LNHA Agency Liaison Meeting | Minutes

February 15, 2023 | 9:30 a.m. | LNHA Office

Committee members present: Jamie Shelton (Central Management), Scott Broussard (TrustCare Management), Kaley Hill (Hometown Healthcare Management), Myles Holyfield (Legacy Management), Andy Hughes (Pathway Management), Branden LeBlanc (Diversified Healthcare), Stephanie Marriott (Priority Management), Dawn Rogers (Central Management), Mike Scanlan (Pathway Management) Absent members: Jack Sanders (TrustCare Management), Steven Boulware (Priority Management), Jeff Burch (Inspired Healthcare Management), Marcus Naquin (Hammond Nursing Home), Tanya Procell (Provider Professional Services), Dale Hewitt (Senior Village)	Staff members present: Mark Berger, Wes Hataway, Karen Miller Guests present: Tasheka Dukes (LDH Deputy Assistant Secretary), J. Michelle Lewis (LDH HHS Long Term Care Supervisor), Alisa Morris (LDH HHS Medical Certification Program Manager), Cullen Brewer (LDH HHS Long Term Care Manager), Chris DeLaune (Priority Management), Cami Baughman (TrustCare Management)

LNHA Agency Liaison Committee Chairman Jamie Shelton welcomed the Louisiana Department of Health (LDH) representatives and thanked them for attending the meeting. The following items were discussed.

- Clarification on requirements
  - Utilizing an Unlicensed Staff Member
    - Is a nursing facility allowed to continue to utilize temporary nurse aides (TNAs) or other non-licensed staff members if the staff member does not provide direct care?
      LDH HHS Long Term Care Manager Cullen Brewer stated that there is nothing prohibiting the use of non-direct care staff, provided regulatory requirements are followed.

    - If they have been trained, may a non-licensed staff member provide dining room assistance?
      Mr. Brewer referenced the Paid Feeding Assistance requirements, 9837.Feeding assistance and noted that based on the staff member's training, they can provide feeding assistance in the dining room.

  - Loss of Nurse Aide Training Program
    - Can the loss of a certified nurse aide (CNA) training program be rescinded? If so, please detail the steps the facility should take.
      No, it cannot be rescinded. However, per S&C 18-02-NH, the guidance *permits a State to waive the 2-year prohibition of the NATCEP* ***offered in (not by)*** *nursing facilities. The prohibition against the offering of a program can be waived if the State:*

      1) determines that there is no other such program offered within a reasonable distance of the facility,

2) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

3) provides notice of such determination and assurances to the State long-term care ombudsman.

CMS defines reasonable distance as an hour from the facility.

- Bed-hold Policy
  - If a nursing facility chooses not to enforce a bed-hold policy, must it still provide written notice to a resident if they become hospitalized?
    The facility must follow its bed-hold policy. Mr. Brewer referenced the regulatory requirement of the State Operations Manual (SOM) Appendix PP F625, dated February 2, 2023 (beginning on page 198 in the PDF).

- Recordkeeping
  - What is the current guidance for the recordkeeping requirement for visitors who enter the nursing facility? Must all who enter the facility (family members, vendors, delivery workers, etc.) be logged? Will there be a change in guidance with the end of the public health emergency (PHE)?
    Mr. Brewer referenced QSO-20-39 NH revised and current CDC guidance dated September 23, 2022. While a visitor log is not mandatory, current CDC guidance states the following:

    Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others
    Healthcare facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed.

    It is unknown if guidance will change with the end of PHE.

- Reporting of Abuse and Neglect
  - Please provide a general review of the current guidance on reporting abuse and neglect thresholds.
    LDH HHS Long Term Care Supervisor J. Michelle Lewis noted that per SOM Appendix PP F609 (beginning at page 150 of the PDF), facilities should *"ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than **2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury**, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures…"*

    She noted that the F609 guidance provides examples of reporting requirements based on various scenarios. Click here and begin reading on page 161 of the PDF. LDH reminded facilities to be sure to thoroughly document all instances of

any suspected or alleged abuse or neglect.

- Please discuss the threshold for reporting resident-to-resident abuse. For instance, should the resident's Brief Interview for Mental Status (BIMS) score be considered or the intent of the parties involved?
  Ms. Lewis referenced SOM Appendix PP F610 (beginning at page 172 of the PDF) and noted that although the requirement does not identify the BIMS score to be a required component, it is viewed as a pertinent finding of a thorough investigation to determine whether appropriate actions were taken by the facility to protect residents from future occurrences. The BIMS score is one of many factors that is considered to help determine whether an on-site survey is warranted.

- State Surveys
  - Once a statement of deficiencies and plan of correction (CMS 2567) is issued and a plan of correction with a completion date is provided, can surveyors check for compliance before the completion date?
    Mr. Brewer answered yes depending on the specific circumstances of the surveys. He requested that committee member Stephanie Marriott send an email detailing the specific situation to resolve the issue.

  - Anecdotally, state surveyors are issuing immediate jeopardy (IJ) citations more frequently. Is this trend supported by data?
    Yes, 2022 had more IJs cited than 2020 and 2021. However, historically, 2019 was comparable to 2022, as there were no recertification surveys or 30-day complaint surveys in 2020. Recertification surveys were not reinstituted until March 2021.

    Five more IJs were cited in 2022 than in 2019 statewide. However, the rate of providers receiving IJs has gone down. In 2019, 28 nursing facilities received IJs compared to 2022, with 19 receiving IJs. Additionally, more severe citations were issued in 2022, including three L Level citations.

  - Please provide common issues when an IJ is cited.
    Mr. Brewer noted that common issues for IJ citations include administration, quality of care, accidents and hazards, infection control, not having an infection control preventionist and abuse and neglect.

    Mr. Berger requested an example of an IJ citation classified as "administration." LDH stated that it would be cited if the facility's administration played a role in creating or allowing conditions for an IJ to occur.

  - If part of the plan of removal for an IJ includes an in-service of all employees, should that include employees who are on leave or quarantined for COVID-19?
    The IJ Plan of Removal should address these situations and include how the provider will in-service staff upon returning to duty and before providing care.

- What are some common issues cited during infection control surveys and traditional surveys? Please provide any observations and trends.
  Common findings during Focused Infection Control Surveys include staff not performing proper hand hygiene, such as changing gloves while providing wound care or care between residents.

  Common findings during traditional surveys include:
  - notification of change relative to failing to notify the physician or the resident's responsible party of change in the resident's condition
  - quality of care relative to nursing staff failing to identify a change in resident's condition and residents not receiving treatment according to their care plan
  - staff-to-resident physical and verbal abuse
  - accidents and hazards relative to failing to use two persons during a lift transfer
  - failure to timely report abuse or not reporting reportable incidents at all

LDH representatives provided information on the following topics:

- Mr. Brewer reminded members of CMS' plan to issue a proposal for minimum staffing requirements for skilled nursing facilities.

- Mr. Brewer noted that CMS continues to work to reduce antipsychotic use. QSO 23-05-NH issued on January 18, 2023, states that CMS will adjust the quality measure star ratings for facilities whose audit reveals inaccurate schizophrenia coding. Audits will be based on MDS assessments. LDH is not involved in the audits. If a facility admits miscoding after being notified by CMS that the facility will be audited, but prior to the start of the audit, CMS will consider a lesser action related to their star ratings, such as suppression of the quality measure ratings (rather than downgrade).

  Mr. Berger inquired what "lesser penalty" is defined as. LDH referred to the guidance as they did not have specifics.

  Mr. Berger asked LDH if a resident is admitted with a schizophrenia diagnosis, what occurs then? Mr. Brewer noted that he would respond to the question via email. Via email, he provided SOM Appendix PP F758 (beginning of page 561 of the PDF).

- LDH Deputy Assistant Secretary Tasheka Dukes noted that LDH has completed reviewing all nursing facilities' emergency preparedness plans in the 22 parishes listed in Act 540. LDH Health Standards is working on completing the letters that include the recommendations for changes to be made and nursing facilities will receive that soon. Ms. Dukes noted that no emergency preparedness plans have been approved and all have recommendations for changes or additional information. Facilities will receive one letter with recommendations and LDH expects a response in two weeks. The letter to the facility with recommendations will be sent in the next couple of days via certified mail and also will be emailed to the administrator. LDH will be working with nursing facilities to approve the plans. Nursing facilities in the remaining 42 parishes have until September 1, 2023, to submit their facility's emergency preparedness plan.

- Mr. Shelton inquired if LDH knows if CMS will resume the regional meetings for CMS Region VI. LDH did not know.

- Mr. Berger noted that LSU Health has Civil Money Penalty (CMP) grant funding that allows them to provide facilities with fall prevention and wound care trainings. He encouraged members to take advantage of the free training opportunity.

Mr. Shelton thanked LDH representatives for their assistance, attendance and continued partnership. He also noted that this meeting will be held quarterly.