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

Partnership News

& Best Practice

SOUTH DAKOTA
DEPARTMENT OF HEALTH

Partnership News   **November 2015**

Special points of interest:

- *Nursing Home Compare:*

  http:// www.medicare.gov/ nursinghomecompare/? AspxAutoDetectCook- ieSupport=1

- *CMS S&C's: http://www.cms.gov/ Medicare/Provider- Enrollment-and- Certification/ SurveyCertification- GenInfo/Policy-and- Memos-to-States-and- Regions.html*

- *Home Health Compare:*

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

Welcome

Welcome to the second edition of the Office of Health Care Licensure and Certification newsletter, *Partnership News & Best Practice.* The goals of this newsletter are to continue open communication and to share information with our partners.

We hope you will benefit from the information contained within this newsletter. The *Partnership News* will be sent via email several times during the year.

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

Thank you.

South Dakota Board of Nursing Medication Aide Registry

The South Dakota Board of Nursing (SDBON) implemented the Medication Aide Registry as of May 1, 2015. These rules were adopted pursuant to ARSD 20:48:04.01 in July 2014 to initiate a registry for medication aides who have completed a SDBON approved 20-hour medication administration training program. Registry status implies only that an unlicensed individual has met the minimal training and testing requirements necessary to accept the delegated task of medication administration by a licensed registered nurse or licensed practical nurse while under nurse supervision. Registry status does NOT imply that an individual has met moral, ethical, or legal standards. The Medication Aide Registry should not take the place of an employer's hiring screening

process or background check or the individual's competency to administer medications.

The direct link to the SDBON Medication Aide information is **http:// doh.sd.gov/boards/nursing/ MATPApproval.aspx**. This link includes information for the current approved 20-hour programs, Medication Aide registration, application forms, ARSD 20:48:04.01, and the Delegation Decision-Making Algorithm.

Approved SDBON medication administration training programs all have required forms the provider is expected to maintain for all individuals the registered nurse trains.

The required SDBON forms to be used may be located at

the following link: **http:// doh.sd.gov/boards/nursing/ assets/ ClinicalSkillsChecklist.pdf.**

The provider may choose to use in addition with the SDBON form their facility specific form for documenting competency.

The direct link to the SDBON is http://doh.sd.gov/ boards/nursing/. For more information on medication aide training programs requirements and the registry please contact Stephanie Orth at **Stepha- nie.orth@state.sd.us.**

For information on UDA (unlicensed diabetes assistant) training and requirements please contact Linda Young at **Lin- da.young@state.sd.us**.

Acceptable Plan of Correction for Cited Deficiencies

As many of you may have noticed lately our office recently had a policy change with regard to obtaining an "acceptable" plan of correction (POC). If your POC lacks a majority of the necessary components required for a plan of correction, we are returning the CMS-2567 (deficiency document) to you with a letter outlining what is missing for each deficiency. We ask that you review each comment and make additions to your POC as necessary.

For guidance please refer to the items below that need to be included in every POC:

Address how corrective action will be accomplished for those residents/patients found to have been affected by the deficient practice. Describe the corrective action for each finding including the specific resident/patient.

Address how the facility will identify other residents/patients having the potential to be affected by the same deficient practice.

Address what measures will be put into place or systemic changes that were made to ensure the deficient practice will not recur.

The facility must develop a plan for ensuring correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction must be integrated into the quality assurance system. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The monitoring must address:

__What__ **data** will be audited/monitored/reviewed to measure the effectiveness of the system change(s)?

__Who__ will do the monitoring? Use **position titles**, not specific names.

__When__ (**how often and for how long**) will the monitoring be done? This must be measurable for effectiveness. Avoid words like periodically, frequently, ongoing, or randomly.

__How__ will the monitoring be included in the provider's **quality assessment system** (i.e. who will report the results of the monitoring, how often will it be reported, and to whom will it be reported __including__ the Quality Improvement committee/quality assessment system in your facility).

Each deficiency requires a date when the corrective action will be completed. This date needs to be entered into the column labeled **(X5) Completion Date**. Please include only **one** date per each deficient practice. This date should be the last date that you expect the deficient practice to be corrected and must not exceed the date as outlined in the original letter that was mailed to you.

Attachments **may not** be referred to in the POC. Summarize any needed content of attachments within the POC.

The administrator/manager's signature, title, and date must be an original and in ink on Page 1 of each CMS-2567. If no deficiencies were cited, the CMS-2567 must still be returned to our office with the administrator/manager's signature, title, and date.

We are here to assist you with any questions you may have regarding the required components of an acceptable POC. Please feel free to contact our office at 605.773.3356.

Assisted Living Centers—Administrative Rules Update

The South Dakota Department of Health, Office of Health Care Facilities Licensure and Certification, has developed this website to allow the public access to the draft administrative rules regulating assisted living centers, prior to the initiation of the formal rules promulgation process which is planned for the spring of 2016.

 To access the draft administrative rules as well as a summary of the major changes proposed, please use the links below. **Only those sections with changes are presented.**

44:70 Assisted Living Centers draft rules: **http://doh.sd.gov/documents/Providers/Licensure/DRAFT-4470-ALC.pdf**

 Summary of changes: **http://doh.sd.gov/documents/**Providers/Licensure/ALC-Rule-Changes.pdf

If you have any questions or feedback please feel free to contact Chris Qualm at **chris.qualm@state.sd.us** or at 605.773.3356. Questions can also be faxed to 605.773.6667, attention Chris Qualm, Program Administrator, Office of Health Care Facilities Licensure and Certification.

Notifications required for any provider holding a CLIA (Clinical Laboratory Improvement Amendment)

Hospitals, nursing homes, assisted living centers, and all other providers holding a Certificate of Waiver: Per federal regulation, CFR 493.39, notify the state agency **within 30 days** when changes in director, name, ownership, and address occur. Notification also has to be made when a certificate is no longer needed.

Email Connie Richards at **connie.richards@state.sd.us**. Also contact Connie when any laboratory or certificate questions or concerns arise.

Retail Food Protection Email Updates and More

FDA is now able to send out email updates on selected FDA posts, such as such as new Food Code Reference System entries, Program Standards information and more on the Retail Food Protection website. You will need to subscribe to this service by following the directions at the last link. In addition, we will be featuring a sign-up link on the following Retail Food Protection webpages:

 Retail Food Protection main page – **http://www.fda.gov/RetailFoodProtection**

Food Code main page – **http://www.fda.gov/FoodCode**

Oral Culture Learner Project main page- **http://www.fda.gov/foodemployeetraining**

Program Standards main page – **http://www.fda.gov/retailprogramstandards**

Food Code Reference System main page - **http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm391534.htm**

This is the direct link to subscribing **https://public.govdelivery.com/accounts/USFDA/subscriber/new?topic_id=USFDA_426**

Please sign up and share this link with your stakeholders!

CDC Recommends All Nursing Homes Implement Core Elements to Improve Antibiotic Use

New recommendations from the Centers for Disease Control and Prevention (CDC) advise all nursing homes to improve antibiotic prescribing practices and reduce their inappropriate use to protect residents from the consequences of antibiotic-resistant infections, such as *C. difficile.*

To guide these improvements, CDC released a new resource: ***Core Elements of Antibiotic Stewardship for Nursing Homes.*** The Core Elements for Nursing Homes expand upon **CDC's recommendation last year**

that all acute care hospitals implement an antibiotic stewardship program designed to optimize treatment of infections while reducing adverse events associated with antibiotic use.

Approximately 4.1 million Americans are admitted to or reside in nursing homes each year.[1] Antibiotics are the most frequently prescribed medications in nursing homes. Up to 70 percent of residents receive one or more courses of antibiotics during a year.[2,3] Up to 75 percent of antibiotics prescribed in nursing homes are

given incorrectly, meaning either the drug is unnecessary or the prescription is for the wrong drug, dose, or duration.[2,3]

"Superbugs that are hard to treat pose a health risk to all Americans, particularly the elderly whose bodies don't fight infection as well," said CDC Director Tom Frieden, M.D., M.P.H. "One way to keep older Americans safe from these superbugs is to make sure antibiotics are used appropriately all the time and everywhere, particularly in nursing homes."

INFECTION CONTROL F441

Infection Control F441 in Appendix PP was the top deficient practice in South Dakota cited in long term care from 5/1/14 through 5/28/15. An infection control program consists of surveillance (monitoring information that would relate to the spreading of infections or disease), investigation, prevention, control of the infection, and reporting those infections to the appropriate entity. The infection control program should provide a safe, sanitary, and comfortable environment to help prevent the development and the transmission of infections.

The provider must identify personnel who will be responsible for the oversight of the infection control pro-

gram.

Infection control program oversight should include:

*Developing and implementing appropriate infection control policies and procedures.

*The initial training and continued training of all staff.

*A process by which the program can monitor and document infections.

*A process by which the program can track and analyze those infections.

*How that surveillance resolved the issues of the infections.

*Continuing communication to staff, residents, and family regarding the findings of

the surveillance.

The components of an Infection Control Program would include the following:

*Policies, procedures, and practices which promote consistent adherence to evidence based infection control practices in an interdisciplinary approach.

-The responsible person for oversight of the program should review the current policy and procedures for infection control practice and revise those policy and procedures as needed.

*The program must have oversights which include planning, organizing, implementing, operating, monitoring, and maintaining all the elements of the program.

INFECTION CONTROL F441 *(continued from page 4)*

Acute Care Hospital Update

Effective 7/10/15, CMS guidelines for Appendix A for acute care hospitals made changes to the conditions of participation for radiologic and nuclear medicine services. A notable change is policies and procedures must be modeled after adopted professional standards. Please go to **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf** to review other guideline changes.

ALCs should have an effective infection control program that follow similar practices as the long term care providers. Refer to 44:70:02:09 Infection prevention and control.

*The entire interdisciplinary team must be involved in infection prevention and control of those infections.

*Surveillance (monitoring, data collection, analysis of the data collected, documentation, and the plan put in place to promote effective and consistent infection control practices.

*Education of ALL staff and the continued training of all staff. Infection control log of all the staff that has completed the education and the on-going education regarding infection control practices.

*The responsible person for oversight of the program should have a system in place to notify the Department of Health of any communicable disease.

*All staff should be aware of the procedures that would be put in place in case of an infectious break-out.

*All staff should be aware of Clostridium Difficile (C. Diff [highly infectious diarrhea]), or at least know where to find the information if there was to a break-out of that infection.

The areas we as health facility surveyors are looking at during the survey process:

*Observations:

- We are observing various disciplines such as dietary, nursing, and housekeeping to determine if all staff is following appropriate infec-

tion control practices.

-Medication administration, dressing changes, glucometer use (following manufacturer's recommendations), cleaning and sanitizing of whirlpools, tubs, and showers (following the manufacturer's recommendations, leaving the appropriate cleaner and/or disinfectant on the surface for the suggested time), when you clean those whirlpools, tubs and showers after each use and how you clean after the end of the day.

-How and when housekeeping cleans resident rooms and, how often they change the mop water, what particular cleaning and/or disinfecting agent they are using and for what purpose. To make sure staff are following manufacturer's recommendation.

-Are all staff wearing the appropriate PPE (personal protective equipment) when entering a resident's room? We are observing for the appropriate washing or sanitizing of hands before and after glove use.

-We are observing clean and soiled linen handling, how it is processed, transported and stored to prevent any contamination or transmission of infections.

-Employees who are ill are not in contact with the resident of the resident's food.

-We are observing residents with special precautions.

*Record review:

-Documentation of how the program collects, analyzes, and uses the data, and implements a program to guide all disciplines to prevent the spread of infection and to appropriately identify infections.

-Employee and resident records are reviewed for immunizations, TB, free from communicable diseases, and looking for the initial and on-going infection control training.

*Interview:

*The designated person for the oversight of the infection control program will be interviewed in regards to the training you have received, how many hours you spend on the infection control program, and what standards of practice you base your infection control program on.

*Random interdisciplinary staff will be interviewed regarding their knowledge and the policies and procedures of the infection control program.

*All the policies and procedures of the infection control program will be reviewed.

The infection control program is vital to the continued safety and well-being of the resident's, staff, and visitors. As you can see infection control is more than a program and has to have a team approach.

How To Code Urinary Tract Infections (UTIs) On The MDS

For coding UTI (I2300), there are guidelines outlined *in the RAI manual* for determining whether this diagnosis is active <u>in the last 30 days</u>. It is important to note the look-back for this item; it is not the traditional seven days as in the rest of section I, "Active Diagnoses," nor does the item have the same rules and guidance. There are a total of **four** criteria that <u>must</u> be met to code I2300 as an active diagnosis. They are as follows (*RAI User's Manual*, chap. 3, p. I-8):

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI <u>in last 30 days</u>,

2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),

3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and

Current medication or treatment for a UTI in the last 30 days.

All four of the following requirements must be met.
*Diagnosis—most times, the diagnosis for UTI is missing in the clinical record. A common question is whether this diagnosis must be obtained on or before the assessment reference date (ARD). The short answer is **yes.** Since this item has a 30-day look-back period, information that is collected should be on or before the ARD. If the diagnosis is missing, I2300 Urinary Tract Infection is not coded on the MDS.
*Sign or Symptom—a common misconception is that there needs to be more than one sign or symptom present. In fact, if a resident has only a single sign or symptom, this requirement is met. Since the look-back period is 30 days, review all hospital and clinic records as well. By interviewing the resident, staff, and family members, you can acquire information that may not be noted in the clinical record. If no signs or symptoms of a UTI had been present, I2300 is not coded on the MDS.
*Significant Laboratory Findings—this is an area that causes a lot of confusion. Many facilities are under the impression that to be "significant," there **must** be a culture with greater than

100,000 of an organism, indicating an infection. The RAI does **not** define *significant* in that way. A resident could have an abnormal urinalysis (U/A) and meet the definition of significant. It would be up to the physician to determine whether a culture was needed to assist with prescribing an antibiotic. If there are no significant laboratory findings, I2300 is not coded on the MDS.
*Current Medication or Treatment—Physicians (or other advanced practitioners, as permitted by state regulations) are able to prescribe medications and/or treatments for UTIs and other conditions. Most medications are captured in section N, "Medications," and have a 7-day look-back window. UTI, in section I, has a 30-day look-back window, creating the possibility that the information may be captured during a hospital stay. A resident could conceivably have a UTI in the hospital, receive an antibiotic, and become free of the infection during the look-back period. If **all four** conditions were met, I2300 would need to be coded, even though the resident does not have an active infection. If there is no evidence that a medication or treatment was present in the look-back window, I2300 is not coded on the MDS.