perception to activities already in place at your residents' home.

https://www.pinterest.com/explore/nursing-home-activities/

http://www.ssww.com/blog/10-winter-activities-for-nursing-home-residents/

https://www.facebook.com/nursinghomeactivitiesresource

Planning for men's activities is also a must. Here are just a few ideas for men's programming.

1. Music, Bingo, Food
Men can select the music played in the dining room, can have a group discussion of famous musicians, can sing, whistle, and play music, and can call numbers for bingo games.

What was their favorite food they cooked, baked, BBQed? Do they remember the recipe to share with the kitchen?

2. Create a Romeo Club
This can be a special meeting place and time for the guys to talk about their brides, the one who got away, etc. Serve food and make it their own private time. Find an empty corner of a hallway or a room and furnish it as a men's place. A bar counter, tables and chairs, fishing poles in the corner, a tool box, men's magazines, and a TV/DVD with stacks of men's movies on a set of shelves. Sometimes the best activity for retired men is a place where the men can be together.

3. Clubs
Ask the Rotary, Lions, Knights of Columbus, Elks, etc. to occasionally meet in your facility. The clubs get a meeting space and your residents get to be a member of a club again. Also, ask if the boy scouts, girl scouts, 4-H, etc. want to use your facility for a meeting place.

Ask if members of the local high school or university sports teams will come and talk about their season.

Ask the local game warden to come and talk about the hunting and fishing seasons.

4. **Handymen**
Ask the maintenance department workers to allow the male residents to watch the workers changing light bulbs, painting hallways, etc. These members of the 'resident crew' will feel part of the team even if they only say, "You missed a spot." Let them "figure" out a project for the facility and how it should be built/ constructed.

Facility Self-Reports—Missing patient/resident

Between June and December 2017, the South Dakota Department of Health received 155 reports of missing patients/residents. These reports are for all of our provider types including AL, NF, IMR, and hospitals and do include elopements of cognitively impaired and cognitively intact persons.

Listed in your reports were residents who had been assisted out by visitors or had followed people out, including following staff out a service entry door. Other causes were listed as residents who had left through the unalarmed front door when the monitor had left the area, residents who had gone through a laundry area to an outside door, door alarms that were not working properly, and residents who regularly went outside but became confused and left the area.

Interventions facilities have implemented include new signage by doors, educational materials for new resident's families and/or at family council, elopement drills, residents at risk identification binders being provided to attached providers (AL and NH sharing information), and reviewing policies/plan with local law enforcement.

Other ideas include educational information that a local newspaper could run or a facility representative could present the information to groups in your community.

In your reports please include the resident's cognition level, how the person exited, if they needed medical treatment, what the temperature was outside, how was the resident dressed when outside, and what interventions were put in place to prevent future elopements for that resident as well as other residents.

Some things to evaluate in your facility:

- How long ago did your team review your facility's missing resident policy & procedures?
- Consider working with a facility that has had an actual elopement to see if your plan covers all the areas it should.
- Who is responsible for testing door alarms? Are they documenting the results? Are they informing maintenance & administration of any irregularities? If a door is not working, do you have a plan to safeguard that door until it can be repaired?
- Who tests elopement bracelets and how often?
- How often are you assessing the residents? Do you re-evaluate their risk for elopement after a significant change in condition?
- If doors are unalarmed during business hours, are they truly being monitored?
- Are staff turning door alarms off for their convenience?
- Are you educating staff, family, volunteers, and visitors regarding the doors and not assisting others through the doors? How often are you educating them? Educating does not mean putting up signs only.

Please contact **Jeannie or Jessica** at (605)773-3356 if you have questions.

Event Reporting Link:

http://doh.sd.gov/providers/licensure/complaints.aspx

Reporting of injuries of unknown and reasonable suspicion of a crime algorithm is located at the following link:

https://apps.sd.gov/PH91HcOsr/Website/CompFormOnline.aspx

New Long Term Care Survey Process

Tuesday, November 28, 2017, the "go live" date for the New Long Term Care (LTC) Survey Process has come and gone, but many of you continue to have questions as do the surveyors. On the "go live" date, we chose to conduct two "mock" surveys utilizing the new process. Each team of surveyors came away from the experiences with varied perspectives, but all agreed this will be a fantastic way to accomplish our mission once we are familiar and have an established comfort level with the system.

For those of you who may not have had the time yet to review what is out there about the process or experienced a survey with the process, let me share a few items. There are three parts to the new LTC survey process: the initial pool process, sample selection, and the investigation. This process is not utilized with a complaint survey. The initial pool process is actually the beginning of the survey in the facility. While the team coordinator makes introductions and shares the paperwork with the provider leadership, the rest of the survey team begins their observations, interviews, and limited record review. The initial pool process is used to determine which of the initial pool residents should be included in the sample for an in-depth investigation. The process takes about eight to ten hours. At the end of the initial pool process, the survey team identifies the sample based on the results of the initial pool review. The process is pretty straight forward. The remainder of the survey is completing the investigations for all the concerns that require them. While we are working on the facility tasks throughout the process, we need to complete those and the closed record reviews as well.

For those who have had a visit from us with the new process, you've found we are most likely doing much more communicating with residents, families, and your "front line" staff. It's not that we're ignoring anyone, it is just the way the process is driven. If we don't find major problems with previous tasks such as infection control, we're not going to belabor it. The process is pretty much driven by the observations and interviews. Many of the surveyors have found it is much easier to sit down with a staff person and review the necessary record items right alongside them.

Once the survey team has completed all the investigations and assigned tasks, there is review and discussion of potential citations. The system actually pulls the documentation and indicates the most likely citation tag(s). The team determines a compliance as well as scope and severity for individual potential deficiencies.

It has been most interesting with the completed surveys what each team or individual surveyor takes away as exciting. Many of you have shared your takeaways from the experience as well. There is still much to be mined from the new LTC survey process; a year from now I can only imagine the comments from surveyors and providers alike.

Please feel free to contact **Diana Weiland** at (605)995-8057 with questions.

The **provider training** on the new survey process has been released on the Surveyor Training Website. The expected run time for this training is an hour. To access: ***https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSLTCSurProc_LTCProviders***

Special points of interest:

- ***Nursing Home Compare:*** ***http://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1***
- ***CMS S&C's:*** ***http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html***

Infection Control Task with the New Long Term Care

This facility task is used to investigate compliance at F880 (Infection Prevention and Control), F881 (Antibiotic Stewardship Program), and F883 (Influenza and Pneumococcal Immunizations). The Infection Prevention and Control program must be facility wide and include all departments and contracted services. Observation and interview of all staff would include employees, consultants, contractors, volunteers, and others who provide care and services to the residents on behalf of the provider.

One surveyor would be coordinating the facility to task to review:

- The overall Infections Prevention and Control Program.
- Ensure an annual review has been completed on the Infection Control and Prevention policies and practices.
- The review of the surveillance and antibiotic stewardship program.
- The tracking of influenza/ pneumococcal immunization of residents.

The survey team will conduct reviews of laundry services and resident(s) on any transmission-based precautions.

There will be five residents chosen for influenza/pneumococcal immunizations, and any other care-specific observations or concerns that are identified by the team. Every survey team member would assess compliance throughout the survey by observations and interviews.

Hand hygiene is an important area in infection prevention and control. The survey team will ensure staff have implemented standard precautions and the appropriate use of PPE (personal protective equipment). The surveyors will be monitoring for alcohol-based hand rub use and appropriate placement in locations. Those areas may include the following:

- Entrances to resident rooms.
- At the bedside (as appropriate for resident population).
- Individual pocket-sized containers by healthcare personnel.
- Staff work areas.
- Other convenient locations.

Observations will be conducted with direct care staff, professional nursing staff, dietary staff, volunteers, consultants, and contracted staff to ensure appropriate hand hygiene before and after caring for a resident that would include glove use, alcohol-based hand rub, and washing hands with soap and water. Any C. Diff or Norovirus outbreaks will be investigated. Interviews will be conducted with all staff in regards to the availability of hand hygiene supplies and the location of sinks in resident care areas, food and medication preparation areas, and other areas as identified.

The infection control task asks the following questions:

- Did staff implement appropriate hand hygiene?
- Did staff implement appropriate use of PPE?
- Did staff implement appropriate transmission-based precautions?
- Did the facility store, handle, transport, and process linens properly?
- Did the facility develop and implement an overall Infection Prevention and Control Program including policies and procedures that are reviewed annually?
- Did the facility provide appropriate infection surveillance?
- Did the facility conduct ongoing review for antibiotic stewardship?
- Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate?

The infection control task does not direct the survey team to look at the use and cleaning of the provider's whirlpool as previously directed in the old survey procedure for infection control. Surveyors will continue to ask staff about the appropriate cleaning of the whirlpool tub and the shower areas. The environment will still be observed for infection control issues. The New Long Term Care Survey Process focuses on hand hygiene, policy and procedures, antibiotic stewardship program, linens, any transmission-based precautions in use, surveillance of infections, and immunizations. The Critical Element Pathway can be found at https://cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsandRegulations/Nursing-Homes.html.

Skin Integrity/Pressure Ulcers

The new long term care regulations took effect last year along with the New Long Term Care Survey Process (LTCSP).

F686 Skin Integrity/Pressure Ulcers was F314 in the previous regulation text.

The intent of this requirement is that a resident does not develop a pressure ulcer/injury unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- Promote the prevention of pressure ulcer/injury development.
- Promote the health of existing pressure ulcer/ injury (including prevention of infection to the extent possible).
- Prevent development of additional pressure ulcer/ injury.

The computer system will generate those residents who have pressure ulcer/injury based off the information on the individual resident's MDS (Minimum Data Set), and those residents will be investigated if chosen or if during the initial pool process a resident is identified by the health facility surveyor by observation or interview to have pressure ulcer/ injury concerns.

There is a Pressure Ulcer/Injury Critical Element Pathway used in the new LTCSP to investigate pressure ulcer/injury. There will be multiple observations and interviews conducted by the health facility surveyor with direct care staff, professional staff, and family to ensure the interventions in the residents individual comprehensive care plan are followed by all staff. Are there preventative measures in place such as the use of pressure reducing devices and are those devices being used per manufacturer's instructions, is turning and repositioning occurring in a timely manner and is the resident correctly positioned to prevent further injury? Ensure the resident is assessed for pain by the nursing staff, and that dietary and nursing are assessing the nutritional status of the resident. If the resident is refusing or resisting current interventions does the care plan or medical record reflect staff efforts to find alternatives to address the needs identified in the assessment? Unavoidable means that the resident developed a pressure ulcer/injury even though the facility had evaluated the resident's clinical condition and risk factors; defined and implemented interventions that were consistent with the resident's needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Thoroughly document in the medical record and update the individualized resident care plan as the needs, goals, and condition changes. Focus on the individualized person-centered care for each of the residents you serve.

We encourage provider's to become familiar with the Critical Element Pathway for Pressure Ulcer/Injury. This pathway and many others can be accessed at: https://cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsandRegulations/Nursing-Homes.html.

If you have questions regarding the New LTCSP and the Critical Element Pathways please do not hesitate to ask the health facility surveyors.

We are all in this new survey process together.