Partnership News
& Best Practices

Office of Health Facilities Licensure & Certification

SD Department of Health | November 2023, Partnership News

A: 600 E Capitol Ave. Pierre, SD 57501 | P: 605.773.3356

CONTENTS:

Residential Living Center Annual Registration Renewal

Julie Jenssen

On December 1, 2023, the annual Residential Living Center registration renewals for the 2024 calendar year will be emailed to providers. Please watch for an email from DOHOLCLicensing@state.sd.us outlining the renewal process. As a reminder, our renewal process is completely electronic, and forms must be completed and submitted online. No paper renewal forms are available.

If you have any questions, please contact Jennifer Maeschen or Julie Jenssen at 605-773-3356.

Radiation Annual License Renewal

John Priest

On December 1, 2023, the annual Radiation license renewals for the February 1, 2024, through January 31, 2025 licensing year will be emailed to providers. Please watch for an email from donotreply@sdhls.org or DOHOLCRadiation@state.sd.us outlining the renewal process. Radiation licenses must be renewed and paid for electronically. Please note, our credit card system only accepts Mastercard and Visa.

If you have any questions, please contact John Priest at 605-367-5672 or 605-201-3928 or Melissa Slaba at 605-773-4065.

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Office of Health Facilities Licensure & Certification List Serv

Incident Reporting

Shelly Walstead, RN, Complaint Advisor

The SD Department of Health, Office of Licensure and Certification reviews all incident reports submitted through the online portal for potential issues involving abuse, neglect, or misappropriation of resident property and/or funds.

The Centers for Medicare and Medicaid Services (CMS) has made updates to facility reported incidents (FRIs) in *Chapter 5 - Complaint Procedures* of the State Operations Manual (SOM). Changes went into effect October 1, 2023.

For initial reports, *Chapter 5 – Complaint Procedures* of the SOM, §483.12(c)(1) states "Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury…"

A facility must provide sufficient information to describe the alleged violation and provide indication of how the resident(s) are being protected. As a result, at minimum, the state agency is looking for the following information in the initial report.

1. Type of allegation: abuse (physical, sexual, mental/verbal), neglect, misappropriation, injury, or unknown source
2. Time and date the facility become aware of incident
3. Alleged victim(s)
4. Alleged perpetrator(s)
5. Details of the event, for example but not limited to:
    a. Who was involved in the event? Who was notified of the event?
    b. What was the situation?
    c. When did the event occur?
    d. Where did the event occur?
6. If any physical harm, pain, or mental anguish occurred
7. If the resident is protected and how
    a. Did the resident need medical intervention and was it provided?
    b. Does the resident feel safe? Did they need a room relocation and/or increased supervision?
    c. Were the physician and resident representative notified?
    d. If the perpetrator was staff or a visitor, were they removed from victim and other residents?
    e. Was law enforcement notified?

Please contact the complaint coordinators if you have any questions. We will also be scheduling several webinars in the upcoming weeks related to the changes. Dates and times to be announced.

COMPLAINTS DEPARTMENT CONTACT INFORMATION:

Email Address: doholccomplaint@state.sd.us
Shelly Walstead: 605-367-4640
Juli Van Engen: 605-367-4603
Jolene Juneau: 605-773-6373

RN Waiver Request Process

Diana Weiland, RN, Nursing Home Advisor

The Office of Licensure and Certification has received several questions related to RN staffing requirements as a result of the Study Committee on Sustainable Models of Long Term Care workgroup meetings and would like to share the following information for awareness.

There is not a form required to initiate the RN waiver request process. The request is typically through email or by phone call. This process has been determined to expedite coordinated communication with providers, the Department of Health, and Centers for Medicare and Medicaid Services (CMS).

If a facility is unable to meet the staffing requirements of federal regulation 483.35 (a)-(b), the provider should contact the long-term care advisor via phone or email and discuss their staffing challenges and efforts. The LTC advisor will discuss the process for obtaining an RN waiver as indicated in federal Regulation 483.35 (e)-(f) F731 Nursing facilities.

To determine approval of an RN waiver, the Department of Health (DOH) will request the information below. It should be noted that the same information is requested for SNF and NF.

1. Number of full-time [full-time 36 or 40 hours per week], part-time, and any agency RNs, LPNs, and CNAs.
2. Attempts to recruit and retain staff [advertising, bonuses, job fairs, etc.].
3. Number of healthcare providers [other LTCs, ALCs, clinics, hospitals, etc.] within 50-75 miles of the facility.
4. Medical director acknowledgement of the provider's staffing situation and no identified resident care need requiring an RN 7 days per week. The provider must commit to the ability to provide an RN on-call if needed for care concern response.
5. Current list of residents on a Medicare A stay.

Once the DOH receives the requested information, the DOH will conduct a thorough review of the information in comparison to the last 2 years of survey history.

1. If the requesting provider is a NF and meets the criteria for an RN waiver, the DOH may prepare a waiver and notify the CMS Regional Office of approval by the DOH. The DOH will notify the provider of approval or disapproval through letter to the provider.
2. If the requesting provider is a SNF, the DOH will prepare a summary letter based on information gathered in comparison to the last 2 years of survey history and will prepare a summary letter for recommendation and request to the CMS Regional Office (RO). CMS is responsible for the approval of RN waivers in SNF. Acknowledgement from the CMS RO indicating a waiver may be granted prompts the DOH to prepare an approval letter to be sent to the provider.

The provider must agree to the following:

1. Have a full-time RN regularly on duty 40 hours a week [DON].
2. An RN or physician is obligated and available to respond to phone calls from the facility.
3. Residents and their representatives must be notified of the waiver.
4. Request waiver in writing annually as long as needed.

Federally, providers are required to submit their staffing data into the Payroll Based Journal (PBJ) on a fiscal quarterly basis. If a provider has seven (7) days per quarter without 8 hours per day of RN coverage, the provider receives a 1 Star rating for staffing. It should be noted that the RN waiver does not stop the impact on the Nursing Home Compare staffing rating. The RN waiver is only in place to prevent citation of inability to meet federal RN staffing requirements.

Proficiency Testing Failure – Now what do you Do?

Denise Broadbent MT, ASCP, Laboratory Certification Advisor

You just reviewed your latest proficiency test (PT) results and you had unacceptable and/or ungraded results. The CLIA regulations require laboratories to investigate and document the finding of their investigations for all results not graded acceptable.

Often facilities will repeat the sample and if the results are within the acceptable range, it is assumed that all is great and well – it was just a random error! Random error does occur, but was it actually a random error? Repeat testing of the sample verifies everything is working well today. What about when the samples were originally tested a month or two ago? Was the test method accurate that day? Were patient specimen's results run before and after that day accurate? How do you know the issue leading to the PT failure has been corrected? Are you sure you will pass your next testing event?

Failing 2 out of 3 PT testing events could lead to a condition level deficiency. Failing 3 out of 4 could require the laboratory to cease testing the affected analyte/subspecialty/specialty for a minimum of 6 months. During which time you would need to successfully complete 2 remedial PT events before the Centers for Medicare and Medicaid Services (CMS) would allow the laboratory to begin testing patient specimens again. What if it were a critical analyte such as glucose or PO2, or a specialty like Hematology?
Most companies that provide PT samples have a worksheet or checklist to assist you with your investigation. Following the checklist could help you identify the underlying cause of the failure or rule out all other potential causes, including random error.

CLERICAL ERROR: Were the results transcribed correctly? Was the correct analyzer code entered? Are the results entered with the appropriate units of measurement, for example mg/dl or mEq/L?

SPECIMEN HANDLING: Were the PT samples received in acceptable conditions (too hot, frozen, hemolyzed)? Were the PT samples handled and stored appropriately? Follow the PT company's instructions for storage and handling of your PT samples. If necessary, were the specimens reconstituted correctly using the correct amount of the correct diluent? Were the samples tested within the allowed timeframe for analysis? Some analytes are unstable and must be tested within a limited number of hours.

QUALITY CONTROL: Were controls within acceptable range the day of testing? What about immediately before and after? Was there a shift or trend in QC during that time frame? Was the QC material expired? Was the QC material's open date stability exceeded?

CALIBRATION: Was the last calibration acceptable? Was calibration due or overdue at the time of testing? Was the reagent lot in use at the time of testing calibrated?

ANALYZER: Were there any issues noted with the analyzer the day of testing? What about immediately before or after the day of testing? Was required maintenance up to date? Was the next calibration successful?

REAGENTS/TEST SUPPLIES: Were the reagents expired? Had the reagent's open date stability been exceeded? Were the reagents stored properly? Had there been a recent change in the manufacturer's instructions for use?

CULTURE SAMPLES: Was the appropriate media set up based on the specimen's source? Was the media expired? How had the media been stored? Had the media passed sterility and growth checks? Were the plates incubated at the proper temperature in the proper atmosphere and humidity levels?

Proficiency Testing Failure – Now what do you do? Cont'd

You are required to document all steps in your investigation of unsuccessful PT performance in your PT testing documentation. If in doubt at the end of the investigation, contact the manufacturer of the analyzer, reagents, or test kit. Has anyone else reported issues?

Once you have determined the issue, document your corrective action(s). If the issue could have potentially affected patient results, you will need to review all results reported during that time frame and if necessary, notify the provider(s) of the potential affect(s) the issue may have had on patient test results. Unsuccessful PT performance has many potential causes and some potentially serious consequences. How certain are you that it was just a random error?

Residents receiving hospice services in an Assisted Living Center

Jennifer Maeschen, RN, Assisted Living Advisor

The Office of Licensure and Certification (OLC) occasionally receives inquiries regarding hospice residents in an assisted living center (ALC) and the administrative rules of South Dakota (ARSD) that relate to the additional services. A primary goal of our office is to ensure the health, safety, and quality of care of South Dakota's residents. Through partnership with providers, we ensure quality health care for ALC residents, including for those receiving hospice care, and we ensure licensed ALC facilities follow the ARSD.

Each ALC should only accept and retain residents based on their facility's licensed services and their staff's ability to care for those residents safely and effectively. The ALC must have policies and procedures that provide guidance to their staff for the care and services provided in the facility. Staff must be trained and/or qualified to perform their assigned tasks to ensure safe and effective care for all residents. Each ALC is responsible to meet their residents' needs from the time they are admitted until discharge. When a resident is receiving hospice services in an ALC, hospice staff visits are in addition to the ALC's staff and services. Typically, hospice staff are not available to assist with the resident's care daily. Therefore, the ALC needs to ensure they can meet the residents' needs overall and in-between hospice staff's visits.

We encourage you to consider your staffs' training and qualifications. That includes reviewing the differences and quality of training that your staff may receive based on their background, role in the facility, their certifications or licenses (if applicable), and their on-the-job training. Let's review some staff roles in an ALC setting.

- Most ALCs employ **unlicensed medication aides** (UMAs) as the main caregivers in their facilities. UMAs receive training specific to medication administration and are delegated the task of medication administration by the licensed nurse. UMAs do not receive training to assist residents with activities of daily living (ADLs) as part of their certification.
- **Licensed nurses** and other licensed professionals have training and knowledge based on their specific license's rules and laws. Most ALCs do not have a licensed nurse working onsite 24/7. In some ALCs the nurse may work limited hours and is not readily available to the unlicensed staff who are responsible to provide the daily care needs for residents.
- Other **unlicensed staff** in an ALC may be called caregivers, assistants, techs, or another title. These staff may only receive training within 30 days of their hire date and then annually for the topics required within ARSD 44:70:04:04. Some of these unlicensed staff may receive additional training depending on each facility's training program. Often, the unlicensed staff's training does not include providing care for residents who require ADL assistance which is likely what hospice residents will need.

Residents receiving hospice services in an Assisted Living Center Cont'd

- Some ALCs employ **certified nursing assistants (CNAs)**. Through our surveys it seems most ALCs do not regularly employ CNAs. CNAs may have been certified prior to being hired or the ALC may have a CNA training program. Please note, these CNAs have received a more thorough training through a CNA training program for resident care areas such as assisting with personal care and ADLs (dressing, hygiene, toileting, bathing, etc.), safe transfers, and many other topics. CNAs are also required to be a part of a state registry for their certification.

Please review your facility's staffing to ensure the residents are receiving safe and effective care by appropriately trained and qualified individuals.

In relation to the staff's training and competence in caring for residents on hospice services it is important to note that hospice residents typically decline as part of their health condition(s). These residents may need assistance with some or all ADLs as their status changes. If the unlicensed staff are assisting residents who require ADL assistance due to the resident's inability to perform those tasks on their own, the facility needs to determine if those staff have been trained and if they are competent to perform the tasks safely. Ultimately, it should be up to the nurse to determine if certain tasks are appropriate to delegate and if the staff performing the tasks are competent. Unlicensed nursing staff, including the roles identified above, work under the delegation and supervision of a licensed nurse. Nursing delegation should be done according to the SD Board of Nursing guidance and rules. You may refer to the Board of Nursing website for more information.

Hospice services according to ARSD 44:79:01:01(14) is defined as a coordinated interdisciplinary program of health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill resident and the resident's family. The needs may arise out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and include formal bereavement programs as an essential component.

Keep in mind, if the word hospice is not mentioned in a specific ARSD, it does not mean the rule does not relate to that type of service. Below are some ARSD requirements that are directly or indirectly related to hospice and the care of residents:

- 44:70:01:05. Acceptance and retention of residents.
- 44:70:04:03. Personnel.
- 44:70:04:04. Personnel training.
- 44:70:04:06. Admissions or retention of residents.
- 44:70:04:11. Care policies.
- 44:70:04:13. Resident admissions.
- 44:70:05:01. Nursing policies and procedures.
- 44:70:05:02. Resident care plans, service plans, and programs.
- 44:70:05:03. Resident care.
- 44:70:05:05. Hospice services.
- 44:70:05:06. Total activities of daily living assistance.
- 44:70:06:18. Dining assistance program.
- 44:70:08:01. Record service.
- 44:70:09:07. Choice in planning care.
- 44:70:09:09. Quality of life.

Residents receiving hospice services in an Assisted Living Center Cont'd

Note - ARSD 44:70:05:05, 44:70:05:06, and 44:70:06:18 are additional services that require the facility to be licensed with specification of these additional services. If approved, the additional service(s) will be listed on the printed license.

As previously mentioned, hospice residents' health status typically declines resulting in additional assistance needed from staff. Some key questions to ask yourselves would be:

- Do we have sufficient staff to meet all residents' needs?
- Have the staff been trained to meet the resident's needs in addition to the facility's licensed additional services, including hospice related services? Is that training documented?
- Prior to or when a resident's decline in condition and abilities occurs, do the staff need additional training and/or qualifications to meet those needs safely and effectively?
- Has the facility reviewed ARSD 44:70:05:06 and 44:70:06:18 requirements to ensure one or both are being followed, if residents require that type of care?
- Does the current facility license list the additional services you are providing (if applicable)?
- Does the facility have an effective and prompt discharge plan in place if the facility is not able to meet a resident's additional needs to always ensure safe care of the resident?
- Is discharge planning coordinated to ensure the resident is transferred or discharged to an appropriate setting that can meet their individualized needs? Is the discharge planning documented?

If your facility is planning to add care of a resident on hospice services to your license, please inform our office so we can update our records and your license. If your facility is already providing care to hospice residents, then this information is a good refresher. We want to ensure safe and effective care to all residents accepted and retained at a facility while also following the requirements for ARSD. We hope this information is helpful to those navigating this area in an ALC setting. For questions, contact Jennifer Maeschen.

Foodborne Bacteria Becoming Antibiotic Resistant: The Importance of Infection Control in Food Service

Rachel Landmark, MS, RD, LN, Health Facilities Surveyor

When surveying a facility, we are constantly observing for breaks in infection control. Not only in patient and resident rooms, but especially in less thought of places that are often forgotten.

The kitchen may not be the first place you think of when considering infection control. However, we must keep food preparation and food safety at our forethought when strategizing infection prevention and control practices.

One of the top 10 cited nursing home citations in South Dakota is F812: Food Procurement, Store/Prepare/ Serve-Sanitary. In review of the regulation verbiage:

> §483.60(i) Food safety requirements.
> The facility must –
> §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
>
> (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

Foodborne Bacteria Becoming Antibiotic Resistant: The Importance of Infection Control in Food Service Cont'd

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Infection control and prevention in food service starts with well-educated employees. It's important for food-handling employees to not only know how to prevent the spread of infections, but to also understand why. A recent article highlighted a study that found the common foodborne illness-causing bacteria, Campylobacter jejuni, is becoming antibiotic-resistant. The study found that the resistant bacteria leave their genetic material within a person's microbiome, further leading to the potential for new strains of bacteria to incorporate those genes into their own genome, thereby becoming resistant to antibiotics. Now more than ever, the importance of food safety is at the forefront because of the development of antibiotic-resistant bacteria. The population we work with is at an especially high risk for contracting foodborne illnesses. It's our job to minimize that risk to protect those in our care.

The following list is a compilation of practices to enforce in food service to minimize cross-contamination and the spread of potential foodborne illness-causing bacteria:

- Use separate utensils for every food item served.
- Perform hand hygiene at appropriate times. Be sure that hand washing stations are available, clean, and well-stocked.
- Follow manufacturer's guidelines for proper food storage.
- Educate staff on the proper use of gloves. Change gloves and perform hand hygiene:
    - When touching one food item to the next. The preferred method is to use utensils when touching ready-to-eat foods.
    - After touching surfaces like drawer handles, cupboards, doors, food containers.
    - After touching hair, face, skin, clothes, fabric.
- Do not touch ready-to-eat foods with bare hands.
- Purchase foods from approved sources. An example of an unapproved source would be your local butcher unless they have been inspected by the USDA.
- Cook foods to proper temperatures.
- Be sure to clean and sanitize food thermometers before temping food and in-between temping different foods.
- Clean and sanitize dishes and cookware according to guidelines.

Drug Diversion in Healthcare

Jean Koch, RN, Acute Care Advisor

Drug diversion is the illegal distribution or abuse of prescription drugs that are used for purposes not intended by the prescriber. It occurs when the medication is redirected from its intended use and is used for personal purposes, sale, or distribution to others. This is occurring through drug theft, self-use of the drug, or tampering/substitution of the medication with another drug or another substance such as normal saline.

Drug Diversion in Healthcare Cont'd

Drug diversion is a felony and on the rise in healthcare settings. Diversion of drugs is challenging because it is underestimated, undetected, and underreported. Some of the outcomes stemming from drug diversion can include patient harm, patient death, damaged careers, loss of professional licenses, civil and criminal penalties, and infectious disease outbreaks.

Healthcare facilities carry the burden of fines for failed or lack of safeguards in place to prevent drug diversion from occurring in their facility. Facilities should routinely evaluate their employees, systems, and patient care environments for opportunities to prevent diversion. It is recommended that facilities develop a controlled substance diversion prevention program (CSDPP) to help with protecting the patients, healthcare workers, their organization, and the community. For this program to be successful, it must be developed to:

- Comply with applicable federal regulations and state laws.
- Apply technology and diligent surveillance to routinely review their processes for compliance and effectiveness from drug diversion.
- Strengthen and develop policies, processes, and controls to protect patients from potential harm related to drug diversion.
- Be proactive versus reactive when seeking to prevent or detect diversion.
- Include support systems for their workforce.
- Have processes in place to monitor the effectiveness of their diversion prevention processes and adaptability to change those processes if indicated.
- Educate their healthcare workforce on:
    - The signs and symptoms of impaired healthcare workers.
    - Their policies and procedures for the prevention of drug diversion during orientation, yearly training/education requirements, and as needed.
    - Reporting processes if drug diversion is suspected within their area/department.
- Have engaged leadership oversight that strives to work towards continuous improvement.
- Pharmacists participate in or contribute to the development of substance abuse prevention and assistance programs within the healthcare organization.
- Define the chain of custody to ensure that only those healthcare workers who are authorized to access the controlled substances are allowed.
- Develop a policy for thorough investigations should a drug diversion should occur which should include the following, at minimum:
    - Interviews of the diverter, their peers, director and/or supervisor.
    - Review security and drug review and accountability processes to ensure that they are still up-to-date or determine if they require changing. If no change required, be prepared to support why.
    - Monitor and audit staff during medication administration. Develop an audit process to ensure compliance with new process.
    - Educate staff on the new process or re-educate on existing policies and procedures to ensure understanding.

Healthcare facilities must establish an environment that discourages diversion and strengthens accountability leading to rapid response to suspected diversional activity. Facilities should continually strive to improve processes and controls to ensure the safety of their patients and healthcare workers. A structure that adheres to accountability and encourages healthcare worker participation provides a framework for a capable and strong anti-diversion program.

Drug Diversion in Healthcare Cont'd

Identifying signs and symptoms of drug diversion can be challenging but is an important step in stopping drug diversion in facilities. All facilities that carry, handle, and distribute controlled substances are at risk for drug diversion. The signs of drug diversion can be subtle and those who divert can range from veteran staff, new staff, and a well-respected and known licensed professional. Common signs of drug diversion include but is not limited to:

- Wasting complete doses, wasting no doses, or heavy drug wasting.
- Failure to document waste.
- Frequently wasting drugs that never reach the patient (dropped medications, patient refusal, discontinued orders).
- Repeatedly wasting with the same person as a witness.
- Repeatedly holding waste until the end of the shift or carrying medications in pockets.
- Frequently asking peers to sign off on waste they didn't witness.
- Frequently pulling as needed (PRN) controlled substances.
- Poor documentation, omissions, and care inconsistencies.
- Recurrent mistakes, poor judgement, and a variable work performance.
- Extended or frequent breaks and disappearances during the shift.
- Constricted pupils, sweating, chills, runny nose, anorexia, needle tracks, diarrhea, and vomiting.

The most common drugs diverted from the healthcare setting are Fentanyl, Dilaudid, Demerol, Morphine, Oxycodone, and Methadone and Hydrocodone combinations.

It is important that healthcare facilities and organizations approach controlled substance diversion prevention with the same diligence they would apply toward any potential compromise to patient safety through creating a culture of awareness and implementation of proper policies, practices, and procedures to best detect, deter, and respond to drug diversion.

Home Health Agencies Regulations Review

Sue Bakker, RN, Home Health Advisor

The Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Appendix B: Home Health Agencies regulations were last revised in 2020. The Office of Licensure and Certification would like to highlight several tidbits of the Oasis regulations for review, but also encourages providers to review Appendix B for more detail.

G350
§484.40 Condition of participation: Release of patient identifiable OASIS information.

- The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable OASIS information to the public.
- The HHA and their OASIS vendors must develop and implement policies and procedures to protect the security of the patient records. The HHA is ultimately responsible for these requirements.

Review of Home Health Oasis Regulations Cont'd

G370
§484.45 Condition of participation: Reporting OASIS information.

- Home Health Agencies must electronically report all OASIS data collected in accordance with 484.55. The OASIS data collection set must include the data elements listed in 484.55(c)(8), as determined by the Secretary. The OASIS data items determined by the Secretary must include: clinical record items, demographics, and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.
- Items collected must be updated under G544; 484.55(d). A marked improvement or worsening of a patient's condition, which changes, and was not anticipated in, the patient's plan of care would be considered a "major decline or improvement in the patient's health status" that would warrant update and revision of the comprehensive assessment.

G372
484.45(a) Standard: Encoding and transmitting OASIS data.

- The HHA must encode and electronically transmit each completed OASIS assessment to the CMS system within 30 days of completing the assessment of the beneficiary.
- Exceptions to the transmittal requirements are patients:
    - Under age 18
    - Receiving maternity services
    - Receiving housekeeping or chore services only
    - Receiving only personal care services; and
    - Patients for whom Medicare or Medicaid insurance is not billed
- As long as the submission time frame is met, HHAs are free to develop schedules for transmission of the OASIS assessments that best suit their needs.

G374
484.45(b) Standard: Accuracy of encoded OASIS data.

- The encoded OASIS data must accurately reflect the patient's status at the time of the assessment.

G376
484.45(c) Standard: Transmittal of OASIS data.

G378
484.45(c)(1) Successful transmission of OASIS data is verified through validation and feedback reports from QIES ASAP.

G380
484.45(c)(2) Successfully transmit test data to the QIES ASAP System or CMS OASIS contractor.

- The purpose of making a test transmission to the QIES ASAP system or CMS OASIS contractor is to establish connectivity. Prior to the initial certification survey, HHAs must demonstrate connectivity to the OASIS QIES ASAP system.

Review of Home Health Oasis Regulations Cont'd

G382
484.45(c)(3) Transmit data using electronic communications software that complies with the Federal Information Processing Standard from the HHA or the HHA contractor to the CMS collection site.

G384
484.45(c)(4) Transmit data that includes the CMS-assigned branch identification number, as applicable.

G386
484.45(d) Standard: Data Format.

- Successful transmission of OASIS data is verified through validation and feedback reports from QIES ASAP.

G416
484.50(a)(1)(iii) An OASIS privacy notice to all patients for whom the OASIS data is collected.

- Use of the OASIS Privacy Notice is required under the Federal Privacy Act of 1974 and must be used in addition to other notices that may be required by other privacy laws and regulations. The OASIS privacy notice is available in English and Spanish on the CMS website. The OASIS Privacy Notice must be provided at the time of the initial evaluation visit.

The Office of Licensure and Certification recommends that providers review Appendix B for more details of the regulations.

Home Health and Hospice Website Updates

Sue Bakker, RN Home Health and Hospice Advisor

The Office of Licensure and Certification has made changes to the South Dakota Department of Health website in an effort to provide several resources to Home Health and Hospice providers and the public.

The home health website includes, but is not limited to:

- The consumer home health agency hotline for questions and/or filing a complaint
- CMS Appendix B regulations
- Steps to open a certified home health agency through CMS
- SDAHO (SD Association of Healthcare Organization) information for Quality Measures
- Oasis data sets
- Home Health Compare

The hospice website includes, but is not limited to:

- The consumer hospice hotline for questions and/or filing a complaint
- CMS Appendix M regulations
- SD codified law
- Residential hospice administrative rules
- Steps to open a certified hospice through CMS
- Medicaid.gov – Hospice benefits
- Compare Hospice Providers
- SD Department of Social Services – Medicare eligibility

Office of Licensure and Certification Staff Contact
https://doh.sd.gov/providers/licensure/StaffContacts.aspx

Name	Title	Email	Phone
Cassie Deffenbaugh, RN	Administrator	Cassandra.Deffenbaugh@state.sd.us	605-773-3356
Deb Carlson, RN	Assistant Administrator (Rapid City)	Deb.Carlson@state.sd.us	605-394-1991
Patricia Brinkley, RN	Assistant Administrator (Sioux Falls)	Patricia.Brinkley@state.sd.us	605-367-5375
Jim Bailey	Medical Facilities Engineering Supervisor	James.Bailey@state.sd.us	605-367-5434
Julie Jenssen	Licensing, Certification and Enforcement	Julie.Jenssen@state.sd.us	605-773-3901
Jean Koch, RN	Acute Care Advisor	Jean.Koch@state.sd.us	605-995-8985
Jennifer Maeschen, RN	ALC, RLC, CLH, and AFC Advisor	Jennifer.Maeschen@state.sd.us	605-995-8147
Diana Weiland, RN	Nursing Home Advisor	Diana.Weiland@state.sd.us	605-995-8057
Shelly Walstead, RN	Complaint and CNA Programs	Shelly.Walstead@state.sd.us	605-367-7499 or 605-367-4640
Susan Bakker, RN	Hospice, Home Health, and PRTF Advisor	Susan.Bakker@state.sd.us	605-367-7495
Denise Broadbent MT (ASCP)	Laboratory Advisor	Denise.Broadbent@state.sd.us	605-394-6173
John Priest	Radiology & Rural Health Clinic Advisor	John.Priest@state.sd.us	605-367-5672
Jolene Juneau, RN Tina Mueller, LNHA	MDS Coordinators	Jolene.Juneau@state.sd.us Tina.Muller@state.sd.us	605-773-6373 605-773-5116
Kathy Welken, RN	Surveyor Education Coordinator	Kathleen.Welken@state.sd.us	605-367-5373

SOUTH DAKOTA DEPARTMENT OF HEALTH
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