



# Partnership News & Best Practice

Partnership News

February 2016

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## Welcome

Welcome to the *Partnership News & Best Practice*. The goals of this newsletter are meant to continue open communication and to share information with our partners.

We have received excellent

feedback from many of you including numerous requests to be included on the email list to receive the newsletter.

We hope you will benefit from the information contained within this newsletter. The *Partnership News*

& *Best Practice* is sent via email several times during the year.

Please contact us with questions or comments. We welcome your feedback.

Thank you.

## CMS Team Meets with SD Licensure Staff

The beginning of December the Office of Health Facilities Licensure and Certification hosted a team from the Centers for Medicare and Medicaid Services (CMS). The visit included discussions and updates of survey certification and enforcement activities on the state and national level. The CMS team had the opportunity to meet with all OLC staff during the December 8 - 10 staff meeting. In addition the CMS team met with key stakeholders from partnering organizations of the South Dakota Health Care Association and South Dakota Association of Health Care Organizations, staff from Adult Services and Aging, South Dakota Department of Social Services and other mem-



bers from other partnering organizations.

The CMS team included (l. to r.) staff members Steven Chickering, Associate Regional Administrator, CMS Western Division of

Survey & Certification; Linda Bedker, Branch Manager, CMS Regional Office, Certification & Enforcement; and Robert Casteel, Branch Manager, CMS Region 8 Denver Office.

<http://doh.sd.gov/providers/licensure/>

**Event reporting Link:**

[http://doh.sd.gov/  
providers/licensure/  
complaints.aspx](http://doh.sd.gov/providers/licensure/complaints.aspx)

The Reporting of injuries  
algorithm is located at the  
following link:

[http://doh.sd.gov/  
documents/Providers/  
Licensure/  
Reporting\\_Final.pdf](http://doh.sd.gov/documents/Providers/Licensure/Reporting_Final.pdf)

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## Social Media – How did we live without it? How do we live with it?

Facebook... Twitter...  
LinkedIn... My Space...  
Snapchat... for something  
that has been around for just  
a few short years, social me-  
dia sites sure have created a  
stir.

Social media is a tool, a link,  
a social utility, or a network-  
ing service used by millions  
to “stay connected.”

To many individuals an  
event hasn’t happened un-  
less the world gets a “selfie”  
or some other social media  
posting about it. Postings  
may be thought of as eye  
catching marketing, inno-  
cent pictures and text con-  
tent, or seen as defamatory,  
pornographic, harassing,  
libelous, or something that  
can create an unpleasant  
home or a hostile work  
place.

Social media can be a  
HIPAA nightmare in health  
care facilities when not uti-  
lized appropriately. It can be  
downright ugly when those  
pictures and texts thought  
of as innocent are about a  
person with dementia or  
other infirmity and an image  
of part of their body in com-  
promised positions.

How do we live and work  
with social media? In health

care we are familiar with  
HIPAA; it is covered in eve-  
ry employee handbook. It is  
about protecting individual  
resident or patient infor-  
mation. It would seem social  
media policies are now just  
as necessary as HIPAA.  
While many employers have  
policies restricting employ-  
ees from carrying around  
their electronic devices,  
many employees still have  
them stashed in a jacket  
pocket, “just in case there is  
an emergency.”

Maybe the focus should be  
about courtesy and respect  
for the individual. Educa-  
tion should include a review  
of dignity and privacy of  
confidential information.  
When preparing or revising  
a policy to address social  
media it would be reasonable  
to include:

\*Reminder to staff to famil-  
iarize themselves with their  
employment agreement and  
any confidentiality or  
HIPAA policies included in  
the employee handbook.

\*The use of social media  
carries responsibility that  
include – content posted, the  
audience the posts reach,  
and the potential effects of  
that post. When information  
gets posted on social media,

it does not mean it is abso-  
lutely protected by law.

\*Courtesy and respect of  
those they provide care for  
and those they work with.

Everyone is expected to be  
courteous, polite, and re-  
spectful of those they pro-  
vide care for as well as to  
their fellow co-workers.

\*It may be the time to actu-  
ally enforce any existing  
policies about leaving the  
personal electronic device  
secured in the locker room.

While residents and family  
members may still use their  
electronic devices; there  
should still be education  
about appropriate use.  
When providing education  
for residents and family ask  
them to respect the rights  
and dignity of others. Pho-  
tos may be taken of them-  
selves or of their own family  
member without any re-  
strictions even if the device  
is being used to gather evi-  
dence of poor care. Other  
residents or facility staff  
should not be captured in  
the image.

Social media is not going  
away, we learn to live with it  
by extending mutual courte-  
sy and respect.



## What is an Elopement?

Federal regulation F323 483.25 (h) Accidents and supervision indicates: "An elopement occurs when a resident leaves the premises or a safe area within the premises without staff knowledge or authorization." In the Administrative Rules of South Dakota for LTC 44:73:02:18(6) and for ALC 44:70:02:17(5) Occupant Protection states "... The facility shall take at least the following precautions: (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed."

When a resident leaves the facility through an alarmed exit door; staff respond to the alarm; discover the resident and redirect them back into the facility; the system

has worked. This is not an elopement and would not be reportable to our office.

However, when a resident leaves the facility through an alarmed exit door; the alarm sounded and no one responded to the alarm other than silence it; the resident exited the facility without staff knowledge, that would be an elopement and reportable to our office.

Address the following questions when determining

elopement and reporting:

- ◆ What door did the resident exit through?
- ◆ Was the door attended or alarmed?
- ◆ Was the attendant present or did the alarm sound?
- ◆ Did staff respond to the alarm, did they ensure all residents were accounted for?

Please note, a wander management system is not a substitute for a door alarm system.

## Carbapenem-resistant Enterobacteriaceae (CRE) Update

Please see the new CDC CRE Toolkit just released: CRE Toolkit: <http://www.cdc.gov/hai/organisms/cre/cre-toolkit/index.html>

As a reminder, in July of 2015 South Dakota adopted the new CDC CRE Surveillance definition: CRE are Enterobacteriaceae that are:

Resistant to any carbapenem antimicrobial (i.e., minimum inhibitory concentrations of  $\geq 4$  mcg/ml for doripenem, meropenem, or imipenem OR  $\geq 2$  mcg/ml for ertapenem)

OR · Documented to produce a carbapenemase

CRE is a reportable condition in South Dakota: The South Dakota Department of Health is authorized by SDCL 34-22-12 and ARSD 44:20 to collect and process mandatory reports of com-

municable diseases by physicians, hospitals, laboratories, and institutions. You may find a listing of reportable diseases and conditions here: <https://doh.sd.gov/diseases/infectious/reporting.aspx>

This document updates CDC's Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE): 2012 CRE Toolkit. Unless otherwise specified, the term healthcare facility refers to all acute care hospitals and any long-term care facility that has patients who remain overnight and regularly require medical or nursing care (e.g., maintenance of indwelling devices, intravenous injections, wound care, etc.). This includes all long-term acute care hospitals and nursing homes providing skilled nursing or rehabilitation services, but generally excludes assisted living facilities and nursing homes that do not provide more than

long-term custodial care. In addition, this toolkit is not intended for use in ambulatory care facilities.

Control of resistant organisms is a national problem and requires that facilities that share patients work together to prevent transmission. These efforts may be best coordinated by local public health. Facilities are strongly encouraged to participate in these regional efforts.

The following is a list of the major changes from the 2012 toolkit:

- 1) The CDC CRE surveillance definition has been modified.
- 2) The two intervention tiers have been replaced by a single tier. Not all interventions might be applicable in all settings or situations. Information is provided about situations in

which specific interventions might be most important.

- 3) Further discussion has been added on the use of Contact Precautions in post-acute settings.
- 4) Information on regional interventions has been removed in order to target this document specifically to facilities. Coordinated regional approaches to prevent infections with multidrug-resistant organisms remain important; additional information on these approaches will be made available in other documents.
- 5) Inter-facility communication has been added to the interventions.

Please contact Angela Jackley, RN, Healthcare Associated Infections Program Coordinator at email [angela.jackley@state.sd.us](mailto:angela.jackley@state.sd.us)

*The mission of the South Dakota Department of Health, Office of Health Care Facilities Licensure and Certification is to partner with consumers, families, healthcare providers, healthcare organizations, and other regulatory agencies to ensure the health, safety, and appropriate care of patients and residents in South Dakota.*

## Legislation Review

**House Bill 1025 is an Act to place certain substances on the controlled substances schedule and to declare an emergency.** The South Dakota Department of Health has introduced legislation for the scheduling or deletions of certain proposed controlled substances. This legislation typically mirrors the federal scheduling of controlled substances that has occurred since the last

legislative session. This year's bill, House Bill 1025, proposes to amend certain sections of South Dakota Codified Law 34-20B. The proposed additions or deletions are as follows: 25 new anabolic steroids will be added to Schedule 3; acetyl fentanyl to be added to Schedule 1; naloxegol to be removed from the list of Schedule 2; ioflupane to be removed from Schedule 2;

and eluxadoline to be added to Schedule 4. Naloxegol is a new product which will be used to treat constipation, and eluxadoline is a new product which will be used to treat diarrhea. By adding or deleting these drugs or substances, this will assist in the appropriate use of the medication, and preventing abuse or misuse of the drug or substance identified.



**House Bill 1026 is an Act to revise certain provisions regarding the annual inspection requirement for licensed health care facilities.** Current state law requires all licensed health care facilities (hospitals, nursing homes, assisted living centers, etc.) to be inspected on an annual

basis. However for Medicare/Medicaid certified facilities, CMS dictates the inspection schedule (i.e., hospitals average every 3 years, nursing homes, average every 13 months, etc.). This bill would remove language requiring annual inspection of health care facilities to

reflect the current and accepted practice. While the current inspection frequency will not change, HB 1026 amends §34-12-16 to clarify that periodic inspections of health care facilities will be conducted.

### 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/SurveyCertificationGen-Info/Policy-and-Memos-to-States-and-Regions.html>

*Home Health Compare:*

<https://www.medicare.gov/homehealthcompare/search.html>

**House Bill 1029 is an Act to appropriate money to the Department of Health to fund the rural residency program and to declare an emergency.**

This bill is the result of a recommendation from the Governor's Primary Care Task Force Oversight Committee and would provide

\$205,000 to the DOH to fund start-up of a rural residency track.

**Senate Bill 27 is an Act to revise certain personnel requirements for ambulance services and to repeal the hardship exemption.**

Changes the minimum staffing level required for ambulance calls from two EMTs to one EMT and one driver and repeals the hardship exemption in

statute and the corresponding administrative rules. Requirements for the driver will be established in administrative rule.

The direct link to all Bills is at [http://legis.sd.gov/Legislative\\_Session/Bills/](http://legis.sd.gov/Legislative_Session/Bills/)

## Clarification for 44:73:05:02 Admissions and Physician Delegation of Tasks in Skilled Nursing Facilities and Nursing Facilities

Effective October 13, 2015, in the Administrative Rules of South Dakota (ARSD) 44:73:05:02 recognizes:

Each resident may be admitted only on the order of a physician, physician assistant, or nurse practitioner.

The facility shall follow the physician visit requirements as outlined in the federal regulations for nursing facilities. A physician may not delegate a task when the regulations specify the physician shall perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

The resident shall be seen by the attending physician,

physician assistant, or nurse practitioner at least once every 30 days for the first 90 days following admission. Subsequent to the 90<sup>th</sup> day following admission, the physician, physician assistant, or nurse practitioner shall visit the resident whenever necessary; but the time between visits may not exceed 60 days.

What does all that mean? It may be confusing. You were first introduced to an Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certification/Recertification When Permitted by the State table in S & C: 13-15-NH March 8, 2013. The contents of that S & C

are now incorporated within Federal 483.40 (a) – (f).

These are the Federal regulations that are meant in the State rule.

With the included table please note you as a dually certified (Medicare/Medicaid) provider need to pay particular attention to the differences between the SNF and NF setting as well as those physician assistants or nurse practitioners employed by the facility or not employed by the facility.

Those providers who are SNF only need to pay particular attention to that portion of the table. A physician must provide the ini-

tial and comprehensive visit and orders for admission.

Those providers who are NF only need to pay particular attention to that portion of the table and whether the physician assistant or nurse practitioner is employed by the facility or not employed by the facility.

It is highly recommended a copy of the table be readily available for staff and physician review should questions or concerns arise.

Please contact Diana Weiland at email

[Diana.Weiland@state.sd.us](mailto:Diana.Weiland@state.sd.us) or phone 605.995.8057 with questions or comments.

### S & C: 13-15-NH Physician Delegation of Tasks in Skilled Nursing Facilities and Nursing Facilities

	Initial Comprehensive Visit/Orders	Other Required Visits ^	Other Medically Necessary Visits & Orders +	Certification/Recertification
<b>SNFs</b>				
PA, NP & CNS Employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform & sign	May not sign
PA, NP & CNS Not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform & sign	May sign subject to State require.
<b>NFs</b>				
PA, NP & CNS Employed by the facility	May not perform/ May not sign	May not perform	May perform & sign	Not applicable ~
PA, NP & CNS Not an employee	May perform/ May sign	May perform	May perform & sign	Not applicable ~

- \* ^ Other required visits are the required monthly visits.
- \* + Medically necessary visits may be performed prior to the initial comprehensive visit.
- \* ~ This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

## Professional Standards F281

Infection Control F441 topped the number one federal deficiency in South Dakota for the year 2015 and not far behind F441 was Professional Standards F281.

The intent of F281 is to assure that services that are being provided meet professional standards of quality and are provided by appropriate qualified persons (licensed or certified).

What are professional standards?

- Standards of practice are needed to practice safely.
- Professional standards:
  - \* Outline what the profession expects of its members.
  - \* Reflect a desired and achievable level of performance against which actual performance can be compared.
  - \* Main purpose is to promote, guide, and direct professional nursing practice.
  - \* Provides nurses with a framework for developing competencies.
  - \* Aids in developing a better understanding and respect for the various and complimentary roles that nurses have.

Professionalization of nursing:

Professionalization is the process by which an occupation achieves professional status. The status of nursing as a profession is important because it reflects the value society places on the work of nurses and the centrality of this work to the good of society, a profession is characterized by prolonged education that takes place in a college or university. A professional is autonomous in decision making and is accountable for his or her own actions. The workers are supervised, and ultimate accountability rests with the employer.

Professional standards ensure that the highest level of quality nursing care is promoted. Excellent nursing practice is a reflection of sound ethical standards. Client care requires more than just the application of scientific knowledge. A nurse must be able to think critically, solve problems, and find the best solution for client's needs to assist clients in maintaining, regaining, or improving their health. Critical thinking requires the use of scientifically based and practiced-based criteria for making clinical judgements. These criteria may be scientifically based on research findings or practice based on standards developed by clinical

experts and quality improvement initiatives.

Nursing is not simply a collection of specific skills, and the nurse is not simply a person trained to perform specific tasks. Nursing is a profession. No one factor absolutely differentiates a job or a profession, but the difference is important in terms of how nurses practice. When one can say a person acts "professionally", for example, it is implied that the person is conscientious in actions, knowledgeable in the subject, and responsible to self and others.

Professional standards provide a method to assure clients they are receiving high-quality care, the nurses know exactly what is necessary to provide nursing care, and measures are in place to determine whether the care meets the standards.

Possible reference sources of practice include:

- \* Current manuals or textbooks on nursing, social work, physical therapy, etc.
- \* Standards published by professional organization such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurs-



The most important piece of fire safety equipment in your building is the automatic fire sprinkler system.

It is also one of the most expensive systems to replace.

The proper testing and maintenance of your system ensures fire safety and may lengthen the life of the system.

The National Fire Protection Association (NFPA) publishes NFPA 25 *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems*. This is THE document your facilities maintenance personnel should be using to ensure testing and maintenance is completed correctly. If you don't have this document you may be able to acquire a copy from your fire sprinkler inspection company.

## Professional Standards F281 (continued)

es Association, National Association of Activity Professionals, National Association of Social Work, etc.

- \* Clinical practice guidelines published by the Agency of Health Care Policy and Research.
- \* Current professional journal articles.

During the survey process team members will ensure:

- \* Medication administration is accurate, and the technique of the medication administration is appropriate.
- \* Nurses are notifying physician as appropriate, and show evidence of discussion of acute medical problems.

\* Residents with acute conditions who require intensive monitoring and hospital level treatments that the facility is unable to provide appropriate treatment and services are promptly hospitalized.

\* Staff are following policy and procedures for assuring each resident has a sufficient supply of medication to meet the needs of residents, and staff adhere to the provider's system for reordering medications.

\* Resident assessment and care planning is sufficient to meet the needs of newly admitted residents, prior to completion of the first com-

prehensive assessment and comprehensive care plan.

\* Residents have re-assessments as their condition changes to continue to provide current needs to those individuals.

\* Resident physician's orders are carried out, unless otherwise indicated by an Advanced Directive.

Nursing has a code of ethics that defines the principles by which a nurse provides care to their clients. In addition, nurses incorporate their own values and ethics into practice.

The code of ethics for nurses with interpretive statements provides a guide for carrying

out nursing responsibilities that provide quality nursing care and provides for the ethical obligations of the profession.

In order to ensure quality care the nursing care needs some standards. Standards are degree of excellence. The aim of standard nursing care is to support and contribute to excellent practices. The roll of nurse is constantly changing to meet the growing needs of health services. Practice professionally.

Thank you to all the nurses who go above and beyond their duty to ensure residents have the quality of care they deserve.

References:  
State Operations Manual/  
Appendix PP Long Term Care  
[http://current.nursing.com/nursing\\_management/nursing\\_standards.html](http://current.nursing.com/nursing_management/nursing_standards.html)

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## The South Dakota Department of Health Launches a New Strategic Plan. Learn More at <http://doh.sd.gov/strategicplan/>

The department's mission is to promote, protect and improve the health of all South Dakotans.

The new Strategic Plan offers a roadmap for improving public health over the next five years under the broad goal areas of healthcare accessibility and quality, health across the lifespan, response to public health threats, strategic partnerships, and strengthening the public health infrastructure. Each goal area includes detailed objectives and strategies along with key performance indicators and a commitment to eliminating health disparities cuts across the entire plan.

The strategic plan and supporting materials can found on the department's website at [doh.sd.gov/strategicplan/](http://doh.sd.gov/strategicplan/). As work on the plan proceeds, watch the site for progress reports and trend information on performance indicators. The latest addition at the site is a set of detailed data dashboards for selected indicators—routine physician checkups, infant mortality, smoking, immunizations, and suicide.

The Department of Health looks forward to continued collaboration with the provider community in the many areas where our missions overlap. Working together, we can achieve the vision of Healthy People, Healthy Communities, Healthy South Dakota.

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## Assisted Living Centers

The Spotlight on South Dakota Assisted Living Centers conference will be held March 10, 2016 at the Mitchell Technical Institute from 9:00 a.m. to 4:00 p.m. The conference is partnered by Avera Education & Staffing Solutions, Assisted Living

Association of South Dakota, and South Dakota Department of Health (DOH). Presentations include:

How hearing and vision impact the elderly.

Information regarding unlicensed assistive personnel

from the SD Board of Nursing.

Emergency preparedness from the coordinator of the SD DOH Hospital Preparedness Program.

Assisted Living dietary regulations from the perspective of

a registered dietitian.

The top twelve deficiencies cited in 2015 in the assisted living centers.

Conference registration may be completed online at [www.averasolutions.org](http://www.averasolutions.org) or calling 605-668.8475.

## Reportable Disease List Update

South Dakota Department of Health Licensure and Certification Office require nursing facilities, assisted living centers, hospitals, and ambulatory surgery centers, conduct annual personnel training on incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. The new year 2016 brings updates to the list of South Dakota's mandatory reportable disease and conditions:

Additions:

- Chikungunya.
- Carbon monoxide poisoning.
- Coccidioidomycosis.
- Colorado tick fever.
- Haemophilus influenzae invasive, all subgroups (previously only serogroup b (Hib) was reportable.
- Hantavirus pulmonary infection (in addition to

Hantavirus pulmonary syndrome).

- Lead blood, elevated levels.
- Leptospirosis.
- MERS (Middle East respiratory syndrome).
- Pesticide-related illness or injury (acute).
- Silicosis.
- Vibriosis.
- Active Tuberculosis upgraded to Category I.

Deletions:

- Vancomycin-intermediate Staphylococcus aureus (VISA). (Note that Vancomycin-resistant Staphylococcus aureus [VRSA] remains reportable.)

The full disease list is found at: <http://doh.sd.gov/documents/diseases/infectious/RptDiseaseList.pdf>

## The Bipartisan Budget Act of 2015 Impacts Hospital Outpatient Departments

On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015 (Public Law 114-74). The new law is an update to Section 1833(t) of the Social Security Act (42 U.S.C. 13951(t)). As written the law will impact how Medicare pays for some off-campus hospital departments items and services. Section 603, "Treatment of Off-Campus Outpatient Departments of a Provider" indicates the new law will:

- a. Become effective January 1, 2017.
- b. Not affect a department or provider that was billing for covered outpatient services furnished prior to the enactment date. However, all requirements for such payments must be met.
- c. Exclude certain hospital outpatient department services from the prospective payment system in which predetermined amounts form the basis for payment under Medicare. Services will be excluded from this system if they are furnished by a provider's off-campus outpatient department.
- d. Not be applicable to items and services furnished by a dedicated emergency department.

The Bipartisan Budget Act will not affect facility licensing, this is a reimbursement action by the Centers for Medicare and Medicaid Services. It is recommended by the South Dakota Department of Health, Licensure & Certification Office each provider review the new law to determine its impact on projects or planned projects. In addition, the review should be conducted with legal counsel and contact with your applicable Fiscal Intermediary regarding reimbursement concerns.

The Bipartisan Act of 2015 web link is <https://www.congress.gov/public-laws/114th-congress> or a PDF version can be obtained at <https://www.congress.gov/114/plaws/publ74/PLAW-114publ74.pdf>.