LNHA Agency Liaison Meeting | MINUTES

August 20, 2025 | 1:30 p.m. | LNHA Office

Committee members present:	Staff members:
Jamie Shelton (Central Management), Scott Broussard (TrustCare Management), Dale Cooney (Inspired Management), Kaley Hill (Hometown Healthcare Management), Myles Holyfield (Legacy Management), Andy Hughes (Pathway Management), Andy Hughes (Pathway Management), Marcus Naquin (Hammond Nursing Home), Tanya Procell (Provider Professional Services), Dawn Rogers (Central Management), Mike Scanlan (Pathway Management), Wade Welborn (PMC)	Wes Hataway and Karen Miller
Absent: Branden LeBlanc (Diversified Healthcare), Jack Sanders (TrustCare Management), Stephanie Marriott (Priority Management), Steven Boulware (Priority Management)	Guests: Cullen Brewer (Louisiana Department of Health Health Standards Section Long Term Care Manager), J. Michelle Lewis (LDH HHS Long Term Care Supervisor), Darren Guillory (HSS Operations Manager), Myron Chatelain (LNHA Service Corp.), Toni Parkinson (Administrative Systems)

LNHA Agency Liaison Committee Chairman Jamie Shelton welcomed the Louisiana Department of Health (LDH) representatives and thanked them for attending the meeting. Mr. Brewer introduced LDH Health Standards Section Survey Operations, Information Systems, State Performance and Training Manager Darren Guillory to the committee. The following questions were discussed and LDH's answers are provided in blue.

- Surveys
    - Administration F835: According to data compiled by the American Health Care Association, the most frequently cited immediate jeopardy deficiency in Cycle 1 for Louisiana was F835 (Administration). The data show Louisiana receives a disproportionately high number of citations in this category compared to the rest of the nation. What trends are driving these citations and what strategies can be implemented to address them?

      Answer:
        - F835 citations have been trending down since 2023.
        - Administrative personnel are aware of issues and not addressing as they are discovered.
        - Guidance in Appendix PP for citation is as follows:
          "Cite this tag if the actions, inactions, or decisions in administering the facility contributed to deficient practice(s). The facility's administration is not limited to the administrator and may also include the facility's governing body, management company, and/or others identified by the facility as part of the facility administration."
        - We continue to examine F835 citations to ensure proper citation.

- During a recent survey, several policy requests were made that fell outside typical requirements.
  - Example 1: whirlpool disinfection
    Given the wide variety of whirlpool models, nursing facilities follow each manufacturer's recommended sanitation procedures rather than maintaining a single, universal policy.

  - Example 2: bedrails
    Federal guidelines are followed as appropriate use of bedrails vary significantly based on individual resident needs and circumstances. While we understand and appreciate the intent behind the requests, the realities of day-to-day operations make compliance increasingly challenging. How can we work together to resolve this issue?

    Answer:
    - Policy review is part of the record review process. Surveyors may ask for a policy if potential non-compliance is being investigated.

    - Example 1: if a staff member is not following a manufacturer's sanitation procedure for whirlpool disinfection, they may ask to see the policy that states staff shall follow it.

    - Example 2: while individual resident needs and circumstances may vary significantly, minimum requirements must be met to ensure their use. A surveyor may ask to see a policy, if a surveyor finds that minimum requirements are not being met for a resident to determine if it's a possible system issue.

- Is LDH considering moving to a 10-hour, 3-day survey process? If so, what is the anticipated implementation timeline?

  Answer: Many surveyors have transitioned from a 5-day work week (8 hour/day) to a 4-day work week (10 hour/day). This schedule was implemented with 4 goals in mind:

  - Increase efficiency – Surveyors spending more time on site during work day

  - Reduce travel cost – Surveyors completing surveys in fewer days resulting in a reduction in costs for overnight stays and mileage reimbursement

  - Address recruitment and retention challenges – Department was having a difficult time recruiting and retaining RNs

  - Address provider complaints – Many providers were complaining that surveyors were spending too many days on-site during surveys

  - Not all surveyors are on a 4-day work week, due to personal preference or training.

- Requesting discussion on F627 and F628, specifically regarding the required components of a discharge notice and strategies to ensure compliance with these requirements.
  Answer:
  - F627 (Transfer and Discharge)
    - The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
      - The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
      - The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
      - The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
      - The health of individuals in the facility would otherwise be endangered;
      - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
      - The facility ceases to operate.
  - The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.
  - When the facility transfers or discharges a resident under any of the circumstances the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
  - Documentation in the resident's medical record must include:
    - The basis for the transfer.

- The specific resident need(s) that cannot be met, facility attempts to meet the resident's needs, and the service available at the receiving facility to meet the need(s).

- The documentation must be made by the resident's physician when transfer or discharge is necessary.

- A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

- A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following:

    - A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident:

        - Requires the services provided by the facility; and

        - Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

    - If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements as they apply to discharges.

- The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

    - Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

    - Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

    - Involve the interdisciplinary team in the ongoing process of developing the discharge plan.

    - Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

- Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

- Address the resident's goals of care and treatment preferences.

- Document that a resident has been asked about their interest in receiving information regarding returning to the community.

- If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

- Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

- If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

- For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

    - Publicly available standardized quality information, as reflected in specific quality measures, such as the CMS Nursing Home Compare, Home Health Compare, Inpatient Rehabilitation Facility (IRF) Compare, and Long-Term Care Hospital (LTCH) Compare websites, and

    - Resource use data, which may include, number of residents/patients who are discharged to the community, and rates of potentially preventable hospital readmissions.

- Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

- When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

- A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

- F628 (Transfer and Discharge – Documentation)

  - When the facility transfers or discharges a resident under any circumstances the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

  - Information provided to the receiving provider must include a minimum of the following:

    - Contact information of the practitioner responsible for the care of the resident.

    - Resident representative information including contact information.

    - Advance Directive information.

    - All special instructions or precautions for ongoing care, as appropriate.

    - Comprehensive care plan goals;

    - All other necessary information, including a copy of the resident's discharge summary and any other documentation, as applicable, to ensure a safe and effective transition of care.

    - Before a facility transfers or discharges a resident, the facility must—

    - Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

    - Record the reasons for the transfer or discharge in the resident's medical record and

  - Include in the notice the following items:

    - The reason for transfer or discharge;

- The effective date of transfer or discharge;
- The location to which the resident is transferred or discharged;
- A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
- The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
- For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
- For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

- Timing of the notice.
  - The notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged, or
  - Notice must be made as soon as practicable before transfer or discharge when:
    - The safety of individuals in the facility would be endangered;
    - The health of individuals in the facility would be endangered;
    - The resident's health improves sufficiently to allow a more immediate transfer or discharge;
    - An immediate transfer or discharge is required by the resident's urgent medical needs, or
    - A resident has not resided in the facility for 30 days.

- Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

- Notice of bed-hold policy and return—

  - Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—

  - The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

  - The reserve bed payment policy in the state plan, if any;

  - The nursing facility's policies regarding bed-hold periods.

- Discharge Summary (in addition to requirements at F627)

  - When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

    - A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

    - A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

    - Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

- Requesting discussion on abuse reporting requirements for altercations between residents with low BIMS scores. For example, if two such residents dispute a personal item, at what point is reporting required—following a verbal altercation with cursing, a physical struggle over the item, or a physical altercation (shoving) resulting from the disagreement?

  Answer: Resident to resident altercation should be reviewed as a potential situation of abuse. Resident-to-resident altercations that must be reported in accordance with the regulations include any willful action that results in physical injury, mental anguish, or pain, as defined at §483.5 of the State Operation Manual (SOM) – Appendix PP. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. It is important to remember that

abuse includes the term “willful”. The word “willful” means that the individual’s action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (“willful”) action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. An alleged violation of not only abuse, but also, neglect, misappropriation of resident property and exploitation would be considered to be reasonable suspicion of a crime. In these cases, the facility is obligated to report to the administrator, to the state survey agency, and to other officials in accordance with State law. Please review F609 in the SOM, Appendix PP (most current) that gives in-depth information of the reporting requirements and also a list (not all inclusive) of multiple examples of mental/verbal, sexual, physical offenses that are required to be reported to the appropriate authorities within the prescribed timeframe.

- Request for clarification on definition of a restraint.
  We have received conflicting explanations from surveyors regarding what constitutes a restraint. For example, pommel cushions, self-releasing seat belts, mattresses with raised sides and lap buddies. What specific criteria determine when these items are **not** considered a restraint?

  Answer: “Physical restraint” is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:

  - Is attached or adjacent to the resident’s body;
  - Cannot be removed easily by the resident;
    - “Removes easily” means that the manual method, physical or mechanical device, equipment, or material, can be removed intentionally by the resident in the same manner as it was applied by the staff.
  - Restricts the resident’s freedom of movement or normal access to his/her body.
  - Examples of facility practices that meet the definition of a physical restraint include, but are not limited to:
    - Placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed;
    - Placing a resident on a concave mattress so that the resident cannot independently get out of bed;
    - Tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident’s freedom of movement is restricted;
    - Placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently;

- Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising;

- Applying leg or arm restraints, hand mitts, soft ties or vests that the resident cannot remove;

- Holding down a resident in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care;

- Placing a resident in an enclosed framed wheeled walker, in which the resident cannot open the front gate or if the device has been altered to prevent the resident from exiting the device; and

- Using a position change alarm to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm.

▪ Assessment, Care Planning, and Documentation for the Use of a Physical Restraint

- The regulation limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints. There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint.

- However, the practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint. The facility is accountable for the process to meet the minimum requirements of the regulation including appropriate assessment (see § 483.20 – Resident Assessment), care planning by the interdisciplinary team (see § 483.21 Comprehensive Person-Centered Care Planning), and documentation of the medical symptoms and use of the physical restraint for the least amount of time possible and provide ongoing re-evaluation.

- The resident or resident representative may request the use of a physical restraint; however, the nursing home is responsible for evaluating the appropriateness of the request and must determine if the resident has a medical symptom that must be treated and must include the practitioner in the review and discussion. If there are no medical symptoms identified that require treatment, the use

- Facilities are responsible for knowing the effects devices have on its residents. If a device has a restraining effect on a resident, and is not administered to treat a medical symptom, the device is acting as a physical restraint. The restraining effects to the resident may have been caused intentionally or unintentionally by staff, and would indicate an action of discipline or convenience. In the case of an unintentional physical restraint, the facility did not intend to restrain a resident, but a device is being used that has that same effect, and is not being used to

treat a medical symptom. These effects may result in convenience for the staff, as the resident may require less effort than previously required.

- The use of a restraint must be individualized and based upon the resident's condition and medical symptoms that must be treated. While a physical restraint may be used to treat an identified medical symptom for one resident, the use of the same type of restraint may not be appropriate to treat other residents with the same medical symptom. If a resident is identified with a physical restraint, the facility must be able to provide evidence that ensures:
    - The resident's medical symptom that requires the use of a physical restraint has been identified;
    - A practitioner's order is in place for the use of the specific physical restraint based upon the identified medical symptom;
    - Interventions, including less restrictive alternatives were attempted to treat the medical symptom but were ineffective;
    - The resident/representative was informed of potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use;
    - The length of time the restraint is anticipated to be used to treat the medical symptom, the identification of who may apply the restraint, where and how the restraint is to be applied and used, the time and frequency the restraint should be released, and who may determine when the medical symptom has resolved in order to discontinue use of the restraint;
    - The type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of the monitoring;
    - The identification of how the resident may request staff assistance and how needs will be met during use of the restraint, such as for re-positioning, hydration, meals, using the bathroom and hygiene;
    - The resident's record includes ongoing re-evaluation for the need for a restraint and is effective in treating the medical symptom; and
    - The development and implementation of interventions to prevent and address any risks related to the use of the restraint

- In April 2024, CMS piloted a risk-based survey (RBS) for nursing facilities, allowing higher quality facilities to receive a more focused recertification survey that takes less time and resources than the traditional format. What is the status of this pilot program and is CMS planning to roll it out nationally?

Answer: CMS is still working on refining and evaluating the RBS based on feedback from the states where this was piloted, stakeholders, including providers and advocacy groups like Leading Age.

- The thought behind the RBS is instead of the standard, comprehensive recertification survey, nursing homes meeting specific criteria can receive a more targeted and potentially shorter survey.
- While the exact criteria for eligibility are still being refined, some factors being considered include:
- History of fewer citations for non-compliance.
- Higher staffing levels.
- Fewer hospitalizations.
- No citations related to resident harm or abuse.
- States will only be able to conduct a % of eligible providers per year utilizing RBS and RBS cannot be used for consecutive re-certifications at a provider.
- No decision has been made regarding the implementation of utilization of the RBS.

- Have there been any new CMS requirements for policy requests made by surveyors that nursing facilities should be aware of? What is the standard for policies requested by onsite surveyors?

  Answer: No, there are no new requirements. Policy review is part of the record review process. Surveyors may ask for a policy if potential non-compliance is being investigated.

- Regulations
  - QSO-25-20-NH announced that CMS will begin including Medicaid, Medicare and Medicare Advantage encounter data to supplement MDS data related to antipsychotic medication use. This change will take effect on October 29, 2025. What will be required of nursing facilities to implement the change?

    Answer: Nothing is required of nursing facilities to implement this change.

    Data collected will be used to determine accuracy of MDS information submitted by nursing facilities concerning anti-psychotic medication use.

    This data will be integrated into the Nursing Home Compare Five Star ratings.

    No further information has been given.

  - QSO-25-14-NH, which introduced revised guidance and training for Nursing Services and Payroll Based Journal to the updates for Appendix PP and the Long-Term Care

Survey Process, took effect on April 28, 2025. Since implementation, what trends or compliance issues have emerged? In what areas should nursing facilities focus additional attention?

Answer: No new trends have emerged. Citation rates are the same.

Ensuring accuracy prior to submission. A few citations indicated that what was submitted by corporate office for PB&J did not match time entries.

- Preadmission Screening and Resident Review (PASRR)
  - Please review the specific diagnoses that require a second-level PASRR screening.

Answer: An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:

- Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987.

- This mental disorder is—

  - A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or

  - Another mental disorder that may lead to a chronic disability; but

  - Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder.

- Level of impairment. The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis:

- Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

- Concentration, persistence, and pace. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks; and

- Adaptation to change. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social

interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

- Recent treatment. The treatment history indicates that the individual has experienced at least one of the following:

  - Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or

  - Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

- Request for clarification on Level 2 reviews
  For example, if a resident returns from a psychiatric stay and experiences a medication change within the month, should two submissions be made — one upon return and another following the medication change?

  Answer: No, unless the medication change was related to a change in diagnosis.

  Additionally, at what point should a resident who has completed a PASRR Level 1 screening, but was not initially classified as Level 2, be referred for a Level 2 evaluation? Specifically, what changes in condition or presentation would warrant initiating this next level of assessment?

  Answer: Citations related to non-completion of a PASRR level 2, fall into two categories:
  - Hospital discharges to nursing facilities with only a level 1 and the submission fails to indicate a diagnosis that would trigger a level 2; however, the NH submits an MDS which indicates a diagnosis that does indicate one is required. The facility fails to request a Level 2; or,

  - The facility does not submit a level 2 for the following:
    - A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).

    - A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.

    - A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

- Common issues cited
  - What common deficiencies are cited under abuse/neglect? Please share any observations or trends.

Answer:

- Resident to resident abuse and staff abuse
- Staff knowing the care plan, and willfully failing to provide the care and services according to the CCP.

- What common deficiencies are cited during infection control and traditional surveys? Please share any observations or trends.

Answer:

- HSS is no longer conducting Infection control surveys as per QSO-25-23, revised July 30, 2025.
- For traditional re-certs, the following are common deficiencies:

F-Tag	Tag description	# of times cited
656	Develop/Implement Comprehensive Care Plan	134
884	Reporting - National Health Safety Network	101
880	Infection Prevention & Control	100
812	Food Procurement, Store/Prepare/Serve - Sanitary	97
609	Reporting of Alleged Violations	84
689	Free of Accident Hazards/Supervision/Devices	82
600	Free from Abuse and Neglect	80
677	ADL Care Provided for Dependent Residents	76
641	Accuracy of Assessments	66
695	Respiratory/Tracheostomy Care and Suctioning	62

A committee member inquired about National Healthcare Safety Network (NSHN) reporting requirements. Mr. Brewer noted that the original rule expired on December 31, 2024. On January 1, 2025, new NHSN reporting requirements went into effect. The data elements for which NHSN reporting is required include:

- Facility census
- Resident vaccination status for COVID-19, influenza, and RSV,
- Confirmed resident cases of COVID-19, influenza, and RSV (overall and by vaccination status)
- Hospitalized residents with confirmed cases of COVID-19, influenza, and RSV (overall and by vaccination status).

He emphasized that NHSN reporting remains an integral part of quality reporting and cautioned that noncompliance could cause the facility to lose Medicare dollars.

Mr. Shelton thanked LDH representatives for their assistance, attendance and continued partnership.

Mr. Hataway noted that LNHA formed the LNHA AIM-5 Committee to review state-specific quality measures and staffing data with the goal of identifying opportunities to improve Louisiana's overall Five-Star rating.