North Dakota Department of Health
Division of Health Facilities

# LONG TERM CARE ADVISORY COMMITTEE MEETING MINUTES

March 7, 2008

Committee Members Present:

Darleen Bartz, Chief, Health Resources Section, ND Department of Health
Bruce Pritschet, Health Resources Section, ND Department of Health
Shelly Peterson, Executive Director, North Dakota Long Term Care Association
Kurt Stoner, Administrator, Bethel Lutheran Home, Williston
Helen Funk, State Ombudsman, Div. of Aging Services, ND Dept. of Human Services
David Remillard, North Dakota Health Care Review, Inc.
Carole Watrel, AARP
Representative Gary Kreidt, ND House of Representatives (New Salem)
Karen Tescher, Division of Medical Services, ND Department of Human Services
Arvy Smith, Deputy State Health Officer, ND Department of Human Services
Lucille Torpen, Manager, Division of Health Facilities, ND Department of Health
Monte Engel, Manager, Division of Health Facilities, ND Department of Health
Kaye Hessinger, Division of Health Facilities, ND Department of Health

Committee Members Absent:

Dr. Jonathan Berg, Nursing Home Medical Director's Association
Randal Albrecht, ND Board of Examiners for Nursing Home Administrators
Maggie Anderson, Division of Medical Services, ND Department of Human Services
Betty Keegan, Rolette County Social Service Board
Craig Lambrecht, MD, State Medical Officer, ND Department of Health

## Welcome

A meeting of the Long Term Care Advisory Committee was called to order at 10:00 a.m. on March 7, 2008. Darleen Bartz welcomed everyone, and asked that they introduce themselves.

## Approval of Minutes

Minutes of the August 16, 2007 meeting were approved as distributed. Representative Kreidt made a motion to approve the minutes; seconded by Carole Watrel. Motion carried.

Standing Reports and Legislative Session Recaps

Legislative Update

Representative Kreidt indicated there had just been a meeting of the Long Term Care Committee this week. The committee is going to be coming out with a draft basic care facility bill relating to advance notice requirements of any transfer or discharge of a resident from a nursing home, swing bed hospital, or basic care or assisted living facility. This amendment would require basic care facilities to give a 30 day written advance notice to residents before any transfer or discharge. Rep. Kreidt doesn't see any objection to this.

Rep. Kreidt said they are also looking at the moratorium issue, and possibly continuing the moratorium into the next session. Shelly said the Association supports the moratorium. The Long Term Care Association provided some very good information at the last committee meeting, and he thanked Shelly Peterson for the report which was titled, "2008 Overview of Long Term Care". On the nursing home side, there are currently 6,300 beds, with an estimated increase of 3,500 additional beds in the future. Rep. Kreidt felt the move would be more toward assisted living and basic care.

Rep. Kreidt said the committee had received information on the pilot project for construction surveys. He wanted to thank the Department of Health for their assistance and the report. It is hopeful that as this process goes forward, it can be fine-tuned and continue it into the future. He said testimony from the facilities at the meeting was very positive; and that in the future the legislature could look at dollars to move forward with this.

Darleen Bartz asked about the year 2020 projection as far as increase of 3,500 additional long term care beds. Kurt Stoner responded that this figure was presented by the Legislative Council. Shelly Peterson said the Legislative Council based their statistics purely on demographics. The NDLTCA addressed issues relating to what needs to be done to meet the increase in demand in urban North Dakota. Shelly feels this information is necessary to give specifics relating to the Legislative Council's projection of beds they feel will be needed in the future. Shelly said there has been continued growth in assisted living also. Kurt Stoner commented that length of stay has shortened up, and what used to be 3.5 years is now 1.1.

Comments from the North Dakota Long Term Care Association

Shelly Peterson discussed a handout prepared for the Legislative Long Term Care Committee ("2008 Overview of Long Term Care"). Long term care in North Dakota reflects the following: 83 nursing facilities with 6,327 beds at a 2008 average cost of $165.59 per day; 56 basic care facilities with 1,574 beds at a cost of $78 per day; and 60 assisted living facilities with 2,157 units at a cost of $100 per day. She said that two out of every five North Dakotans will need long term care sometime in their lives. The NDLTC would like to see incentives created for North Dakotans to purchase long term care insurance. Statistics show that the most common reasons given for nursing home placement include the need for assistance in daily care (52%); need for continuous supervision (44%); risk of falls (24%); and confusion/dementia (24%). Statistics show that two out of every five North Dakotans will need long term care sometime in their lives. Shelly testified on availability of beds in North Dakota from highest to lowest occupancy. This information was based on a Department of Human Services census. Other testimony included a chart prepared with data from the Department of Health that included all basic care facilities in the eight regions of North Dakota. Statistics on this document addressed each facility individually regarding total beds, average filled beds, and average occupancy rate percentage.

Darleen Bartz said the Department of Health is currently looking at existing basic care beds and occupancy issues within a 50 mile radius of Bismarck and Grand Forks. This information will be presented next week at a meeting with the New/Additional Basic Care Beds Workgroup. Shelly Peterson said the Department of Health does a very good job of tracking where the beds go, and this information is updated regularly on a log. Shelly uses this information, contacts the facilities, and prepares a chart that summarizes the redistribution of nursing facility beds from rural to urban North Dakota. Redistribution of nursing facility and basic care beds were documented on charts for the four major cities in North Dakota – Bismarck-Mandan, Fargo-West Fargo, Grand Forks, and Minot. This was information requested in discussions with Representative Kreidt and Senator Dever. Rural facilities are selling their beds and facilities in the four urban settings are purchasing them. It is estimated that from 2007 through 2011, 260 nursing facility beds will be redistributed from rural North Dakota to the four major cities. It will take another 8 to 28 months for the nine nursing facilities in these four major cities to complete their expansion plans to accommodate the 260 beds.

When asked what North Dakota is doing to lessen the need for instititutional care, Shelly provided the following response:

- North Dakota's criteria for entering a nursing facility is stringent. For individuals covered by Medicaid, each state is required to establish medical criteria to determine if nursing facility placement is necessary.
- Money follows the person – seek our individuals in North Dakota nursing facilities and assist them to move back home. This will begin in June, 2008.
- PACE is a five year project to help the poor, who screen in need of nursing facility care, to remain at home with day support, care and services. This project was implemented in 2008.
- Twenty-five percent of all residents admitted to a nursing facility return to their own home. One-third of the residents return home or to a lower level of care.

As far as good news, Shelly reported that the percentage of Medicare enrollees age 65 and older who lived in long term care institutions such as nursing facilities dropped dramatically from 7.5% to 4%. Nursing facility utilization has been on a steady 10 year decline, with 2007 at an all time low. North Dakotan's value their independence, families and informal supports provide immeasurable care, and the vast majority of North Dakota's will never access the formal care system. Shelly also said that technology will allow people more independence, drug research will have a tremendous impact on health, and chronic disability among older Americans has dropped dramatically.

There was a discussion on waiting lists in the long term care facilities, and Shelly said that each facility determines who is admitted and the "waiting list" does not determine priority (it is not a first come, first serve). The admission priority of each nursing facility varies. Not all facilities keep their waiting lists current. When an individual has their name on multiple waiting lists and then take a bed, they rarely call the other facilities to delete their name from the waiting lists. Shelly presented a February 2008 list of North Dakota basic care facilities and nursing facilities that had waiting lists. The Terrace in Bismarck is in great demand. There were 13 basic care facilities, and 24 nursing facilities on these lists.

There was a brief discussion on ventilator use in the nursing homes. Karen Tescher voiced her concerns/opinions. Shelly Peterson said the North Dakota Long Term Care Association maintains a list of those facilities that are able to care for ventilator dependent individuals.

Shelly stated that the number one long term care issue is staffing retention and recruitment. The goal is that the annual inflator needs to cover the cost of operation, and provide a measurable salary and benefit enhancement for caregivers. Staff turnover is as high as 53% for the CNAs. Besides salary issues, other turnover factors include the fact that staff are aging and retiring. The long term care facilities employ over 10,000 individuals and within the next four years, one-quarter will be at or over retirement age.

Shelly Peterson talked about the issue with the Richardton Hospital. She said the Long Term Care Association is very concerned about them, their desire to become a long term care facility, and asked for support of their proposal. Dave Remillard questioned where the political push would come from to try and save the hospital in Dickinson. Darleen Bartz stated we had received a letter from the Richardton Hospital, but we have not yet received a completed application. There have been no formal requests for waivers at this time. She said there would be some ADA issues that would come up. At the present time they are in compliance with the federal life safety code requirements as they relate to their designation as a critical access hospital.

Comments from the Ombudsman Program, ND Department of Human Services

Helen Funk reported on points of interest in the Long Term Care Ombudsman Program. She said that the Division of Aging Services and the State LTC Ombudsman office moved to Prairie Hills Plaza in November of 2007. Their contact address is: Aging Services Division, 1237 West Divide Avenue, Suite 6, Bismarck, 58501. The fax number is 701-328-8744, and the toll free phone number remains the same at 1-800-451-8693. The Senior Info-Line name has been changed to North Dakota Aging and Disability Resource-LINK. The LTC Ombudsman number has been rolled into this same toll free number.

Helen stated that staff shortages have been a problem for many rural nursing homes during the past few months. A few nursing facilities had to close their facility for admission until additional staff could be hired. When it becomes necessary to contract with an agency to locate nurses and CNA's, expenses increase greatly for the facilities.

Helen said there have been several residents who have entered Psychiatric Units in hospitals throughout the state, and nursing facilities have been reluctant to re-admit the residents due to the seriousness of the resident's behaviors. Resources for specialized units, who will provide care for people with serious behavior issues, is an area that needs further development. The specialized unit approved by the Legislature has not been implemented yet. The State Hospital is difficult to access, due to the increase in patient numbers.

Linda Wright, Director of Aging Services Division, and Karen Tescher, Administrator of Medical Services, have formed a committee to address initiating standards for North Dakota Assisted Living Facilities. These standards may eventually evolve into law and administrative rules. Karen Tescher said at the meeting on February 21, Kenan Bullinger presented information regarding the current law as it relates to assisted living. A list of complaints from the Ombudsman were reviewed, most of which are now resolved. Other issues brought up were the fact there is a need for additional guidelines, what problems are being faced, and funding. Consumers will sit in and give any recommendations they feel would be appropriate. Shelly Peterson said the Association brought some proposed additional requirements to the group which included:

- Administrators – education;
- Direct care staff – required training;

- They would like all facilities to complete an initial assessment – obtain health related information; and
- Look at standards and what will work for North Dakota.

Shelly said the NDLTCA put together a log of all the laws affecting assisted living. She felt this was a very good meeting.

Comments from the ND Department of Health, Division of Health Facilities

Monte Engel gave a report regarding the average number of life safety code deficiencies in the Medicare/Medicaid skilled nursing facilities in North Dakota. The report indicates the average number of deficiencies per survey based on scope and severity, and compares Region VIII with the other regions nationally. In Region VIII, North Dakota has an average of 4.0 life safety code deficiencies per survey as compared to Colorado with 6.8; Montana with 8.3; South Dakota with 2.8; Utah with 4.3; and Wyoming with 7.5. The national average is 3.9 life safety code deficiencies per survey. This report reflects statistics during calendar year 2007. Kurt Stoner stated it seems like the average for North Dakota is coming down compared to the national average. Monte agreed that we have come down slightly, and this will probably continue on a downward trend. Dave Remillard asked if this was a fair reflection of what goes on in the facilities? Monte said we focus on what is seen in our facilities in North Dakota, and that generally what is cited by state, regionally, or nationally is going to be pretty much the same. He said we don't use this data as necessarily being a trend.

Monte also discussed the citation frequency report and said that K18 (Corridor Doors) is the number one deficiency cited nationally. North Dakota's number one cited deficiency (K62) is sprinkler system maintenance. Twenty-five percent of the deficiencies pertained to lack of documentation. Out of 83 active providers, 32.5% of the providers were cited in this area.

Bruce Pritschet talked about the Double G Citations Report for calendar year 2007. He explained that if you are a facility that has an actual (G) citation on one survey, and then again on the next survey, you end up with a double G citation on two consecutive back to back surveys. In Region VIII, the following states were cited for the following number of Double G Citations: Colorado, 79; Montana, 5; North Dakota, 3; South Dakota, 5; Utah, 2; Wyoming, 5.

The next report Bruce discussed was the average number of deficiencies per survey based on calendar year 2007. The ten regions were compared as to the average number of deficiencies per survey by scope and severity. More specifically, the states in Region VIII were compared with each other. Colorado listed an average of 9.7 deficiencies per survey by scope and severity in a total of 164 surveys; Montana, 7.0 in 81 surveys; North Dakota, 4.3 in 77 surveys; South Dakota 4.3 in 91 surveys; Utah, 5.7 in 68 surveys; and Wyoming, 13.3 in 31 surveys. On a national average, which includes the figures from all ten regions, there was an average of 7.1 deficiencies in 11,868 surveys.

The Citation Frequency Report for the standard health surveys compared data from the state, regional, and national level. Tag F371 (store, prepare, distribute food under sanitation conditions); and F323 (facility is free of accident hazards) ranked at the top or in second place in all levels. F309 (provide necessary care for highest practical well being) ranked third; and F329 (drug regimen is free from unnecessary drugs) placed 4$^{th}$ for North Dakota. Bruce indicated there is a slight shift in comparison regarding the data on all levels, but not a lot. For Tag F323, North Dakota issued 38 citations in 44.6% of the active providers; for Tag F371, there were 26 citations in 31.3% active providers ; for Tag 309

there were 17 citations in 20.5% of active providers; and for Tag F329 there were 14 citations in 16.9% of active providers.

LSC Business Process Reengineering Update

Bruce Pritschet summarized the Business Process Reengineering project, which began in 2006 for purposes of looking at the life safety code survey process and to strive for consistent survey outcomes. The groups meet quarterly, and consist of an internal and external workgroup. Input from several stakeholders was requested, which outlined a number of areas of interest, including:

- A desire for LSC surveyors to provide training during their survey
- A desire for consistency among surveyors
- The roll of quality assurance in ensuring compliance with the life safety code standards, and the need for training of facility staff, other than through the survey process
- Provide facilities information regarding good environmental products, determination of current knowledge base of facility environmental staff, and impact of staff turnover

Throughout the meetings, it became clear that improving information exchange would benefit all stakeholders involved. Since early 2007 several communication tools and other strategies have been implemented:

- Providing on-site information to facility staff during the survey, and update the Health Facilities webpage with life safety code information which would include the top ten citations.
- Established an email distribution list for healthcare facility environmental services staff so communication can be provided directly to maintenance staff.
- In conjunction with the Long Term Care Association, the group studied the possibility of providing NFPA handbooks to facilities. Information could be included on the Health Facilities website on how to obtain the handbooks, and also how to sign up for or take online courses offered by NFPA.
- A quality assurance checklist has been developed which is given to staff during survey.
- Life safety code compliance training was presented to facility administrators in December, 2007. Many forms and documents were given as handouts to assist the facilities. Additional life safety code training was provided during the NDLTCA spring and fall conferences.
- Input from the external stakeholders was used to define the core components of the LSC consultation demonstration project for new construction or major renovations (HB 1004).
- A “Best Practice” category is being considered for LSC to reward innovative and creative ideas for achieving compliance and maintaining compliance.
- The possibility of having LSC survey staff be included on the agenda for the quarterly State Regional meetings.

Shelly Peterson said that the issues which have been identified at these meetings will be touched on at each of their quarterly meetings. Shelly asked if there was a potential resource for providing the health care facilities with the NFPA handbook. Darleen Bartz said the Health Department has put in a request to the Regional Office to obtain LSC manuals for the providers, but we have not heard back from them yet.

Arvy Smith asked if the Business Process Reengineering group is looking at the top citations to determine what kind of training will be presented to the providers. Monte Engel said that is what we

would gear our training towards. Shelly Peterson said the association is extending additional invitations to the spring conference, including architects, contractors, and construction managers.

Darleen Bartz talked about testimony that was presented by Arvy Smith on behalf of the Department of Health to the Long Term Care Legislative Committee on March 4, 2008. In House Bill 1004, the legislature charged the Department of Health with developing and implementing a demonstration project for a life safety code process for long term care and basic care construction and renovation projects. Arvy provided an update on the status of the life safety code construction and/or renovation demonstration project, and also the Health Department's response to some of the issues faced by facilities that have recently completed construction projects. Included with the testimony was a fact sheet addressing life safety code construction/renovation issues and challenges. Arvy asked if there was feedback after the testimony. Gary Kreidt said there has been a lot of progress and the feedback has been positive. He still feels there will need to be some fine-tuning done, but the process is a win:win for everyone involved. Potentially there could be five or more facilities coming forward to become involved in the LSC construction and/or renovation project. Arvy Smith said the budget would depend on how many visits would have to be made to facilities to head off problems. Right now they are looking at a two visits, but that would probably not be enough. The Health Department is required to perform the demonstration project within the department's 2007-2009 appropriation and staffing levels, and may charge a reasonable fee to cover the food, lodging and transportation expenses of surveyors performing the surveys. The Centers for Medicare & Medicaid Services (CMS) provides federal funding for life safety code surveys completed as part of federal certification of already state licensed facilities only. Monte Engel said he has reviewed a total of 137 plans for construction during 2006 and 2007. The majority of construction and remodeling takes place in the hospitals.

9th Scope of Work and Nursing Homes

Dave Remillard said that North Dakota Healthcare Review contracts with Medicare/Medicaid Services, and that each contract involves a scope of work. The work with nursing homes this time falls under patient safety. The QIO will be working with six facilities versus 32 that they have worked with in the past. He said nursing homes participate on a voluntary basis and select what they want to work with. Dave talked about the 9th Scope of Work related to nursing homes and indicated the following:

- Work with nursing homes is aligned under a Patient Safety theme, which includes improving inpatient surgical safety; reducing MRSA infections; improving drug safety; reducing ratio of pressure ulcers; and reducing ratio of use of physical restraints.
- Focus is on pressure ulcers and physical restraints.
- Nursing homes eligible to work with QIO on physical restraints are eight or more percentage points away from the goal of 3%.
- They will also work extensively with one "Nursing Home in Need" each year, selected by CMS.
- The maximum number of nursing homes the QIO can work with are:
    - Pressure ulcers – 5
    - Physical restraints – 2
    - Nursing home in need – 1 per year for three years
- Work with a group of hospitals to reduce pressure ulcers (hospitals located in same county and/or referral pattern for eligible nursing home). Nursing homes are teamed up with the hospital in the same area to work with the pressure ulcer issues.
- Required to do a study of disparities in nursing homes within the state using available data.

The QIO will provide special technical assistance to a small number of nursing homes in need of assistance with quality improvement efforts. This is a mandatory component under Patient Safety. Dave said this special technical assistance will be for the QIO to conduct a root cause analysis with an anticipated one nursing home in its state per year (three nursing homes over the three-year contract period). It is expected that within the first quarter of the contract period, CMS will assign one nursing home to each QIO. The determination of which nursing homes are eligible under this component will be made by CMS. Some of these facilities may meet criteria for Special Focus Facilities. The QIO may provide continued assistance to each nursing home after it is assigned throughout the contract period. Baseline data will be taken from the most recent available reporting quarter. The QIO will conduct an onsite assessment of the facility to identify the underlying causes of the performance problems that affect the facility's quality of care and prepare a root cause analysis based on those core findings.

Dave Remillard said that based on the findings presented in the root cause analysis, an action plan will be developed for the facility and will include specific actions to be taken and related timelines and measurement strategies designed to bring about change in the facility to improve its compliance status. It is expected that the QIO will submit the root cause analysis and action plan for each nursing home with which they work to CMS.

To monitor performance, Dave stated CMS will evaluate the QIO on both nursing home satisfaction with the process (survey data) and on relevant outcome data. CMS or their designee will administer a questionnaire to nursing homes to evaluate the nursing homes' perception of effectiveness of QIO technical assistance.

In closing, Dave commented that the ND Healthcare Review is just the facilitator; the people who do the work are the people in the facilities.

Centers for Medicare & Medicaid Services Update

Darleen Bartz stated that CMS is expecting us to do more with less. She said we still see an increase in workload without the necessary resources to complete the work. Lucille Torpen and Bruce Pritschet summarized the following guidelines from CMS that have come out since the last meeting of this group in August:

- **Ref: S&C-07-36 (Release of Report "Study of Paid Feeding Assistant Programs")**
  This memorandum announces the release of the "Study of Paid Feeding Assistant Programs" report and Web site location. There is a 147 page report available on the website at http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage. This report provides a description of the degree of implementation of paid feeding assistant programs nationally; the characteristics of and design of these programs; and the effect paid feeding assistants have had on the quality of care in nursing homes. Lucille stated that paid feeding assistants are there only to feed the resident, versus all of the duties performed by the nursing assistants. She said we have developed a guide that the surveyors can look at when they go into the facilities.

  The regulation, "Requirements for Paid Feeding Assistants in Long Term Care Facilities" had two immediate goals:

  1. To increase the availability of staff during mealtimes; and

2. To mandate minimum training and supervision standards for paid feeding assistant programs.

Lucille said that issues that are being cited on survey include:

**L1682** – Use of the paid feeding assistant to feed the resident must be included in the resident's plan of care.

**L1683** – In an emergency, a paid feeding assistant must call a supervisory nurse for help using the resident call system.

**L1684** – The nursing facility must ensure that the ongoing competency of paid feeding assistants is evaluated and documented at least annually.

- **Ref: S&C-08-03 (Initial Surveys for New Medicare Providers)**
  Bruce Pritschet said that if we start doing Tier 4 work, we need to be sure the other three tiers have been completed first; and there is a lot of political pressure to make initial surveys a priority. Initial surveys of new providers or suppliers have become more challenging for four reasons:

  1. Resource Limitations: For the past three consecutive years the final federal budget for Medicare survey and certification has been considerably less than the level requested by the President.
  2. Many New Providers: Many additional providers have been seeking to participate in the Medicare program. Since 2002, for example, the number of Medicare participating rural health clinics has increased by 48.7%, ambulatory surgical centers by 38.4%, hospices by 37.4%, home health agencies by 31.9%, dialysis facilities by 18.2%, and non-accredited hospitals by 9.5%.
  3. More Responsibilities: Additional survey responsibilities have further stretched survey resources and have increased the need to pay careful attention to survey priorities.
  4. Anti-fraud Initiatives: Growth in the number of certain provider types, particularly home health, has been accompanied by evidence of higher levels of fraudulent activity by a minority of such providers.

  Regarding CMS priorities, longstanding CMS policy makes complaint investigations, recertifications, and core infrastructure work for <u>existing</u> Medicare providers a higher priority compared with certification of <u>new</u> Medicare providers. CMS directs States to prioritize federal survey functions in four priority "Tiers." Tier 1 consists of statutory mandates, such as surveys of existing nursing homes and home health agencies. Tier 2 consists of lower priority workload which is lower than Tier 1, but higher than Tiers 3 & 4. Tier 3 includes ESRD facilities, transplant centers, and hospitals without an accrediting organization option. Tier 4 consists of other important work, but work that is considered reasonable to accomplish <u>only if</u> higher priority functions can be accomplished within the federal budget limitations. Bruce said the burden is put on the provider to substantiate a Tier 4. The revised policy in Appendix A refines the CMS policy for initial surveys in order to recognize the different situations being experienced by different providers and suppliers, and accomplishes a number of objectives: process for exceptions, higher priority for some unique situations, and Tier 4 options.

All other newly-applying providers/suppliers not listed in Tier 3 and Tier 4 priorities, unless approved on an exception basis by the CMS Regional Office due to serious health care access considerations or similar special circumstances include:

1. Comprehensive Outpatient Rehabilitation Facilities
2. Long Term Care Units in Hospitals
3. Nursing Homes that do not participate in Medicaid
4. Outpatient Physical Therapy
5. Rural Health Clinics

Note: This list will be amended in the following S&C.

- **Ref: S&C-08-13 (Initial Surveys of Rural Health Clinics and Skilled Nursing Facilities Raised to Tier 3 Priority – And Continued Encouragement for Dialysis Facility Priority Within Tier 3)**

This memorandum dated March 7, 2008 amends Survey and Certification (S&C) memorandum S&C-08=03 issued on November 5, 2007. A summary of this memorandum includes:

1. **Raising RHC+SNF initial surveys to Tier 3 priority:** Congress's appropriation of part of the increase in Medicare survey and certification funds requested in the President's proposed FY 2008 budget permits us to raise initial surveys of RHCs and SNFS to Tier 3 priority from Tier 4.

2. **Prioritizing within Tier 3:** For initial surveys assigned Tier 3 priority status, States may prioritize the initial surveys within Tier 3. States are encouraged to offer a high Tier 3 status for initial surveys of dialysis facilities given the unique reliance on Medicare on the part of end state renal disease patients.

Darleen Bartz said that we do have budget concerns related to obtaining the Medicare funding necessary to match the state and Medicaid funds to complete the required workload. We have seven vacancies, and are basically taking away 20% of our staff to get the workload done. She said that about a year ago, the average months between surveys was 11.2 months. Currently, the SSA is at 12.6 months between surveys (12.9 is as high an average that is allowable). That means the SSA is not able to complete the workload in the required timeframes and is falling further behind. I statutory work is not completed, the SSA will be fined, and our budget further reduced.

- **Ref: S&C-08-02 (Improvements to the National Special Focus Facility (SFF) Program for Nursing Facilities—Notice Requirements)**

In summary, this memorandum amends S&C Memorandum 05-13 to improve the national "Special Focus Facility (SFF)" initiative. The SFF is designed to increase the probability that nursing homes which have consistently exhibited serious quality problems will significantly improve their quality of care and safety of residents in the near future. The revisions emphasize:

- Improved notification so that administrators, owners, and boards of directors are all fully apprised of the seriousness of the issue and the imperative for action;
- Public notice to provide a list of nursing homes that have been designated as a SFF and, after one survey, continue to provide poor care. This information will be made available

on the Centers for Medicare & Medicaid Services web sie with a link from Nursing Home Compare; and
  - Focus on quality of care and quality of life deficiencies. Life safety code deficiencies will not be used in calculations.

Lucille Torpen stated that the Health Department goes in twice yearly to survey special focus facilities. A special focus facility (SFF) can graduate from the designation of an SFF when it demonstrates on two consecutive standard surveys that it has deficiencies cited at a scope and severity level of no greater than "E" and no intervening complaint-related deficiencies cited greater than "E". Once the SFF has successfully met the criteria for removal, the State Agency will notify them and all accountable parties that the facility is no longer designated as a special focus facility.

A facility's selection as a special focus facility is not subject to appeal. However, a facility has the right to an informal dispute resolution regarding the findings of a survey, and the right to appeal the noncompliance that led to a remedy through an Administrative Law Judge of the Department of Human Services. Specific requirements for requesting a formal hearing are contained in the notice of imposition of the remedy. Bruce Pritschet stated that a ban on admissions is the remedy used.

- **Ref: S&C-08-09 (Nursing Homes: Surveying Facilities that Receive Food Prepared by Off-Site Kitchens)**

  When a nursing home facility receives food services from an off-site location, the surveyor must assess whether the facility is compliant with 42 CFR 483.35(i) which states, "a facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities."

  The purpose of this memorandum is to instruct surveyors on the appropriate action when surveying nursing homes that procure food prepared by sources external to the facility for the purpose of consumption by residents. Surveyor(s) should determine if there are any:

  - Food safety and/or sanitary condition concerns related to when, where, and how the food received for residents' consumption is prepared, packaged, and delivered;
  - Food safety and/or sanitary condition concerns related to when, where, and how the food is stored and served once it arrives at the facility; and
  - On-site food safety and/or sanitary condition concerns such as, but not limited to, food-borne illness.

- **Ref: S&C-08-10 (Use of Interpretive Guidance by Surveyors for Long Term Care Facilities)**

  The Centers for Medicare & Medicaid Services (CMS) has been asked to clarify the use of Interpretive Guidance to Surveyors for Long Term Care Facilities in reviewing for compliance with the regulatory requirements for nursing homes. Surveyors must cite all deficiencies based on a violation of statutory and/or regulatory requirements.

  Surveyors should refer to SOM Section 2712 "Use of Survey Protocols in the Survey Process" and Principle #5 in the Principles of Documentation found in Exhibit 7A for clarification in using information found in the interpretive guidelines. Both sources make it clear that surveyors must base all cited deficiencies on a violation of statutory and/or regulatory requirements, rather than sections of the interpretive guidelines. The deficiency citation must be written to explain how the

entity fails to comply with the regulatory requirements, not how the facility fails to comply with the guidelines for the interpretation of those requirements.

Skilled/nursing facility payment for nursing aide training and competency evaluation

Darleen Bartz responded to a question from Shelly Peterson regarding skilled nursing facility payment for nurse aide training and competency evaluation. Darleen distributed a document outlining the process and stated it was something Shelly could share with the membership.

The interpretation requested was based on the following: "We have so many CNA's that we have paid for their training and they end up leaving shortly after. It seems we should be able to require them to work for us for 6 months to a year or have them pay a portion of the fees?" The response was: Both state and federal regulation **prohibits** requiring a nurse aide to work for 6 months to a year prior to reimbursing them or to require that the nurse aide pay a portion of the fees related to nurse aide training and competency evaluation. To do so, facilities would place themselves at risk for loss of their approval to conduct a training program at their facility.

Consistent with the regulations, if an individual has an offer of employment or is employed by a facility **prior** to training and competency evaluation, the individual cannot be charged for any portion of the training and competency evaluation, including books or other course materials. If an individual receives an offer of employment and is employed by a facility within the immediate 12 months **after** the completion of a nurse aide training, the facility must reimburse the individual for the cost of the nurse aide training and competency evaluation. The payback to the CNA in this second situation can occur on a pro rata basis, not to exceed 12 months.

Next Meeting and Suggestions for Future Agenda Items

The next meeting of the Long Term Care Advisory committee was set for Thursday, June 19, 2008 from 10:00 a.m. to 3:00 p.m. in Room 212 of the Health Department. Agenda items will include:

Standing Reports:

- Division of Health Facilities
- ND Long Term Care Association
- Ombudsman, Department of Human Services
- Legislative Update – Interim Committee

Suggestions for future agenda items included:

- Bed Hold Policy – Barb Fischer
- New Life Safety Code Demonstration Project Information
- Assisted Living Regulations
- Funding and Reimbursement – Potential Legislative Issues
- Optional Package for Life Safety Code

The meeting adjourned at 3:10 p.m.