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

Partnership News

& Best Practice

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Welcome

Welcome to the ***Partnership News & Best Practice.*** We hope this newsletter will answer questions and provide information useful as you care for the residents/patients receiving care in your facility. We are happy to announce the development of our new listserv. The listserv was developed in hopes of sharing information with all providers. Interested providers can subscribe at https://listserv.sd.gov/scripts/wa.exe?A0=SDOLC by utilizing the **Subscribe** function found on the right side of the page. Information on licensing, certification, state rules, and federal regulations, and newsletters will be posted on this listserv in the near future.

All future newsletters will be sent out on our new Listserv so be sure to sign up.

Please continue to contact us with questions or comments.

We welcome your feedback.

Nursing Home Compliance with 44:73:04:12. Tuberculin screening requirements.

Tuberculin screening requirements for healthcare workers or residents are as follows:

(1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility.

Two acceptable procedures for conducting the 2-step are as follows:

2-step TB skin test procedure (4 visits)

-Administer the first step on Day 1 and read it at 48-72 hours.

-If negative, administer the 2nd TB skin test at least 7 days after the first and read at 48-72 hours.

-This is probably considered the "gold standard" version.

2-step TB skin test procedure (3 visits)

-Administer the first step on Day 1 and read this test on Day 7.

-If negative, administer the 2nd TB skin test that same day and read at 48-72 hours.

-This version is acceptable because it is based on the theory that a positive TB skin test will most likely persist for at least 7 days and therefore it should still be detectable on Day 7 when it is read. It is commonly done because it allows for some saving of staff time since only 3 nursing visits are required.

It is recommended a facility policy and procedure reflects one or the other as an acceptable practice.

The link to this rule is located at http://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=44:73:04:12

Event reporting Link:

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

MDS 3.0 FAQ (Frequently Asked Questions)

Question 1. Can isolation be coded when two residents with influenza are assigned to the same room?

Answer 1. No. Please note chapter 3 page O-43 in your RAI Manual. It simply states the resident is in the room ALONE because of active infection and cannot have a roommate. You cannot code isolation on the MDS in cases where residents have a roommate.

Question 2. If a resident is admitted to a hospice program and passes away the next day or sooner, should a significant change assessment still be completed?

Answer 2. Chapter 2 of the RAI Manual states you have 14 days to complete the assessment. If the resident dies or is discharged from the hospice program before the deadline the assessment is NOT required. If the resident dies, you do have to complete the death in facility tracking record.

Question 3. If the resident is competently able to be interviewed, and an interview was missed, can we proceed to the staff assessment and code that on the MDS?

Answer 3. No. Missing the resident interview does not allow you to complete the staff assessment. The interview questions should be dash filled.

Question 4. My resident died in the ambulance on the way to ER, what do I do?

Answer 4. Complete the death in facility tracking record. If the resident had been **admitted** to the hospital you would complete a discharge return not anticipated.

Question 5. Is cataract surgery considered a surgical wound?

Answer 5. Section M is about skin only and notes skin ulcers, wounds or lesions, as well as some treatment categories related to skin injury or avoiding injury.

Chapter 3 Page M-39 of the RAI manual specifically states M1200F does not include post-operative care following eye or oral surgery.

Census Status Report questions should be directed to the Department of Social Services. Michelle Hudecek's number is 605.773.3656. We can tell you to make sure the ARD is within the time frames on the CSR.

South Dakota Department of Health

615 East 4th Street
Pierre, SD
57501-1700

Phone: 605.773.3356
Fax: 1.866.539.3886

Did You Know? Preventable medical errors persist as the No. 3 killer in the U.S. – third only to heart disease and cancer – claiming the lives of some **400,000 people** each year.

Critical Access Hospital Reclassifications

The Centers for Medicare and Medicaid Services (CMS) routinely re-evaluates currently certified Critical Access Hospitals (CAH) for compliance with the status and location requirements at 42 CFR 485.610. The evaluation will center on two specific criteria when determining the hospital's ability to remain a CAH:

1. Whether a CAH certified by CMS prior to January 1, 2016 was designated by the State as a necessary provider.
2. The rural and distance requirements for CAHs.

CMS will notify any CAH by mail of their options if the hospital is no longer compliant with the above listed requirements.

Additional information regarding this process can be located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SUrveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html.

If there are questions or concerns please contact Patricia Brinkley via email at patricia.brinkley@state.sd.us or phone (605) 367-5375.

Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Proposed Rule Issues for Fiscal Year (FY) 2017

The Centers for Medicare and Medicaid Services fact sheet dated April 18, 2016 summarizes IPPS and LTCH proposed rule issues for FY 2017. The proposed rules continue to shift Medicare payments from volume to value-based patient care. The Administration goals and timelines continue to move the Medicare program and the health care system towards paying providers based on quality rather than quantity of care given to patients. The fact sheet discusses major provisions of the proposed rule and can be accessed at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets.html.

Life Safety Code Adoption of 2012 Edition

It's here! After many years of work the Centers for Medicare and Medicaid services has finally announced it has amended its fire safety standards adopting 2012 edition of the Life Safety Code.

As of July 5th the 2012 edition will become effective and will be enforced. This code change will affect hospitals, critical access hospitals, long term care facilities, ICF/IID, ambulatory surgery centers, and hospices. As of July 5th our Life Safety Code surveyors will be surveying these facilities to ensure they meet the existing building provisions of the 2012 edition. We currently are enforcing the 2000 edition of the code. On May 6th CMS survey and certification group released S&C: 16-22-LSC which is an announcement and summary of the change. The final rule is published in the Federal Register Volume 81 Number 86. Dated May 4th, 2016. Now is a good time to update your reference material and purchase a 2012 edition of NFPA 101 Life Safety Code.

Code books can be purchased at NFPA.org.

Change of Administrator

Please note, notification in writing of any change of administrator is needed to ensure your licensure information is up to date. References 44:70:04:02 (ALC), 44:73:04:03 (Nursing Home), 44:75:04:03 (Hospital), 44:76:04:04 (ASC).

CLIA Notes

If a change of type of CLIA certificate is being considered, the first step in that process is to contact Connie Richards, Laboratory Certification Advisor. There are several things to consider when changing the type of certificate such as timing and costs that may affect the certificate holder. Please contact Connie at 605-773-3694 or email connie.richards@state.sd.us

A CLIA listserv has been established and interested parties can subscribe at https://listserv.sd.gov/scripts/wa.exe?A0=SDCLIA. All Certificate of Compliance holders will be required to subscribe. It will be the platform for informing laboratories of regulatory changes and expectations. The Subscribe function is found on the right side of the page.

CDC has made available a brochure addressing testing performed under Certificates of Provider Performed Microscopy. The link is http://wwwn.cdc.gov/CLIA/Resources/PPMP/pdf/15_258020-A_Stang_PPMP_Booklet_FINAL.pdf

Package Inserts

Reading package inserts and instrument manuals is one of the most important parts of a laboratory operation. Package inserts often define intended use and specify limitations. If a method is used for other than intended use or outside of the limitations, it then becomes a high complexity method. Additional measures must then be in place such as establishing performance specifications and qualified personnel. The most cited deficiency in 2015 was failing to implement maintenance as required by the manufacturer. The most common maintenance issues not performed were cleaning, lubricating or replacing seals in centrifuges, pipettes, lamps on manual MIC readers, and Renok inoculators at required intervals. Function checks are another manufacturer required component often not performed as required. Some of those were Renok monthly checks, blood banking centrifuge speed/time for optimum blood cell dot formation and suspension, and electrical line leakage and current fluctuation. Other manufacturer specified requirements such as humidity and space are often overlooked and not monitored.

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

Home Health Compare:

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

Rural Health Clinic Notes

RHC: A RHC listserv has been established. Subscribe at https://listserv.sd.gov/scripts/wa.exe?A0=SDRHCLINICS. All South Dakota RHCs will be asked to subscribe. It will be the mechanism to inform providers of regulatory changes and information. The Subscribe function is found on the right side of the page.

Assisted Living Center Notes

South Dakota Department of Health will no longer accept the assisted living administrator's certificate from Senior Living University due to the lack of maintaining current standards of practice. National Center for Assisted Living (NCAL) is reviewing resource options at this point and they would not recommend Senior Living University. At this time the SD Department of Health will only allow the AL administrator's certificate from Easy CEU.

Should you have any questions, please contact Deb Carlson at deb.carlson@state.sd.us or 605-394-1991.

Immediate Jeopardy

Immediate Jeopardy is interpreted as a crisis situation in which the health and safety of an individual (s) is at risk. There are guidelines used to determine if the circumstances pose an Immediate Jeopardy to an individual's health and safety.

The guidelines apply to all certified Medicare/Medicaid entities (excluding CLIA) and to all types of surveys and investigations: certifications, recertification's, revisits, and complaint investigations. "Entity" applies to all Medicare/Medicaid certified providers, suppliers, and facilities. "Surveyor" represents both surveyors and complaint investigators. "Team" represents either a single surveyor or multiple surveyors. The term "Immediate Jeopardy" replaces the terms "Immediate and Serious Threat" for all certified Medicare/Medicaid entities.
The primary goals of the Immediate Jeopardy guidelines are to identify and prevent serious injury, harm, impairment, or death.

The following definitions apply to all certified Medicare/Medicaid entities:
Immediate Jeopardy: "A situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident/patient."

Abuse: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."

Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."

The goal of the survey process is to ensure the provision of quality care to all individuals receiving care or services from a certified Medicare/Medicaid entity. The identification and removal of Immediate Jeopardy, either physical or psychological, is essential to prevent serious harm, injury, impairment, or death for individuals.

*Only one individual needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.

*Serious harm, injury, impairment, or death does not have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the near future also constitutes immediate jeopardy.

*Individuals must not be subjected to abuse by anyone, including, but not limited to, staff, consultants, volunteers, family members, or visitors.

*Serious harm can result from both abuse and neglect.

*Psychological harm is as serious as physical harm.

Upon identifying a situation that may constitute Immediate Jeopardy, the investigation process must continue until it confirms or rules out Immediate Jeopardy. The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the immediate jeopardy situation.

Components of Immediate Jeopardy (IJ):

Harm
Actual- Was there an outcome of harm? Does the harm meet the definition of IJ, has the provider's noncompliance caused serious injury, harm, impairment, or death to a resident/patient?

Potential- Is there a likelihood of potential harm? Does the potential harm meet the definition of IJ? Is the provider's noncompliance likely to cause serious injury, harm, impairment, or death to an individual?

Immediacy
Is the harm or potential harm likely to occur in the very near future to this resident/patient or other in the facility if immediate action is not taken?

Culpability
Did the provider know about the situation? If so when did the provider first become aware of the situation?

Should the provider have known about the situation?

Did the provider thoroughly investigate the circumstances?

Did the provider implement corrective measure when the situation was identified?

Has the provider re-evaluated the measures to ensure the situation was corrected?

All three components of Immediate Jeopardy (Harm, Immediacy, and Culpability) have to be iden-

Immediate Jeopardy *(continued)*

tified in order to call Immediate Jeopardy.

The Department of Health, Office of Licensure and Certification State Agency administration is always consulted by the survey team if Immediate Jeopardy is suspected after a thorough investigation by the survey team into the identified situation.

The State Agency (SA) administration will review the findings with the survey team; if the SA concurs with the team's consensus of Immediate Jeopardy, the SA will inform the Centers of Medicare/Medicaid Regional Office in Denver, Colorado for all Medicare and dually certified providers.

Once the team has decided that Immediate Jeopardy exists, the team will then notify the provider's administration of the Immediate Jeopardy. A verbal notice will be given with specific details, including the individual (s) at risk. The provider then will begin immediate removal of the risk to individual (s), and will immediately implement corrective measures to prevent repeat Immediate Jeopardy situations. The provider will be asked to provide evidence of their implementation of corrective measures.

The notice describing the Immediate Jeopardy will then be delivered to the provider no later than two days from the end of the survey. The form CMS-2567 (statement of deficiencies) will be sent to the provider on or before the tenth working day.

References:

- State Operations Manual
- Appendix Q- Guidelines for Determining Immediate Jeopardy *Rev. 1, 05-21-04*

Coming Soon

The final Federal Long Term Care Rules are scheduled for release in September 2016 with added statutory requirements related to quality assurance, antibiotic stewardship, dementia care and nurse aide training. These new regulation sets are expected to go into affect November 2016.

Required Staffing Data Submission Reminder

Electronic submission of staffing data through the Payroll-Based Journal (PBJ) is required of all long term care facilities beginning July 1, 2016. **ALL** nursing homes are encouraged to register to submit data to prepare to meet this requirement and maintain compliance.

- **Step 1**: Obtain a CMSNet User ID for PBJ individual, corporate and third party users, if you don't already have one for other QIES applications (https://www.qtso.com/cmsnet.html) (many users may already have this access for MDS submission).

- **Step 2**: Obtain a PBJ QIES Provider ID for CASPER Reporting and **PBJ system access** (https://mds.qiesnet.org/mds_home.html)

- **Training**: PBJ training modules for an introduction to the PBJ system and step by step registration instruction are available on QTSO e-University, select the PBJ option https://www.qtso.com/webex/qiesclasses.php

More information is available on the PBJ website. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

Electronic Provider Self-Reporting System — under development

The electronic provider self-reporting system is in the process of revising the online reporting. The pdf format will no longer be available. Faxes will not be permitted. All reporting will be completed online via the South Dakota Department of Health website (http://doh.sd.gov/documents/Providers/Licensure/Initial_DOH_Reporting_Form.pdf) or by using the web based Launchpad application. The Launchpad application is used by all providers for licensing.

The South Dakota Department of Health website is available for staff reporting day or night. The Launchpad application can be used only by the provider assigned staff member. The Launchpad application can be used to file the reports, along with viewing a submission report that lists all the reports that have been submitted for the facility. The Department of Health website does not have the capability to view the submission report.

Providers will need to supply the Department of Health one email address for this new process. Email notifications will be sent to the provider when the report has been accepted or if more information is needed. All the communication will occur via email. This email address will need to be monitored for ongoing communication.

A testing phase will occur with this process change. A few providers will be asked to assist in this testing phase. The South Dakota Department of Health website (http://doh.sd.gov/documents/Providers/Licensure/Reporting_Instructions.pdf.) continues to be a reference to be used for reporting. The criteria for reporting have not changed.

The Department of Health will be offering a web-based training. The topics will be "How to Conduct an Investigation" and "The Reporting Processes." Watch for more information and specific instructions on the new reporting process. The anticipated goal for implementation of this revised online reporting process is July 1, 2016.

Letter of Intent

To assist the Department of Health Licensure and Certification Office in meeting the needs of providers considering establishing a new facility, relocation, reconstruction/remodeling of existing facility the first step is to submit a letter of intent. The letter of intent should describe the structure and function of the proposed project and include at a minimum the following information:

- Facility name, address, and point of contact (please include contact email and phone).
- On-site or off-site construction.
- Construction start date and completion date.
- Occupancy date if a new facility or relocation.
- Changes in services provided or addition of new services.
- Indicate what services will be impacted by the construction/remodeling project.
- Any increase or decrease in bed change.

The letter of intent must be submitted for review by DOH engineers and advisory staff prior to the start of construction/remodeling.

Please address the letter of intent to Chris Qualm, Administrator, Department of Health Care Facilities Licensure and Certification, 615 E 4th Street, Pierre SD 57501 or email chris.qualm@state.sd.us.

Questions or concerns regarding this requirement can be made at (605) 773-3356.

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

ServSafe Course Training

It has been brought to our attention there may be some confusion regarding the ServSafe course training requirements. The Office of Health Care Facilities Licensure and Certification, (OLC), will only accept the certified 8 hour ServSafe course followed by an exam for initial training. Re-certification requirements will be another 8 hours training and by taking the exam or by taking the exam only. We will always require a nationally recognized exam at the end of the training whether it is initial or re-certification.

The compromised health of our residents/clients/patients require us to use due diligence and require the national ServSafe test to complete the initial and the recertification of the ServSafe course.

Should you have any concerns or questions, please do not hesitate to contact Cindy Koopman Viergets, REHS, Senior Health Facilities Surveyor/Sanitarian at email cindy.koopmanviergets@state.sd.us.

Applications Open for Rural Health Recruitment Program

A state program that helps rural medical facilities recruit pharmacists, physical therapists and other health professionals is now accepting applications.

The Rural Healthcare Facility Recruitment Assistance Program provides $10,000 incentive payments to eligible health professionals who complete three-year service commitments in communities no larger than 10,000 people. The state Department of Health and the employing facility split the cost of the incentive, with facilities in smaller communities paying a smaller share. The department pays 75 percent of the cost for communities up to 2,500 people and 50 percent for those larger than 2,500.

“Medical facilities in South Dakota’s rural areas face ongoing challenges in maintaining the necessary workforce,” said Halley Lee, administrator of rural health for the department. “This incentive program is just one tool that facilities have used successfully to recruit professionals from nurses to pharmacists.”

Since its launch in 2012 the program has helped place 239 applicants in hospitals, nursing facilities, community health centers and home health agencies in 55 South Dakota towns. Participating health professionals have included nurses, occupational therapists, physical therapists, paramedics, pharmacists, respiratory therapists, dietitians, medical laboratory professionals and radiologic technologists.

Applications must be submitted by the employing health facility. New this year, ambulance services, healthcare social workers and speech therapists are eligible to use the program. Application forms and additional information can be found on the department’s website, http://ruralhealth.sd.gov.