

North Dakota Department of Health
Division of Health Facilities

LONG TERM CARE ADVISORY
COMMITTEE MEETING MINUTES

February 7, 2007

Committee members and presenters present:

Darleen Bartz, Health Resources Section, ND Department of Health
Shelly Peterson, Executive Director, North Dakota Long Term Care Association
Kurt Stoner, Bethel Lutheran Home, Williston
Helen Funk, State Ombudsman, Div. of Aging Services, ND Dept. of Human Services
Carole Watrel, AARP
Randal Albrecht, ND Board of Examiners for Nursing Home Administrators
Lucille Torpen, Manager, Division of Health Facilities, ND Department of Health
Monte Engel, Manager, Division of Health Facilities, ND Department of Health
David McCowan, Division of Health Facilities, ND Department of Health
Jerry Kemmet, Director, Bureau of Criminal Investigation
Terry Goehring, Administrator, Bottineau Good Samaritan Center
Kaye Hessinger, Division of Health Facilities, ND Department of Health

Committee members absent from the meeting:

Dr. Jonathan Berg, Nursing Home Medical Director's Association
Maggie Anderson, Medical Services, ND Department of Human Services
Bruce Pritschet, Director, Division of Health Facilities, ND Department of Health
David Remillard, North Dakota Health Care Review, Inc.
Betty Keegan, Rolette County Social Service Board
Craig Lambrecht, MD, State Medical Officer, ND Department of Health
Representative Gary Kreidt, ND House of Representatives (New Salem)

Welcome

A meeting of the Long Term Care Advisory Committee was called to order at 10:00 a.m. on February 7, 2007. Lucille Torpen welcomed everyone to the meeting.

Approval of Minutes

Minutes of the November 21, 2006 meeting were approved as distributed. Lucille Torpen made a motion to approve the minutes; seconded by Carole Watrel. Motion carried.

Standing Reports

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

Lucille Torpen reviewed the most current Citation Deficiency Report from 2007. This report gives an overview of the top 25 tags cited. The information is broken down into the number of citations for each tag, the percent of providers cited, and the number of surveys cited. North Dakota has 83 active skilled nursing providers. Also included is the Double G Citations Report. Three of the states in Region VIII indicated the number of Double G Citations during this same time period: North Dakota (1); Montana (1); and Colorado (9). The national total is 185 double G citations. These reports are available from a website that CMS provides to the Health Department, and are a means of comparison between states and regions. Kurt Stoner asked if there were any big changes since the last report. Lucille said they have pretty much stayed the same.

Lucille Torpen also discussed the CASPER Report, which indicates the most frequently cited tags, with the number of citations at scope and severity level listed by frequency. These involved the most current surveys. North Dakota has 83 providers; the total number of providers in Region VIII is 632. The top four tags cited are F371 (35 total deficiencies cited in 42.17% of providers); F323 (30 total deficiencies cited in 36.14% of providers); F309 (29 deficiencies cited in 34.94% of providers); and F324 (28 total deficiencies cited in 33.73% of providers).

Monte Engel presented an overview of life safety code as it relates to the Citation Frequency Report, which covered the last four months. In the region there were 105 surveys, and in North Dakota there were 17 surveys. The top four tags cited for Life Safety Code in North Dakota include: K18-Corridor Doors (10 total deficiencies cited in 12% of providers); K130-Other (10 total deficiencies cited in 12% of providers); K29-Hazardous Areas/Separation (9 total deficiencies cited in 10.8% of providers); and K69-Cooking Equipment (7 total deficiencies cited in 8.4% of providers). Monte stated that what is cited in North Dakota is very similar to what is cited in the Region.

Darleen Bartz talked about several bills affecting the Department of Health, including House Bill 1004 (appropriation for defraying expenses of the State Department of Health); House Bill 1007 (appropriation for defraying the expenses of the Veterans' Home and Department of Veteran's Affairs); House Bill 1154 (relating to regulation of tanning facilities); House Bill 1488 (State Department of Health surveys of basic care facilities); House Bill 1505 (regulation of tattooing & body piercing); and Senate Bill 2109 (moratorium on licensing of basic care beds and moratorium on expansion of long term care bed capacity). Numerous other bills are also being tracked.

Comments from the Ombudsman Program, ND Department of Human Services

Helen Funk said that the Ombudsman Program has assisted with moves that were necessary for sixteen residents of Redwood Village – also known as Pride Wilton, Inc. All sixteen residents have been placed in various locations throughout the state. Monte Engel asked if they all moved

to basic care facilities. Helen said that one moved to a skilled facility; one to the State Hospital; and the rest to basic care.

The Ombudsman Program is planning a two day spring conference and training session for Volunteer Community Ombudsman, which will be held in Mandan in June 2007. They are in the process of looking for speakers to assist with the training.

Several House and Senate bills that are of interest to consumers of the Long Term Care Continuum are being followed by the Ombudsman Program. They have been kept very busy during the Legislative session.

Helen said the Elder Rights Team Meeting will be held March 6 & 7, 2007. Training from staff in the Division of Disease Control in the Health Department will be part of the agenda. She said occasionally a hospital will call to complain that the discharge planner is unable to return the resident to the nursing facility he/she was transferred from, or they have a patient who is unable to locate a nursing facility due to a disease, which is or may be communicable.

Comments from the ND Long Term Care Association

Shelly Peterson talked about several legislative bills that the Association has been involved with. The number one priority is adequate funding, and there is a need for the annual inflator to be at 5%. Senate Bill 2012 contains the 3% annual inflator for all Medicaid providers. The Association will lobby to have this increased from 3% to 5%. Shelly said that nursing facilities received a 6.5% adjustment in 2006/2007; 15% stopped admissions last year because they didn't have enough staff.

Another issue is property limits, and looking at increasing the number of beds in the Bismarck/Mandan community. Darleen Bartz stated that some facilities will downsize their facility, but will not sell their beds. Senate Bill 2403 gives the Turtle Mountain Tribe 72 months to put their nursing facility and basic care beds in service. There are 45 nursing facility beds and 15 basic care beds. The Association is supporting a no vote to the committee regarding this bill.

Shelly briefly talked about House Bill 1333. This bill is a statement or gesture that expresses apology, sympathy, condolences, and compassion. It covers health care providers including assisted living, basic care, and nursing facilities. The ND Medical Association and the NDLTC Association testified in support of this bill. The LTC Association is training their facilities as to what they can do as far as expressing grief and sorrow.

Other legislative bills being tracked are House Bill 1351 regarding nursing home and basic care priority bills at death; House Bill 1482 contains notice requirements when admitting a convicted felon into an assisted living, basic care or nursing facility; Senate Bill 2210 that addresses accounts receivable for medical providers wherein if nursing facility and basic care bills become delinquent after 45 days, the facilities are allowed to charge 1% interest per month.

Water Temperatures

Darleen Bartz talked about water temperatures in long term care facilities, what kind of flexibility there is, and where we can go as a state. She referred to a handout from the November 21, 2006 meeting which was presented by August Pepple from the Baptist Home. He asked consideration of raising the minimum water temperature to 115-116 degrees. Several states were contacted as far as a minimum and maximum temperature. Minimum and/or maximum temperatures for several states were listed as follows:

- North Dakota – not to exceed 110 degrees F.
- Montana – not to exceed 120 degrees F.
- Wyoming – not to exceed 110 degrees F.
- Colorado – 105 to 120 degrees F.
- Utah – 105 to 115 degrees F.
- Minnesota – 105 to 115 degrees F.
- Michigan – 105 – 120 degrees F.

Information gathered from publications and articles was summarized and presented, including a chart which showed the estimated time for persons to receive second and third degree burns at various temperatures. Research also indicated the following issues:

- In nursing homes there is a risk that residents may be scalded by excessively hot water discharged from plumbing fixtures in laboratories attached to their rooms, common bathing and shower areas, public restrooms, or other fixtures to which access is not strictly controlled.
- Most residents in long term care facilities have delayed reactions to a sudden rise in water temperature. At a water temperature of 130 degrees F., only 20 seconds of exposure to scalding water can result in second or third degree burns.
- Demands of safer technology and risks of Legionella liability have stirred a trend toward institutional acceptance of the need to store hot water at 140 degrees F. or more, and maintain water at 124 degrees F. or more in hot water lines.
- Recent studies have shown that water temperatures as high as 180 degrees F. within potable distribution systems cannot immediately kill “biofilm-insulated” bacteria on contact. Simply superheating and flushing water line and fittings periodically will not necessarily ensure disinfection.
- Some facilities distribute hot water temperature as low as 120 degrees F. and some even lower, for example 110 degrees F., to eliminate any risk of scalding. Unfortunately, Legionella will grow in temperatures as high as 122 degrees F., with an ideal grow range of 95 to 115 degrees F.
- As far as scalding versus Legionella, the potential for scalding can be minimized while, at the same time, the risk of bacteria growth is reduced. With a properly designed delivery system and a temperature/pressure-sensing valve (type T/P) at the point of use, both risks are virtually eliminated. Water can be distributed at higher temperatures, reducing the danger of Legionella, while the bather is protected from scalding with temperature/protected sensing technology. With current technology, facilities no longer have to choose between possibly exposing residents to scalding or serious infection.

Darleen Bartz stated when the subject of water temperatures were brought to the table, there wasn't discussion as far as risk factors of the facilities. Kurt Stoner said these seem to be valid issues in looking at other states. Terry Goehring stated it is hard to maintain temperatures at 110 degrees F, and feels that a range would be a good thing. Randall Albrecht agreed with him and said it appears the water temperatures could be increased without a risk to burning. Darleen said we have a maximum now, but not a minimum, and questioned what would be the minimum and maximum acceptable based on Legionella. According to Helen Funk, the Ombudsman Program has received complaints that the air temperatures in the room are too cold, as well as the water temperatures.

Darleen asked if the group wants to take a further look at this with the providers, and that we need to base the information on sound judgment. Kurt Stoner questioned Darleen if she thought 120 degrees F. was too high. Darleen responded that it could be, and that we need to find what is the safest for the residents; and where can we prevent the growth of Legionella. Monte Engel stated that the mixing valve is required by the State Plumbing Code, and that commonly you would find a mixing valve at a sink or faucet. Darleen Bartz said that we don't think August People's request is out of line, and that we should do some more research with the facilities. The Department of Health has adopted the AIA standards, and they would have to adopt an exception to this. Monte Engel said that the ND Administrative Code would have to be amended. Darleen asked what questions would be good to pursue with the industry. Two areas of concern would be the time it would take for a resident to have second and third degree burns; and also at what point to avoid spread or growth of Legionella.

Shelly Peterson indicated this information could be shared at the LTCA Regional meetings, and that the first meeting is on February 8. She felt once this has been shared with the provider, we could come back and present this information as a group. Shelly asked if you want to look at one temperature versus a range, and whether the Department of Health has considered what range would be adequate. Darleen Bartz said from the Health Department's standpoint, the upper range to be considered would be 116-117 degrees F., and the lower range has not been discussed. Randall Albrecht feels if you are looking at such a short range, it would be good to talk to the facilities to see what their range is now. He feels that four degrees as a range would be difficult to maintain. Darleen Bartz said that the rationale for a change should be raised when talking with the facilities. Monte Engel said this is in the construction standards chapter, not the licensing standards. Darleen said we would be looking at an exception to this.

Criminal Background Checks

Jerry Kemmet, Director, Bureau of Criminal Investigation, gave a presentation on criminal history background checks, which are performed by his office. Currently there is legislation to expand who can obtain criminal history background checks. BCI uses one agency to filter all the background checks into. A criminal history record is initiated when an adult is arrested for a "reportable" crime. This individual is fingerprinted by the arresting law enforcement agency; and the arrest fingerprint card is the beginning of the criminal history record. This record includes information about the arrest charge and demographic information of the person who was arrested. By law, North Dakota criminal history record information can be obtained only

from BCI. There are two types of requests for a criminal history record check- “criminal justice” and “non criminal justice”. BCI conducts yearly audits of facilities/agencies who request criminal background checks.

A criminal history record check may be name-based or fingerprint-based. A name-based search will not identify records if the individual was arrested under a different name. A fingerprint-based search will identify arrest records even if the individual used an unknown alias. Before a record may be released, the subject’s name and at least two additional items of information on the request form must match the data in the criminal history record system. When the record check is completed, the criminal history records will be released to the requester.

Randal Albrecht asked if these checks just show convictions. Mr. Kemmet stated that the record check does not include the following:

- Charges that were dismissed, or did not result in conviction, or do not have a court disposition that are more than three years old.
- Jail or prison custody records more than three years old.
- Other reportable events more than three years old.
- Juvenile records.
- Federal records.
- Records from other states (BCI can provide contact information to request records from other states. Each state has different fees and requirements for release of records).
- Most traffic offenses (Contact the ND Dept. of Transportation for traffic records).
- Civil judgments (contact the Clerk of Court).

The BCI is responsible for submitting national criminal history record searches to the Federal Bureau of Investigation (FBI) for criminal justice agencies and those entities allowed by state or federal law to receive federal record check information. All FBI record searches are fingerprint based, which means that a set of fingerprints is required in order for the record check to be processed.

Shelly Peterson asked about long term care staff and whether we should be doing a background check on them. She said that the majority of states have criminal background checks now. The Department of Human Services has a small amount of money in their budget to conduct criminal background checks, but there is not sufficient money in anyone’s appropriations to do this at this time. Darleen Bartz said she will be involved in a CMS conference call next week, and she is wondering where the feds are on this issue.

Mr. Kemmet said BCI is looking at helping local law enforcement with live scan fingerprints. Kurt Stoner asked him if it would be a problem to have the local jail do the checks for us. He said they could absolutely ask them for assistance. Shelly Peterson said the Good Samaritan Society uses one company in North Dakota to do the checks. Jerry Kemmet said this would be a state-wide, not a national check. There are only certain companies you can give a national check to. Darleen Bartz mentioned there are 11,700 active CNA’s eligible to work in long term care facilities. Shelly Peterson feels in the future it is inevitable that criminal background checks will come down as a requirement from the feds. Shelly also said to Jerry Kemmet, “So what you are saying is a State check is worthless – they only involve what that person did in North Dakota?”

He replied, “Absolutely”. Shelly said another issue with residents is the sex offender, and that the Department of Human Services has suggested we should do checks on potential residents. There are currently about 6,000 residents in the State of North Dakota. Mr. Kemmet said that would be your call, but it would be pretty expensive.

Dakota Nursing Program

Elizabeth Pross, PhD, RN, and Sandra Sund, MSN, gave a presentation on the Dakota Nursing Program, which is a quality approach to the nurse shortage. The goal of the program is to provide career ladder opportunities for place bound students in rural areas. This program is an innovative nursing education consortium made possible through the collaborative efforts of four state colleges: Bismarck State College, Lake Region State College, Minot State University-Bottineau, and Williston State College. The Dakota Nursing Program students begin as certified nursing assistants and are first educated as one year practical nurses earning a certificate, and then they are able to progress on to a two year RN degree. When the DNP students graduate, they are educationally prepared to continue on to a four year BSN degree and beyond. The length of education time for a PN is 11 months, and for an RN it is two years. There is a pass rate of 95% for RNs, and 100% for PNs.

Sandra Sund said that in partnerships with nursing homes, they are able to tap into nurses that are already on board in acute care and the long term care facilities. According to Dr. Pross, the North Dakota University System says they are the only program working together collaboratively. Dr. Pross talked about Senate Bill 2379, and asked for support of this bill. This bill provides for a nursing education consortium to establish a mobile clinical nursing simulation laboratory. This is a way of sharing resources and putting a high tech lab in the rural areas. Dr. Pross asked Shelly Peterson what the critical needs are that she observes. Shelly responded that CNA turnover at 53% is critical. She said there are 10,000 staff in long term care facilities, of which 3,500 are certified nurse aides.

Quality Indicator Survey (QIS)

Darleen Bartz, Lucille Torpen, and David McCowan discussed the QIS process. The Centers for Medicare & Medicaid Services (CMS) recognized the need to improve the consistency and effectiveness of the nursing home standard survey process, and awarded a contract in 1998 to develop improvements to the process. This effort is now nearing completion, and is incorporated into a fundamental revised survey called the Quality Indicator Survey. The objectives of the process include:

- Improve consistency and accuracy of quality of care and quality of life problem identification using a structured process;
- Comprehensively review a wide range of regulatory care areas within current survey resources;
- Enhance documentation by organizing survey findings through automation;
- Focus survey resources on facilities with the largest quality concerns; and
- Achieve all improvements to the survey process within the existing survey and certification budgeted resources.

The QIS was designed as a two-stage process for use by surveyors to:

1. Systematically and objectively review a wide range of regulatory areas; and
2. Subsequently focus on selected areas for further review.

The QIS relies on a substantially expanded resident sample that permits the ability to compare facility practice with national norms, and triggers potential areas of concern in a more objective manner than the current survey process. Although the survey process has been revised under the QIS, the federal regulations and interpretive guidelines remain unchanged.

CMS will select additional states to implement the QIS based on the State's application, which must be received by March 1, 2007. The capacity of a state to implement QIS fully in the state will depend on several factors, including the resources to purchase equipment, the number of nursing home surveyors in the state, and the number of staff that a state can devote to learning the QIS process while meeting their survey workload within statutory requirements. A chart was presented which indicated the difference between the QIS and the traditional survey process. David McCowan said that with the QIS process, the surveyors would be utilizing tablet computers. Darleen Bartz said the Long Term Care Association and the ND Department of Health have talked for some time about changing the survey process. She stated that what we have going against us is that we are a small state and the facilities are small. There needs to be 150 plus beds for the survey. North Dakota has seven or eight facilities who would fall under this category. Darleen asked how this group feels about this, and whether we should put our name in the hat for budget purposes. Do we want to look at this new system as soon as possible, or wait until it is a requirement? This survey process is a more objective view. They are looking at four surveyors per survey. Shelly Peterson said she likes the objective of being more consistent. She feels if there is a change, it is important to do some training for the facilities so they are aware of the process.

Darleen Bartz said that in the QIS process regarding random census sample, 40 residents currently in facility are selected through offsite and onsite activities. Modifications to this process are able to work in smaller facilities. Shelly Peterson likes the random selection process, but questioned the surveyor-initiated sample, where residents are selected at surveyor's discretion. Lucille Torpen stated this would be if a surveyor noticed something that triggered a concern, then they would select this sample. Darleen Bartz said this survey process tends to identify more deficiencies. Shelly Peterson would like to send a survey to the other states who have implemented this and get their reaction. Darleen felt it would be good for this group to get feedback from Shelly after she receives input from the long term care facilities, as well as other states who are familiar with the process. David McCowan said the survey teams would be set up and trained prior to the start of the new process.

Life Safety Code Update

Monte Engel said the ND Department of Health has received some concerns from the long term care industry on the criteria used to determine whether corridor doors resist the passage of smoke. He said the Life Safety Code does not define what constitutes a resistance to the passage of smoke. The only CMS guidance Monte could find on this subject is in the draft Appendix I,

which states, “Open and close a random sample of doors to determine if the doors latch properly (holds the door shut) and fits into the frame snugly and does not allow smoke to pass around the edges of the door.” One of the industry concerns was the use of the light test. It appears that our surveyors are using the passage of light around the door to illustrate the door does not fit tightly into the frame.

The response to Monte’s request for clarification from Francis Reuer, CMS Regional Office in Denver, is as follows: “The light test is a practical means of determining whether the door fits snugly in the frame. With the amount of light passing between the room corridor doors and frames, it is not difficult to imagine the amount of smoke that would be billowing into the corridor from a fire in a room. Not at any time have we cited a specific gap between the doors and frames in determining whether they are resistant to the passage of smoke. I like the term, fitting snugly in their frame, however, how many of these doors do that anymore. As of yet, we have no interpretation regarding the smoke resistance of corridor doors. CMS has sent a draft to the Regions for comment regarding this issue, however not thing has been finalized.”

Monte stated that, in summary, Region VIII is suggesting we continue as we have until we receive something different in a directive from Central Office, such as a Survey & Certification letter.

Monte Engel talked about a Federal Register dated October 27, 2006 from CMS regarding proposed rules for automatic sprinkler systems, which would require all long term care facilities nationwide to be equipped with sprinkler systems. This proposed rule especially requests public comments on the duration of a phase-in period to allow long term care facilities to install such systems. Fiscal analysis was based on a five, seven, or ten year period. There would have to be a funding mechanism for this process. One-quarter to one-third of the long term care facilities in this state do not have a sprinkler system.

Monte Engel said a Federal Register dated September 22, 2006 regarding a final rule effective October 23, 2006, addresses alcohol-based hand rub solutions and smoke detectors. This final rule adopts an April 15, 2004 tentative interim amendment. This amendment allows certain health care facilities to place alcohol-based hand rub dispensers in egress corridors under specified conditions. This final rule also requires that nursing facilities at least install battery-operated single station smoke alarms in resident rooms and common areas if they are not fully sprinklered, or they do not have system-based smoke detectors in those areas.

Kurt Stoner asked if this is being enforced consistently throughout the country. Darleen Bartz said we need to look at it consistent with our guidance. Monte Engel said to Kurt Stoner in regard to his earlier question of consistency about corridor doors, that corridor doors are the number one cited deficiency in North Dakota, the Region, and the Nation.

Life Safety Code Business Process Reengineering Update

Darleen Bartz presented an update on the LSC Business Process Reengineering, and summarized it as follows:

The External BPR group met on 12/19/06 to collect information on what the LSC issues are according to the providers in long term care. Issues that emerged included:

- Desire for LSC surveyors to provide training/education to long term care facility staff both during their survey and in other educational venues.
- Desire for consistency among LSC surveyors.
- LTC facility access to information – Dept. of Health and CMS websites.
- Knowledge level of facility environmental staff regarding LSC requirements.
- Need for facilities to do environmental quality assurance assessments – training needed in this area?
- Desire of LTC facilities to be aware of good environmental products.

The Internal BPR workgroup meetings were held to further discuss the above items on January 18 and January 25, 2007. The internal workgroup has been strategizing on ways to:

- Get information out to those that need it.
- Educational methods and opportunities.
- Education targeted to specific facility staff.
- Resources currently available and in what format – how can it be used in ND.
- Research types of LSC citations written, and ways facilities can achieve compliance on an ongoing basis.

The next meeting is scheduled with the external workgroup on February 20, 2007.

Next Meeting and Suggestions for Future Agenda Items

The next meeting of the Long Term Care Advisory Committee was set for Tuesday, May 22, 2007 from 10:00 a.m. to 3:00 p.m. in Room 212 of the Health Department. Suggested agenda items include:

- Standing Reports
 - Division of Health Facilities
 - ND Long Term Care Association
 - Ombudsman, Department of Human Services
 - Update on Legislative Session
- My InnerView Update
- Background Checks – Judy Volk
- QIS Update
- Corridor Doors – Monte Engel
- QIO – LANE Quality Initiative

The meeting adjourned at 3:05 p.m.