North Dakota Department of Health

Long Term Care

Collaborative Workgroup

Report

2015-2016

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Appendices

Introduction

The formation of the North Dakota Long Term Care Collaborative Workgroup resulted from concerns identified by North Dakota Department of Health and the Long Term Care Industry related to the increased number of G-Level deficiencies cited in North Dakota during the Centers for Medicare and Medicaid Fiscal Year 2014. As a result of these concerns, the North Dakota Long Term Care Association surveyed their members in an effort to identify other areas of concern. The results of the survey were brought to North Dakota Department of Health Leadership.

The decision was made to form the North Dakota Long Term Care Collaborative Workgroup. The purposes of the Workgroup were to 1) Identify key issues/concerns related to the survey and compliance of Long Term Care Facilities and prioritize those concerns; and 2) To discuss ways we can collaboratively work together on the identified priority issues/concerns.

The Workgroup members were identified in February 2015, with some additional members added as the workgroup moved forward. Please refer to Appendix A for a listing of the Workgroup Members. Once formed, the workgroup has met every one to three months to work together on these issues.

This document summarizes the work of the workgroup, including action steps, or deliverables which have resulted from this collaborative effort.

Identification of Areas of Focus

The first meeting of the North Dakota Department of Health (NDDoH) Long Term Care (LTC) Collaborative Workgroup was held March 5, 2015. The purpose of the formation of this workgroup was identified to be twofold: 1) Identify key issues/concerns related to the survey and compliance of Long Term Care Facilities and prioritize those concerns; and 2) To discuss ways we can collaboratively work together on the identified priority issues/concerns.

During this meeting, education was provided by Lucille Rostad, NDDoH Division of Health Facilities Long Term Care Program Manager, on the Federal Long Term Care Survey Process and Decision Making. The focus of this presentation was on the Centers for Medicare and Medicaid Services (CMS) Long Term Care Standard Survey process. The survey process was identified to be resident-centered and outcome-oriented. The survey process measures quality of care and services furnished by facilities as measured by indicators including:

- Medical, nursing, rehabilitative care and drug therapy;
- Dietary and nutrition services
- Activities and social participation
- Sanitation and infection control

The survey process also measures the effectiveness of the physical environment to:

- Empower residents
- Accommodate residents' needs
- Maintain safety

Each task of the standard survey was reviewed including:

- Task 1: Offsite Survey Preparation
- Task 2: Entrance Conference and Onsite Preparatory Activities
- Task 3: Initial Tour
- Task 4: Sample Selection
- Task 5: Information Gathering
- Task 6: Information Analysis for Deficiency Determination
- Task 7: Exit Conference

For additional information on these tasks, please refer to the CMS State Operations Manual Appendix P Survey Procedures for Long-Term Care Facilities.

The Workgroup members discussed the information presented. There are 19 surveyors in the LTC survey program. The number of surveyors on a team is dependent upon the size of the facility. Each team will have a minimum of one registered nurse, and other team members come from various professional health care disciplines. Discussion ensued related to the consistency in the survey process being implemented by all surveyors in all facilities. Some workgroup members felt there was a lot of subjectivity in the survey process, which could result in inconsistency in what was cited as a deficiency between facilities. It was identified that the survey process is a Quality Assurance Process which focuses on a point in time, rather than a

Quality Improvement process. Other issues that were identified that could impact the outcome of the survey process and resultant findings include changes/inconsistency in facility staff, changes in leadership positions in the facility, the acuity of residents cared for by the facility, administrator or director of nursing, use of travel staff, and the facility's own quality assurance and quality improvement process.

Shelly Peterson, President, North Dakota Long Term Care Association provided the results of the survey that had been completed via Survey Monkey with her member facilities related to the survey process. There were 53 skilled/nursing facility respondents out of 80 potential respondents. The skilled/nursing facilities provided responses to 23 questions on various topics. Department of Health staff provided a brief status report on each of the topics. Two additional topics were added: Plans of Correction and G-Level Citations.

Next, Bruce Pritschet, NDDoH Health Facilities Division Director, provided data related to survey citations during CMS Fiscal Year 2014. The average number of G-level citations per facility in North Dakota for the CMS Fiscal Year was 0.38, compared to a CMS Region VIII average of 0.21 and a national average of 0.06. Based on the information shared, the top cited G-level citations during this time frame were identified to be:

F325: Nutrition
F323: Free of Accident/Hazards/Supervision/Devices
F309: Provide Care/Services for Highest Wellbeing
F314: Pressure Ulcers

The report also identified that the number of complaints received by the NDDoH regarding LTC Facilities had significantly increased. The data reflected that in 2010, the NDDoH received 59 complaints, in 2011 received 110 complaints, in 2012 received 92 complaints, in 2013 received 120 complaints, and in 2014 received 171 complaints. The more frequent source of complaints was identified to be family members and facility staff members. The number of complaints validated rose some during this time frame, with 10 complaints validated in 2010, 24 in 2011, 27 in 2012, 28 in 2013, and 46 in 2014.

Workgroup members were provided the opportunity to vote on what they believed to be the key issues that should be addressed by the Collaborative Workgroup. Five issues emerged as the key issues to be addressed by the collaborative. Appendix B contains a listing of the questions with the five key areas highlighted.

Action Step 1: During the March 5, 2015 meeting, identify the five key issues to be focused upon by the Workgroup.

Response to Action Step 1: The five key issues were identified by the Workgroup members during the March 5, 2015 meeting in the following priority order as follows:

1. High Number of G-level Citations
2. Objectivity and Fairness of the IDR Process
3. Subjectivity in the Survey Process
4. Communication during the Survey Process
5. Increased Potential for a Citation when Caring for Behaviorally Difficult Patients

Subjectivity in Interpretation and Decision Making

The second NDDoH LTC Collaborative Workgroup meeting was held on April 9, 2015. The topics to be discussed at this meeting were Priorities 1: High Number of G-Level Citations, and Priority 3: Subjectivity in the Survey Process.

General discussion took place by the Workgroup Members. Concern was identified related to the inconsistency in how the federal survey process was carried out between states and CMS regions, an example being given that a neighboring state left draft deficiency statements with the facilities following the exit and prior to leaving the facility. It was acknowledged that this may be due to the neighboring state being a Quality Indicator Survey (QIS) state versus a Traditional Survey process state such as North Dakota.

Concern was also identified related to the number of G-level citations cited in North Dakota when compared to other states. Discussion was held related to the need to get to the root cause of this issue, and for the assessment of facilities using the survey process to be consistent between states and surveyors.

The Workgroup discussed how communication took place with the facility when the NDDoH received new Survey and Certification (S&C) letters from CMS which identified changes in the survey process. The S&C letters are public information accessible to anyone via the CMS website. The NDDoH staff presents new recent S&C letters quarterly at the ND LTC Advisory Committee meetings with the expectation that Shelly Peterson, as the President of the NDLTCA, share the information with her member facilities.

Action Step 2: During the April 9, 2015 meeting, the request was made for S&C letters that pertain to LTC to be emailed from the SSA to Shelly Peterson to distribute to her LTC member facilities.

Action Step 2 Response: It was decided that the Health Facilities Division Director or designee would review the new CMS S&C letters each Friday when working, and any S&C letters that related to LTC providers would be forwarded to Shelly Peterson, who would then disseminate the letters to her LTC member facilities.

Discussion took place related to a possible root cause analysis of G-Level citations, with questions raised regarding what information could be obtained related to facility staff turnover, behavioral residents, and so forth. The need for specialized Gero-Psychiatric facilities in our state was discussed – currently there are two. North Dakota has an aging population and has double the number of residents over the age of 85 than most other states. It was acknowledged that North Dakota may be unique in some areas such as the Oil Impact and the large aging population.

A presentation was provided to the Workgroup by Joan Coleman, LSW, NDDoH Division of Health Facilities Training Coordinator and Resident Assessment Coordinator. The presentation focused on Deficiency Categorization and Levels of Severity. There are four levels of harm and three levels of scope. In addition, there are general deficiency scoring procedures and psychosocial scoring procedures. Appendix C contains information regarding scope and severity determination and a copy of the CMS scope and severity grid.

A presentation was provided to the Workgroup by Dr. Darleen Bartz, NDDoH Health Resources Section Chief, regarding Decision Making. The presentation provided participants with the opportunity to consider what score they would provide various examples of findings and discuss rationales. Consistency in scoring by surveyors was discussed. Scoring takes place on a team basis, and it also goes through quality assurance and supervisory review prior to being finalized. The group felt that providing surveyors training on scoring may promote consistency.

Action Step 3: During the April 9, 2015 meeting, the Workgroup recommended that training be provided to survey staff related to scoring considerations for the most frequently cited deficiency citations.

Response to Action Step 3: Similar training had already been provided to survey staff in March 2015 related to scoring considerations for some of the most frequently cited deficiency citations. Training in this area will be ongoing.

Some workgroup members indicated that certain surveyors tend to cite certain issues more frequently. It was acknowledged that this most likely was the case as surveyors were hired for their professional expertise and work experience. It was expected that registered nurse surveyors would cite quality of care citations more frequently, and licensed social workers would cite resident right issues more frequently, and so forth. The NDDoH Division of Health Facilities schedules a variety of professional staff members on each survey team and varies the surveyors assigned to survey specific facilities. A team approach is used for all decision making on all deficiency citations, and the citations are based on findings identified through the survey process. All LTC surveyors are required to go through state and federal training, and are required to successfully complete a surveyor minimum qualification test prior to surveying in the LTC program independently.

A survey evaluation form is sent to providers following each survey. The NDDoH reported they do not get as many back as they would like. The evaluations are taken very seriously and managers identify training needs for staff.

The question was raised regarding who could complete a root cause analysis to identify the reason for the high number of G-level deficiency citations. Questions were also raised regarding what information would be available to a researcher from the CMS database. The facility deficiency citations and plans of correction are posted on the NDDoH's website so that information would be available. It was identified that while the information would be beneficial, it would be difficult to get information from other states to compare to ND. In addition to the survey process, it was identified that it was important to explore what was occurring at the facility level. The Workgroup agreed that it is important to take a look at the issue from both perspectives.

Action Step 4: During the April 9, 2015 meeting, the Workgroup members identified a need to further explore the possibility of having a Root Cause Analysis completed to see if the root cause(s) of the G-level citations can be identified. Also, explore options regarding who could complete an un-biased analysis.

Action Step 5: During the April 9, 2015 meeting, the Workgroup requested that research be completed related to what federal information can be accessed for use in a root cause analysis. Also, the Workgroup questioned how access to federal information could be requested.

G-Level Citations

Priority 2: G-Level Citations were the focus of the May 11, 2015 and July 24, 2015 meetings. In addition, a CMS Update was provided at the May 11, 2015 meeting.

During the May 11, 2015 CMS Update, the statutory and regulatory requirements for surveyors to follow the CMS survey process when completing surveys were provided. Information was also presented related to the federal requirements to be followed by surveyors when determining facility compliance, and what CMS information is and is not releasable to the public (the workgroup) from the State Survey Agency.

Response to Action Step 5: During the May 11, 2015 meeting, a report was provided related to access to federal information. The Social Security Act, the Code of Federal Regulations, the CMS agreement with states, 42 CFR § 488.26 Determining Compliance, and other CMS information was reviewed related to what information would be releasable to the workgroup or public from the State Survey Agency (SSA). The Workgroup would need to submit a Freedom of Information Act request to CMS to access data from the CMS database. Information that is on the NDDoH website (deficiency statements and plans of correction) is publically accessible as well as information on CMS Nursing Home Compare website.

Following the CMS Update presentation, workgroup members discussed the number of surveyors assigned to complete surveys and the training that surveyors went through. Workgroup members questioned how intensive the training was and if surveyors were allowed to use their professional judgment. Dr. Dwelle shared that the accreditation process had identified a need for uniformity in the approach. Discussion was held related to the role of the survey team leader.

Workgroup members questioned if facilities could preview the deficiency statement prior to it being formally sent to facilities. And, if they were able to provide additional information at that time, could the deficiency citation be rescinded? The response was that CMS had provided a process – the Informal Dispute Resolution Process – for facilities to follow if they had additional information to share following the conclusion of the survey.

Bruce Pritschet, Health Facilities Division Director, reviewed the Scope and Severity Levels for federal deficiencies cited to date for CMS Fiscal Year 2015. There were 5 states higher than ND related to the citation of G-level deficiencies; 12 states higher than ND in the citation of H-level deficiencies; one state was higher than ND in the citation of I-Level deficiencies; and 29 states higher than ND in the citation of J-Level deficiencies; 25 states higher than ND in the citation of K-Level deficiencies; and 10 states higher than ND in the citation of L-level deficiencies. North Dakota LTC facilities did not have any deficiencies cited at the H, I, J, or K-Levels.

During the May 11, 2015 meeting, Bruce Pritschet provided a presentation on 42 CFR § 483.25 (i) Nutritional Status (F-325). This requirement had been cited at the G-Level 4 times in Fiscal Year 2014. This requirement states: "Based on the resident's comprehensive assessment, the facility must ensure that a resident (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem."

Bruce Pritschet presented information from the CMS State Operations Manual Appendix PP related to this requirement, including:

- Intent
- Definitions
- Facility Assessment Considerations
- Analysis
- Facility Care Planning and Interventions
- Facility Monitoring
- Objectives for Investigative Protocol
- Investigative Procedures
- Review of Care Plan
- Review of Facility Practices
- Interview with Health Care Practitioners
- Determination of Compliance
- Potential Tags for Additional Investigation
- Deficiency Categorization

For this requirement, the portion of the CMS State Operations Manual was handed out to Workgroup participants so that they could review the information used by surveyors in surveying for this requirement. The hardcopy detailed information was not provided for the other three most frequently cited requirements for CMS Fiscal Year 2014 discussed below.

The Workgroup discussed how nursing and medical standards of practice correlate to the CMS guidelines. If a practitioner was not following standards of practice for their profession, they would be referred to their respective board for follow-up. The Workgroup discussed physician sign off on facility policies – the two facility Medical Directors present at the meeting both agreed they do this on an annual basis and are kept current related to changes in policy. The Workgroup discussed the role of the medical providers and medical director during the surveys and indicated that minimal contact took place between surveyors and medical providers.

During the July 24, 2015 Workgroup meeting, the discussion on the most frequently cited G-Level deficiencies during CMS Fiscal Year 2014 continued. Bruce Pritschet presented on 42 CFR § 485.25 (h) Accidents (F-323). This requirement had been cited 14 times in Fiscal Year 2014. This requirement states: "The facility must ensure that (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistive devices to prevent accidents." The topics from the CMS State Operations Manual Appendix PP for this requirement were reviewed and discussed covering the same topics identified above for F-325 Nutritional Status.

Lucille Rostad, NDDoH Health Facilities Division Program Manager, presented on 42 CFR 483.25 Quality of Care (F-309). This requirement had been cited 13 times in CMS Fiscal Year 2014. This requirement states: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." It was noted that F-309 included, but is not limited to, care of a resident with dementia, end-of-life care, diabetes, renal disease, fractures, congestive heart failure, non-pressure related skin ulcers, pain, and fecal impaction. The topics from the CMS State Operations Manual Appendix PP for this requirement were reviewed and discussed covering the same topics identified above for F-325 Nutritional Status.

Lucille Rostad also presented on 42 CFR § 483.25 (c) Pressure Sores (F-314). This requirement had been cited 5 times in CMS Fiscal Year 2014. This requirement states, "Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing." Discussion included the definitions for "avoidable" vs. "unavoidable." The topics from the CMS State Operations Manual Appendix PP for this requirement were reviewed and discussed covering the same topics identified above for F-325 Nutritional Status.

As a part of the discussion for each of these frequently cited requirements, a summary was provided which reviewed the deficiencies cited for each requirement. The Fiscal Year 2014 "G" Score Deficiencies Summary is located in Appendix D.

Discussion related to the above requirements took place. The importance of education for facility staff members related to dealing with behaviorally difficult and/or aggressive residents was identified. Also, included in the discussion was the desire for surveyors to interview the resident's providers and/or medical director of the Skilled/Nursing Facility regarding resident quality of care issues when there was a potential of a G-Level citation. The suggestion was made that the department consider sending out a letter to facilities that they could share with their medical director and physicians related to the possibility they may receive a phone call from a surveyor during a survey and the importance of responding to those calls. It was felt this would help Skilled Nursing Facilities talk to their physicians about this possibility of being interviewed during a survey. Concern was also identified that surveyors should limit calls to physicians to only those issues that were identified necessary as a physician's time was limited and it was hard to get physicians to agree to be medical directors.

Action Step 6: During the July 24, 2015 meeting, the Workgroup recommended the Department of Health send a letter to SNF/NF facilities that they could share with their physicians and medical directors to let them know that there may be occasions during the survey process when a surveyor will call them to discuss quality of care issues that raise to the level of harm.

Action Step 7: During the July 24, 2015 meeting, the Workgroup requested that Bruce Pritschet and Lucille Rostad visit with surveyors related to incorporating physician and/or medical director interviews as needed into the survey process for quality of care citations which rise to the level of actual harm.

Response to Action Step 4: During the July 24, 2015 meeting, the Workgroup identified information that should be considered if a root cause analysis was completed related to G-level citations. Suggestions included: CASPER reports; higher acuity residents; high number of residents with pressure sores; high number of hospital admissions and readmissions; residents with mental health or behavioral issues; availability of psychiatric services; turnover of administrative staff, administrator, director of nursing, and unit supervisors; types of residents and staffing needs; reimbursement system support care needs; behavioral residents and staff time needed to respond; residents with co-morbidities; hospital push back to discharge patients before they are ready; increased requirements for EMR; frequency and availability of providers coming to facility to see residents; and lack of physicians and use of Locums.

Communication during the Survey Process

Priority 3: Communication During the Survey Process (sufficient time to discuss findings regarding the area of concern) was discussed at the August 12, 2015 and September 8, 2015 meetings. Steve Chickering, CMS Associate Regional Administrator, and Robert Casteel, CMS Region VIII Survey Branch Manager joined the workgroup meeting.

The meeting started with a status update from previous Collaborative Workgroup meetings. Discussion took place related to the CMS federal monitoring surveys and why they only added citations rather than taking them away. Robert Casteel, CMS, explained it was a point in time quality assurance survey and due to differences in residents and corrections made by the facility, the results may or may not be the same. The federal surveyors do not know what the state cited at the time of the state's survey. So, citations may be different, yet okay.

Steve Chickering, CMS, reviewed the federal survey process. Steve indicated while the requirements reviewed by the state and federal surveyors are the same, the results of the survey may differ as the facility may have already made corrections in some areas. The Workgroup members asked Steve and Robert why North Dakota was experiencing so many G-level citations. They indicated that there are many reasons why this may be occurring including the traditional survey process used in North Dakota vs. the Quality Indicator Survey process used in some states. Robert also noted that while North Dakota appears to be higher than some states related to G-level citations, it is also important to note, that during CMS Fiscal Year 2014, North Dakota did not have any H, I, J, K, or L-level citations while other states did have these higher levels of citations.

Questions were raised related to citations on residents with complex behavioral issues, and if the resident was looked at as a whole, or if each requirement was reviewed related to the resident. Steve and Robert, CMS, indicated that all information that pertained to each applicable regulation needed to be looked at for the resident.

Questions were raised related to if a facility completes a root cause analysis and has proper documentation in place, would they receive a deficiency if the issue was identified to be unavoidable. The response was that if the facility was able to demonstrate they had done everything possible to respond to an issue and the issue was determined to be unavoidable, a deficiency would not be cited.

Concern was expressed by a workgroup member regarding the subjectivity of the survey process. Steve Chickering, CMS, indicated the survey process is not subjective, it is based on factual information collected during the survey process. The needs of LTC residents have increased, and many states are struggling with the increased acuity and complexity of residents.

Several workgroup members stated that the CMS 5-Star rating system was unfair and they do not like it. Some workgroup members felt there should be a formula to categorize residents and identify higher risk residents. Workgroup members indicated that a hospital will not admit a patient to a LTC facility that has a 1 or 2 star rating. Steve Chickering and Robert Casteel, CMS, indicated these issues were much broader than survey and certification.

Lucille Rostad, NDDoH, reported receiving approximately 50 percent of the facility survey evaluation forms back. She indicated this is beneficial information and would like to see more facilities return the completed form.

Steve Chickering offered to reach out to Karen Tritz, CMS Central Office LTC Program Lead. CMS was working on a new survey process so this would be a good time to recommend changes to improve the survey process.

Action Step 8: During the August 12, 2015 meeting, Steve Chickering, CMS, agreed to set up a meeting between Dr. Terry Dwelle and Karen Tritz, CMS CO LTC Program Manager, to discuss concerns related to the survey process.

Action Step 9: During the August 12, 2015 meeting, Steve Chickering, CMS, identified that he planned to contact Karen Tritz, CMS CO LTC Program Manager, to identify a time that she could present to LTC facilities in North Dakota regarding upcoming changes in the survey process.

Darleen Bartz, NDDoH Health Resources Section Chief, provided a presentation on communication during the survey process consistent with the information in the CMS State Operations Manual Appendix P. Following the presentation, the workgroup discussed communication during the survey process.

One workgroup member asked if they could refuse to let a surveyor survey in their facility. Steve Chickering, CMS, indicated a facility couldn't refuse to allow a surveyor to survey in their facility as they had signed an agreement with CMS to allow the survey process to take place. If they had concerns regarding a surveyor, the facility should contact Bruce Pritschet or Lucille Rostad, NDDoH, in Bismarck. Another workgroup participant asked if a facility could refuse to allow a resident be in the sample. Steve Chickering, CMS, stated that the facility could not refuse to allow the surveyors to have a resident in the sample, however, the resident could refuse to be interviewed or observed.

The workgroup discussed how important it was for surveyors to treat facility staff and residents with respect, and also how important it was for facility staff to treat the surveyors with respect. Respect and professionalism is a two way street. If there are problems while the survey team is onsite, the first step is for the facility to visit with the team leader, or the team leader to visit with facility administration.

The exit conference was discussed. Workgroup participants indicated that it was difficult to pull information together for the survey team between the pre-exit and exit conferences. Robert Casteel, CMS, indicated that communication should take place as soon as possible, but that often it is not until the 3rd day of the survey that an issue has been identified as a pattern and can be discussed. Information should be requested prior to decision making – Task 6. It is helpful if facility administrators ask surveyors if there is any information they need on a daily basis. Concern was identified by some participants that they did not know a deficiency was being cited until the exit conference. Steve Chickering, CMS indicated there are times that things will come up at the last minute, but that should not be often. It is a case by case determination related to when a facility can be notified on an issue that is being investigated. Robert Casteel, CMS, concluded by stating that at some point and time, the surveyor will need to let the facility know what additional information in needed.

Steve Chickering, CMS, explained the general objective of the exit conference is to inform the facility of the survey team's observations and preliminary findings. It was discussed that the pre-exit conference used by the North Dakota Survey Agency was initiated at the request of providers and was found to be important and beneficial by providers. Steve Chickering, CMS, indicated that an exit conference is not required and surveyors are directed not to provide the F-tags and regulations, but to share the issues identified. The Workgroup members acknowledged that they understood an exit conference was not required. One participant asked about receiving a list of tags at the exit conference. Steve Chickering, CMS, indicated he would check into the release of tags at the exit conference as this is an area of inconsistency and should be addressed. He indicated that the final decision regarding the tag may not be made prior to the survey team leaving the facility. Any additional information the facility needs to provide after the exit conference should take place through the Informal Dispute Resolution process. There needs to be an endpoint to the survey and that end point is when the survey team leaves the facility.

Action Step 10: During the August 12, 2015 meeting, Steve Chickering, CMS, indicated he would check into whether or not surveyors could provide facilities with a list of tags/release of F-tags at the exit conference and get back to the Workgroup.

The workgroup spent additional time discussing the need for good communication to occur during the survey process, and the importance of the role of the team leader in facilitating good communication.

Workgroup members discussed their concerns related to the time and resources it took to provide copies of documents to the surveyors. Lucille Rostad, NDDoH, indicated that surveyors were directed to not ask for copies unless they have identified a problem or the information was necessary to support the findings.

The discussion on communication during the survey process continued at the September 8, 2015 meeting. One workgroup participant shared that communication during a recent survey had been great during the entire survey. She appreciated it when a surveyor came to her when they needed information. Another participant indicated that it was helpful when the surveyors asked questions. She recommended that a form be used for the team leader to ask questions and request information, however, other group members felt it was better for the surveyor with the questions to ask them personally so that clarification could be requested if needed. Lucille Rostad, LTC Program Manager, indicated that each surveyor is to talk to the Director of Nursing or other facility staff member about issues they have identified. Communication would be more difficult if everything needed to go through the team leader. Steve Chickering, CMS, stated it depended upon what was being asked for – the surveyor should be able to ask staff and/or the appropriate people from the facility for information and receive the information in a timely manner. When asked what steps or strategies the facility can implement to improve communication, the workgroup participants who responded felt that communication was not a problem, however, would like the NDDoH Division of Health Facilities management staff to explore strategies to further improve communication.

Action Step 11: During the September 8, 2015 meeting, the Collaborative Workgroup discussed strategies to foster good communication by facility staff members and surveyors during the

Survey Process. The NDDoH Division of Health facilities management staff should explore strategies to facilitate communication during the survey process.

Response to Action Step 8: A conference call took place between Karen Tritz, CMS, Dr. Terry Dwelle, and Darleen Bartz on October 7, 2015 to discuss concerns regarding the survey process that had been identified and access to federal information.

Informal Dispute Resolution Process

Priority 4 : Informal Dispute Resolution (IDR) Process was addressed at the September 8, 2015, the November 2, 2015, and the February 1, 2016 workgroup meetings.

During the September 8, 2015 Workgroup meeting, Darleen Bartz, NDDoH Health Resources Section Chief, provided a presentation on the Informal Dispute Resolution Process. The presentation included the federal regulatory basis for the process, as well as information from the federal CMS State Operations Manual Chapter 7000. The mandatory elements of an IDR Process were discussed. CMS holds states accountable for the legitimacy of the IDR process including the accuracy and the reliability of conclusions that are drawn with respect to survey findings. States have the option to involve outside persons or entities they believe to be qualified to participate in the process, however, the results may serve only as a recommendation of noncompliance or compliance to the State. The State will then make the final informal dispute resolution decision and notify the facility of that decision. The presentation included situations when a facility can request an IDR, and the process to follow. CMS has the ultimate oversight responsibility relative to a State's performance, and it may be appropriate for CMS to examine specific IDR decisions, or the overall IDR process, to determine if the State is arriving at a correct result. Upon completion of the review of the federal regulations and guidance related to the IDR process, the procedure currently used in North Dakota was presented.

A summary of data collected on IDRs which had been completed between January 2011 and July 2015 was presented. During this time frame, requests for IDR reviews of 91 citations were submitted. Of the requests, 44 citations were in the area of Quality of Care, 14 in the area of Resident Behaviors and Facility Practices, 9 in the area of Resident Assessment, 6 in the area of Quality of Life, and 5 in the area of Resident Rights. Other areas of the requirements had only two or three reviews requested during this time frame. The IDRs resulted in 41 (45%) no change, 9 (10%) supported with some findings removed, 17 (19%) supported with some findings removed or changed, 1 (1%) deficiency statement moved to another citation, 15 (16%) deficiency statement not supported/deficiency removed, and 1 (1%) was not reviewed as the request was received outside prescribed timeframes.

The presentation also included a report regarding other state models including MPRO (Michigan Peer Review Organization) and the work they do completing preliminary IDRs in approximately 10 states. Please refer to Appendix E for additional information regarding MPRO. The Workgroup discussed MPRO as an option and identified the need to obtain additional information regarding this vendor.

Action Step 12: Shelly Peterson, NDLTCA President, was tasked with obtaining additional information related to MPRO.

The Workgroup members acknowledged that using MPRO as a preliminary step in the IDR process would slow up the process, and the cost involved in using MPRO would need to be covered by the facility requesting a preliminary review by MPRO.

Some Workgroup members questioned if there was an appeal process that a facility could implement if they were unsatisfied with the results of the IDR. Steve Chickering, CMS, spoke about the federal appeal process. The appeal process is a formal process while the IDR is an informal process. During the IDR, a facility is to provide additional information to dispute the

survey findings prior to going to a formal appeals process. An enforcement action as a result of the non-compliance will need to take place before an appeal process is provided. A facility can IDR or appeal D level deficiencies or higher with an enforcement action.

Some Workgroup participants questioned if it would be possible for the facility to review a deficiency statement before it was actually sent out to the facility. Steve Chickering, CMS, stated that the survey process is what it is and that there was an IDR process and an appeal process if an enforcement action was imposed that could be used by the facility. Steve Chickering, CMS, indicated that a survey could go on and on, but that it needs to end as some point. Robert Casteel, CMS, indicated the survey ends when Task 6 has taken place and the surveyors exit the facility, and changing this is not an option right now. Some Workgroup members indicated that on occasion, the survey team has allowed them to fax information into them by an agreed upon time.

The Workgroup questioned who makes the final decision on an IDR. Steve Chickering, CMS, stated the State Survey Agency makes the final decision, which is a recommendation to CMS.

Further discussion took place by the workgroup related to having a third party complete an unbiased review and provide preliminary recommendations to the State Survey Agency to consider. Discussion took place related to various options, including a State Level Administrative Law Judge, a Small Group of Stakeholders, the North Dakota Health Council, or MPRO.

Response to Action Step 12: Shelly Peterson provided an update during the September 8, 2015 meeting on the information that MPRO had shared in their presentation to the Long Term Care Administrators. The LTC Administrators would be willing to have an option available for a third party review, however, cost was a concern. Shelly reported she was not able to get cost information from MPRO, however, reported they seemed like a creditable and knowledgeable option.

Action Step 13: During the September 8, 2015 meeting, Darleen Bartz, NDDoH, was asked to reach out to MPRO to obtain information related to the cost of having them complete third party review. In addition, Darleen is to reach out to other CMS Region 8 states to find out what costs they incur related to the IDR process used in their states.

The presentation and workgroup discussion related to North Dakota's IDR process continued at the November 2, 2015 meeting. The presentation included discussion regarding the notification of facilities of their opportunity to request an IDR within the same 10 calendar day period that the facility has for submitting an acceptable POC. If an IDR is requested, an individual who hasn't had any part in the survey process or review of the citations completes the review. At times, the state level reviewer will request additional information be submitted from the facility. The importance for the facility to submit complete documentation to be considered as a part of their review was discussed.

Response to Action Step 13: During the November 2, 2015 meeting, Darleen Bartz presented information related to the costs associated with MPRO completing a preliminary IDR review. The base fee per tag is $160 with an additional hourly rate of $145 per hour. Each tag takes an average of 5 hours dependent upon information submitted. Fees can vary greatly. Darleen also

presented information gathered from the six states in CMS Region 8 related to added IDR costs incurred by their State Survey Agencies related the IDR process. All six states reported NO additional costs related to completion of the IDR process.

Questions were raised by a Workgroup member related to information resulting from Federal Monitoring Surveys, comparing states to one another. Steve Chickering, CMS, indicated he had not heard of that, and that his division had not looked at that information.

Action Step 14: During the November 2, 2015 meeting**,** Steve Chickering, CMS, was asked to see what information he could provide related to state performance standards for CMS Region VIII and North Dakota.

Response to Action Step 14: During the November 2, 2016 meeting, Steve Chickering, CMS, stated he was willing to work on the FOIA request for State Performance Standards for Region VIII.

A workgroup member asked if CMS had ever overturned an IDR decision made by a State. Robert Casteel, CMS, stated they have overturned some, but had not overturned any from North Dakota. If the IDR resulted in a change in the enforcement remedy, they would look at the review more closely.

The scoring procedure for a deficiency citation was reviewed. The deficiency citation goes through many reviews prior to being finalized. It goes through a team decision making review, a peer review process, a team review and scoring process, and a supervisory review and meeting with team members prior to being finalized and sent to the facility. If a facility has concerns, they are encouraged to call the survey team manager. A Workgroup member stated she felt the process was flawed in that the expectation was perfection by the facility.

Workgroup members reported regarding recent survey experiences, communication between the facility and team leader was improved. All agreed that communication between the facility staff and the survey team members was essential during the survey process so there were no surprises. The facility can ask the team leader to bring communication back to the managers in the office if needed.

A workgroup member asked if surveyors could let facility staff members know right away if they saw something that was not being completed correctly. The response was that the surveyor would make note of the situation and need to continue to watch to determine if there was a pattern prior to letting the facility know, unless it was an immediate harm situation.

Based on the discussion by workgroup members, various options were identified for completion of the IDR. Bruce reviewed the five options that had been discussed and the related timelines. Appendix F contains the IDR options that were discussed. One option was for a small group to complete the preliminary review. There were many questions on this option. A vote was completed by the workgroup on the options, resulting in the following two options for further discussion at the next meeting:

- LTC facilities would have a choice between requesting an IDR review by the State Survey Agency (SSA), or a preliminary IDR review by MPRO followed by the final review by the SSA.

- LTC facilities would have a choice between requesting an IDR review by the SSA, or a preliminary IDR review by a Small Group followed by the final review by the SSA

Action Step 15: During the November 2, 2015 meeting, a subcommittee of Workgroup members were identified to meet and discuss the small group IDR preliminary review concept, and to report back at the next meeting with a proposal regarding how a small group preliminary review of an IDR request would work.

The November 2, 2015 meeting concluded with an update and discussion from CMS.
Response to Action Step 9: During the November 2, 2015 meeting, Steve Chickering, CMS, reported that he wants to move forward with the CMS and Department of Health provider presentation – a date needed to be confirmed on this. Steve would work with Karen Tritz, CMS Central Office and Evan to see when they would be available.

Response to Action Step 10: During the November 2, 2015 meeting, Steve Chickering, CMS, reported that the guidance he had received from CMS Central Office was not to give the F-tags during the exit conference. He indicated that from this point forward, this was the guidance being provided to the North Dakota SSA and to other States. Steve indicated that if CMS' stance on this changes he will let the Workgroup know.

Discussion ensued by the workgroup related to the directive from CMS that North Dakota SSA could no longer release the tags at the exit conference. The workgroup felt this was a step backward for the communication between the SSA and facilities. The workgroup members representing facilities indicated that receipt of the F-tag information was essential for them to be able to respond to issues and begin working on the plans of correction in a timely manner.

Action Step 16: During the November 2, 2015 meeting, the decision was made to discuss the concerns regarding CMS' directive to no longer release preliminary F-tags during the Long Term Care Exit Conferences with the State Health Council and with our delegation in Washington, D.C. to see if a change could be made regarding this discussion.

Response to Action Step 14: During the February 1, 2016 meeting, Shelly Peterson reported that she had received the information from CMS related to the Region VIII State Performance Standards.

Response to Action Step 10: During the February 1, 2016 meeting, the letter received from CMS related to release of preliminary F-tags at the facility exit conference was reviewed. Please refer to Appendix H for a copy of this letter. The letter required "the State of North Dakota State Survey Agency follow the directed policy and guidance and not provide F-tags when presenting preliminary findings to providers during the exit conference of Long Term Care Surveys."

Response to Action Step 15: During the February1, 2016 Workgroup meeting, a report was provided from the Small Group IDR Sub-Committee. Please refer to Appendix G for a copy of the minutes of the December 2 and December 8, 2015 meetings of this Subcommittee which outline what a Small Group Preliminary IDR process would look like.

During the February 1, 2016 meeting, the Workgroup discussed the two remaining options related to the IDR process. Each option provided two options for facilities to implement. The options were identified to be:

Option 1: ND SSA IDR process; or option for a small group preliminary IDR review followed by the final state level review by the SSA.
Option 2: ND SSA IDR process; or option for preliminary review by MPRO followed by final state level review by the SSA.

The workgroup members discussed the report provided by the Small Group IDR Subcommittee. Shelly Peterson provided a report regarding her discussion of the Small Group IDR process with the NDLTCA Board and said they did not support the concept due to the potential of conflict of interest, the peer reviews, and the volume of work involved. The NDLTCA Board recommended going with MRPO as an alternative option for a preliminary IDR review.

It was acknowledged by the workgroup that if a facility requested a preliminary review, the cost of the review would be paid for by the facility.

Following the discussion, the workgroup members voted between the two options identified above. All Workgroup members supported Option 2: ND SSA IDR process; or option for preliminary review by MPRO followed by final state level review by SSA.

Action Step 17: During the February 1, 2016 meeting, the Workgroup requested that the NDDoH reach out to MPRO to develop a contract with them to complete the preliminary review of an IDR request if that option was selected by the facility, with the understanding that the facility would pay MPRO for the cost of the preliminary review.

Action Step 18: During the February 1, 2016 meeting, the Workgroup recommended that the NDDoH provide training for the LTC facilities related to the IDR options that would become available tentatively July 1, 2016 which include: the ND SSA IDR process; or option for preliminary review by MPRO followed by final state level review by the SSA. Shelly indicated the soonest training could be scheduled was during the NDLTCA 2016 Fall Conference.

Response to Action Step 4: During the February 1, 2016 meeting, the Workgroup again discussed the potential of a Root Cause Analysis Related to G-Level Citations in North Dakota. The results of the discussion are located in Appendix J.

The February 1, 2016 meeting concluded with a brief discussion related to the next topic to be discussed by the workgroup. That topic was Care of Behaviorally Difficult Residents and Potential for Increased Citations. It was noted that some workgroup members questioned if this issue should be addressed by a separate workgroup altogether, and if this group was the one that would have the most impact on this issue for North Dakota.

Care of Behaviorally Difficult Residents and Potential for Increased Citations

The focus of the April 4, 2016 and May 26, 2016 NDDoH LTC Collaborative Meeting was Priority 5: Care of Behaviorally Difficult Residents and the Potential for Increased Citations.

Darleen Bartz, NDDoH Health Resources Section Chief, presented information at the April 4, 2016 meeting related to the growing number of individuals in North Dakota with Alzheimer's disease, a 74% increase from 2000 to 2012. It is the 3rd leading cause of death in North Dakota. This number will grow as the population in our state continues to age, and more will require care. What does this mean for North Dakota? There will be more and more residents who need Skilled Nursing Facility care who are behaviorally and medically difficult. Does caring for these residents place a LTC facility at increased risk for deficiencies? The answer is that it could possibly place a facility at increased risk for deficiencies, however, only if the care and safety needs of the resident, and other residents in the facility, are not met. Individualized, person-centered approaches based on the resident assessment and individualized care plan may help reduce potentially distressing or harmful behaviors and promote improved functional abilities and quality of life for individuals.

The guest presenter at the April 4, 2016 meeting was introduced: Dr. Rosalie Etherington, North Dakota State Hospital. The topic she was asked to address was Mental Health Services in North Dakota. Rather than a presentation, Dr. Etherington discussed this issue with the workgroup members.

Dr. Etherington acknowledged the aging population in North Dakota and the increase in Alzheimer's disease. She indicated this disease is often misdiagnosed and mistreated. There is a plan to ask the legislators for assistance, as ND has a shortage of psychiatric and behavioral care specialists to respond to the growing need for mental health services in North Dakota. Options to respond to the this concern discussed by the workgroup included: having the patient begin with their primary care provider, however ensure the primary care provider received additional training; use of consultants to work with primary care providers; use of tele-health, and use of care teams.

Dr. Etherington indicated it is not just having providers who can prescribe medications, but also the environmental needs of these individuals, and training for all staff caring for them. The increased staff time needed for training and to care for these residents was seen as a high level concern for workgroup members who are already having difficulty staffing their facilities. Shelly reported that over 75% of the nursing homes have used staffing companies. One participant expressed concern that training of staff to care for these residents is not reimbursable. Another participant questions if the Minimum Data Set captures those with behaviors and mental health issues.

Darleen Bartz, NDDoH, indicated that there had been licensure rules that addressed care of individuals with Alzheimer's disease or related dementia, and mental health. These rules had been repealed many years ago. There currently are no additional requirements placed on facilities related to the care of individuals with Alzheimer's disease or mental health issues.

Dr. Etherington reported that a small group of stakeholders were meeting to discuss mental health issues in North Dakota. The group was formed by legislators from Fargo. She indicated the care of the elderly with mental health issues had not been addressed by this group

yet. This group was looking at making recommendations to the legislature soon for consideration in the next legislative session.

Action Step 19: During the April 4, 2016 meeting, the workgroup decided to form a subcommittee to discuss mental health issues in LTC and present the results of their discussion to the group meeting on this topic to try to get mental health issues in LTC included in what is to be presented to the legislature. Karla Backman, State Ombudsman, was willing to lead this subcommittee. Additional members were identified to work with Karla. The subcommittee was asked to report back at the May 26, 2016 Meeting.

The workgroup discussed if they were the right group to address the issue of behaviorally and medically difficult residents in LTC facilities. The workgroup felt this may not be the right group and did not want to spend time going through the survey requirements related to this issue. They felt the survey process had been covered adequately during other meetings. The preference of the workgroup was for the subcommittee to meet on this issue to ensure that needs related to the care of behaviorally and medically difficult residents was included in what was brought to the legislature during the next session related to mental health services in North Dakota.

Response to Action Step 6: During the April 4, 2016 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, shared a memo which had been sent out to LTC facilities on March 21, 2016 to share with their medical directors and resident primary care providers. The memo discussed that surveyors may be contacting them during the survey of a facility to discuss quality of care issues that raise to the level of harm that have been identified during the survey. Please refer to Appendix K for a copy of the memo sent out to providers.

Response to Action Step 7: During the April 4, 2016 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, reported that training had been provided to LTC surveyors in March 2016 related to incorporating medical provider interviews into the survey process for quality of care findings with actual harm.

Response to Action Step 11: During the April 4, 2016 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, shared the one sheet handout that had been developed entitled Surveyor/Facility Communication during the LTC Survey Process. Bruce reported that surveyors had been provided training on communication with the facility in March 2016. This handout would be provided to LTC facilities during the entrance conference with recommended strategies to be used by both the survey team and facility to improve communication during the survey process. Please refer to Appendix L for the one page handout on communication which will be provided to facilities during the entrance conference.

Discussion was held by the workgroup related to S&C: 16-11-ALL: Exit Conferences – Sharing Specific Regulatory References or Tags. This S&C had been sent to all facilities. The workgroup members were pleased with the release of the S&C by CMS. Shelly indicated that providers were aware that there would no longer be pre-exit conferences and that they had to ask for F-tags at the exit conferences. Surveyors would then provide F-tags for the findings they felt fairly sure about, and not provide F-tags for those that needed further discussion. Facilities understood this was preliminary information only and could change upon final review.
Response to Action Step 16: CMS released S&C: 16-11-ALL: Exit Conferences – Sharing Specific Regulatory References or Tags in response to the concerns that were brought to CMS'

attention by Sen. Hoeven, the NDLTCA and Dr. Dwelle and Arvy. The workgroup was pleased with the outcome. Please refer to Appendix I for a copy of the S&C.

Response to Action Step 17: During the April 4, 2016 meeting, Darleen Bartz, NDDoH Health Resources Section Chief, reported that she had reached out to MPRO regarding completion of preliminary IDR reviews prior to the State Survey Agency final IDR review as an option for facilities. The cost of the preliminary review would be covered by the facility requesting the review. MPRO felt they could take on this workload with a tentative date of July 1, 2016. Specific contract details needed to be worked out.

Response to Action Step 4: During the April 4, 2016 meeting, it was reported that workgroup members met with Laura Hand, UND, on February 22, 2016 to discuss possible research study. Bruce Pritschet sent screen shots from PDQ to Laura to review for possible data collection. No funding source yet identified. Laura Hand sent an email to the NDDoH on March 31, 2016 indicating that she did not believe that she was the right person for the project, as she had reached the conclusion that the project required someone leading/designing it who was familiar with either the facility side or the inspection side, and she had no experience with either. Therefore, she declined the research study opportunity.

The workgroup members questioned if completing the research project at this time would be beneficial. The workgroup acknowledged that there was a new LTC survey process that would be implemented later in 2016, and also the General Fund budget cuts were impacting staffing of facilities negatively. Workgroup members also recognized that quality of care issues may increase in the future due to the decreases in funding to facilities and the impact this would have on staffing. Several indicated there may not be a need to complete the project.

Dr. Dwelle rejoined the meeting and reported that he had called and spoke to Dr. Ray Goldstein, UND. Even though Laura Hand had declined the research project, Dr. Goldstein was personally interested in the research study on G-level citations and would take a look at it.
Action Step 20: Dr. Dwelle and Darleen Bartz, NDDoH, would call Dr. Goldstein sometime after the April 4, 2016 meeting to discuss the research project on G-level citations and report back at the next meeting.

The April 4, 2016 workgroup meeting concluded with general discussion on staff training needs to care for residents with behavioral issues. The use of the CMS *Helping Hands* training tool was identified to be a great resource. One participant recommended a Train the Trainer approach, but more were interested in having someone come to their facility to train staff. With the staffing shortage, sending someone to a Train the Trainer course who would then train staff when they returned to the facility would take someone away from resident care.

The NDDoH LTC Collaborative Workgroup continued their discussion on care of residents with mental and behavioral health issues on May 26, 2016.
Response to Action Step 19: During the May 26, 2016 meeting, Karla Backman reported that the subcommittee had met on April 18, 2016. The subcommittee discussed mental and behavioral health issues in long term care and started putting talking points together. The subcommittee has another meeting scheduled for June 16, 2016. The subcommittee plans to discuss with Pam Sagness, DHS, who is taking a lead on addressing mental health issues with the legislature next session.

During the May 26, 2016 meeting, Bruce provided an overview of the CMS Western Division Survey and Certification Report. The report presented data on surveys completed in the Western Division for fiscal year 2015. North Dakota had 40 complaints in LTC facilities in 2015. The average number of deficiencies cited in 2015 was 7.2, and the number of G level citations was 0.2. Bruce discussed how larger LTC facilities appear to have more citations than smaller LTC facilities.

Darleen Bartz provided an update on the MPRO contract and reported on the cost to the facility to implement the preliminary IDR review process by MPRO, prior to the final review by the survey agency. She reported that there would need to be an agreement for the review as well as a business associate agreement signed by the facility prior to initiation of this process. Darleen was hopeful all would be in place by July 1, 2016.

Response to Action Step 17: During the May 26, 2016 meeting, the workgroup indicated that they were comfortable with the Department moving forward with the contract with MPRO with no further updates to the workgroup.

Response to Action Step 18: During the May 26, 2016 meeting, the workgroup discussed that training by the department on the IDR process and options available should take place at the NDLTCA Fall Conference. The department agreed to provide training on the IDR process and options at the conference.

Response to Action Step 9: During the May 26, 2016 meeting, Darleen Bartz provided an update on the CMS Presentation to ALL LTC Providers. The date will be June 29, 2016 – Shelly had sent out a save the date to the industry. The location will be at the Heritage Center. Darleen reviewed the agenda and presenters. Darleen will present a summary of the work that has been completed by the Collaborative Workgroup. Robert Casteel and Linda Bedker, CMS Denver Regional Office will present on LTC complaints, resident dumping issues, and CMP imposition in North Dakota. Karen Tritz, LTC Program Manager, CMS Central Office will present on the new LTC survey process, payroll based journal, nursing home compare, the five star ratings, and the CMS 2016/2017 LTC Action Plan. Steve Chickering, CMS Western Division, will provide a report on the CMS Western Division Data for 2015. There will be some time set aside for questions. The workgroup members thought the agenda looked good. The registration for the presentation will be emailed out to the industry in the next week or as soon as possible. Please refer to Appendix M for a copy of the agenda.

Response to Action Step 20: During the May 26, 2016 meeting, the workgroup discussed the G-Level Citation Research Project and questioned the benefit or ability to continue to pursue this research. No funding source was identified for completion of the research. The number of G-Level citations in 2015 and 2016 are close to that of the region and nation. And, with the state funding cuts and the resultant negative impact this would have on staffing in facilities, the potential for increased G-Level citations was identified. After discussion, all workgroup members present agreed the G-Level Citation research project should be placed on hold.

The Workgroup reviewed the NDDoH LTC Collaborative Summary Report. The Workgroup members felt the summary was a good document and that much had been accomplished. Some recommendations for edits and reorganization were made by the workgroup members.

Shelly spoke about the poor provider response to the evaluations following a survey. Discussion took place by the workgroup on how this could be improved upon.

Action Step 21: During the May 26, 2016 workgroup meeting, members discussed strategies for increasing the number of responses to post survey evaluations by providers. The workgroup members determined that it may be helpful to provide the post survey evaluations to the Directors of Nursing in addition to the Administrators.
Response to Action Step 21: Beginning July 1, 2016, the post survey evaluations will be provided to both the LTC Directors of Nursing and Administrator for completion.

Shelly Peterson presented the Top Ten (Federal) Regulatory Requirements that should be repealed or modified that had been identified by the North Dakota Long Term Care Association. Shelly reported that she has met with Senator Heitkamp on the issues and plans to meet with her again soon.

One participant indicated that she would like to have the admission and discharge issues in LTC facilities discussed. Shelly recommended addressing the issue with Karla Backman, the State Long Term Care Ombudsman, and a representative from the Health Department, to jointly work the issues. The participant agreed to write a letter regarding her concerns on this issue and it would be discussed further at the NDDoH LTC Advisory Committee Meeting as it was not one of the key issues identified to be addressed by this workgroup.

Conclusion

The North Dakota Department of Health Long Term Care Collaborative Workgroup was formed in February 2015. The purpose of the Workgroup was to: 1) Identify key issues/concerns related to the survey and compliance of Long Term Care Facilities and prioritize those concerns; and to discuss ways we can collaboratively work together on the identified priority issues.

The Workgroup identified five key issues/concerns to be addressed. The five key issues/concerns in order of priority included: 1) High number of G-Level citations; 2) Objectivity and fairness of the informal dispute resolution (IDR) process; 3) Subjectivity in the survey process; 4) Communication during the survey process; and 5) Increased potential for a citation when caring for behaviorally difficult patients.

The Workgroup met March 5, 2016; April 9, 2015; May 11, 2015; July 24, 2015; August 12, 2015; September 8, 2015; November 2, 2015; February 1, 2016; April 4, 2016; and May 26, 2016. As a result of these meetings, each of the five key areas of concern/issues were thoroughly discussed by the Workgroup members and invited guests. As a result of the meetings, 21 Actions Steps were identified to respond to the key issues/concerns to be addressed by the Workgroup . Please refer to Appendix N for a summary of the action steps and responses.

During the May 26, 2016 meeting, the Workgroup Members agreed that all five key issues/concerns had been thoroughly discussed and addressed to the extent possible by the workgroup. The Workgroup members determined that there was no need for further meetings of the workgroup to be scheduled. All members indicated that the discussions and actions taken by this Workgroup have been beneficial. The final deliverable of the Collaborative Workgroup would be the June 29, 2016 CMS/NDDoH All Provider Presentation. All LTC facilities in the state would be invited to attend this meeting.

The minutes of the May 26, 2016 meeting and the Workgroup Summary Report would be finalized within the next few weeks and sent by email. The Mental and Behavioral Health Subcommittee would report back the NDDoH LTC Advisory Committee at a future meeting, and the concerns of admission and discharge issues would also be discussed at the Advisory Committee meetings held each quarter. All members present indicated that the Workgroup had been beneficial and much had been accomplished.

Appendix A

North Dakota Long Term Care Collaborative Workgroup

03-16

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Appendix B

ND LTCA Provider Survey Questions and

NDDOH LTC Collaborative Workgroup Priorities

# of Votes as Study Issue	**Issues** (Areas selected by the workgroup members for further discussion highlighted in yellow)
0	Q5 In you most recent survey how many days after the date of the survey exit did it take to receive your 2567?
0	Q6 What statement represents your experience in reporting an allegation of abuse, neglect, or exploitation against a CNA?
12	Q7 Do you believe the survey team or an individual on the survey team has subjectively interpreted and applied regulations?
0	Q8 Has the survey team ever refused to accept information, which is not in the residents file, from a NP, specialist, doctors, after the survey?
4	Q9 Do you believe the survey team accepts resident and family comments as factual unless specific documentation can be found to specifically refute the information?
1	Q10 Have you experienced citations not based on specific events and or actual cases?
14	Q11 Do you believe the IDR process to be fair and objective?
7	Q12 If you take difficult resident both medically and behaviorally, do you believe it is more likely that you will have more deficiencies?
0	Q 13 Has the survey team ever changed their sample of residents (in phase one or phase two) after beginning the phase?
0	Q14 Have you experienced inconsistencies in the interpretation of standards between surveyors and their supervisors?
1	Q15 Have you experienced additional citations being given to your facility after the survey team has exited your facility?
0	Q16 Have you experienced cases of "acceptance" on Plans of Correction, only to have that acceptance rescinded at a later point?
0	Q17 Have you found the Health Department to be timely in returning phone calls?
0	Q18 Have you found the survey teams to be timely in conducting their follow-up onsite visits for validating POCs?
2	Q19 Have you experienced greater frequency of Complaint Surveys?
8	Q20 During the survey, and at the Exit Conference do you believe you are given sufficient time to discuss findings regarding the area of concern?
1	Q21 Do surveyors ask to printout the MARS and Care Plans, wasting time and supplies?
0	Q22 Do you have sufficient computers to provide every surveyor?
0	Q23 Do you believe one observance has ever resulted in multiple tags?
0	Q24 Do surveyors treat your staff and residents with respect?
0	Q25 Have you ever provided the Health Department with written negative feedback following a survey? (This could be via the form they provide with the 2567, email, or other written means)
0	Q26 Have you ever had the Health Department approve your construction plans, the construction inspector on cite an issue during the construction phase, and later have it "cited" by a Life Safety Inspector?
1	Q27 On a scale if 1-5 with 5 being very satisfied, rate your overall experience with the Health Department survey process.
0	Q (New 1) Plans of Correction – What can it include?
16	Q (New 2) G level citations – Tougher grading system compared to others OR are we really not as good?

Scope and Severity

States, when determining remedies for cited deficiencies, will now consider severity and scope as outlined in the actual enforcement regulations, published in the Nov. 10, 1994 Federal Register, reproduced here with expanded information below.

Severity Levels

Level I	A deficiency that has the potential for causing no more than a minor negative impact on the resident (s).
Level II	Non-compliance that results in minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial wellbeing as defined by the resident assessment, plan of care, and provision of services.
Level III	Non-compliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and psychosocial wellbeing as defined by the resident assessment, plan of care, and provision of services.
Level IV	Immediate Jeopardy, a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in a facility. Facility practice establishes a reasonable degree of predictability of similar actions, situations, practices or indents occurring in the future.

Scope Levels

Isolated:	When one or a very limited number of residents are affected and/or one or a very limited number of staff are involved and/or the situation has occurred only occasionally or in a limited number of locations.
Pattern:	When more than a very limited number of resident's are affected and/or more than a very limited number of staff are involved and/or the situation has occurred in several locations. The effect of the deficient practices is not found to be pervasive throughout the facility.
Widespread:	When the problem causing the deficiencies is pervasive in the facility or represents a system failure.

SCOPE AND SEVERITY GRID

	Isolated	Pattern	Widespread
Level IV Immediate Jeopardy to Resident Health & Safety	POC **J**	POC **K**	POC **L**
Level III Actual Harm that is not Immediate Jeopardy	POC **G**	POC **H**	POC **I**
Level II No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy	POC **D**	POC **E**	POC **F**
Level I No Actual Harm with Potential for Minimal Harm	No POC **A** Citation is not on CMS-2567 Citation is on Form A	POC **B**	POC **C**

Substandard Quality of Care: Any Deficiency in 483.13 Resident Behavior and Facility Practices, 483.15 Quality of Life, or in 483.25 Quality of Care that constitutes: immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is no immediate jeopardy with no actual harm.

Substantial compliance. During a mail or on-site revisit these areas do not need to be reviewed.

Appendix D

SUMMARY OF FISCAL YEAR 2014 "G-LEVEL" DEFICIENCIES

(Updated 5/8/2015)

F221 – Freedom from Restraints. "G" score in one facility as follows:

#1 (Complaint survey) Resident manually held/wrapped in blanket during personal cares and treatment to peri-rectal abscess without assessment of pain exhibited during cares/treatment. (record review, review of facility policy, and staff interview)

F223 – Freedom from Abuse. "G" score in two facilities as follows:

#1 (Regular survey) Two residents verbally abused, physically threatened, and prevented from entering their rooms by another resident without timely and effective intervention by facility staff. (Record review, policy/procedure review, resident interview, and staff interview)

F246 – Reasonable Accommodation of Needs/Preferences. "G" score in one facility as follows:

#1 (Regular survey) One resident, requiring extensive assistance with toileting, experienced incontinence due to waiting 35 and 65 minutes for assistance after activating his/her call light which resulted in avoidable psychosocial harm. Resident brought to the attention of the surveyor two times during the survey. (record review, review of facility policy, review of facility call light reports, resident interview and staff interview)

F309 – "G" Score in fourteen facilities as follows:

#1 (Regular survey) Recurring aspiration related to lack of adequate assessment, monitoring of swallowing problems/needs, and implementation of appropriate preventative interventions. (4 of 4 observations, record review, review of facility policy/procedures, review of professional literature, and staff interview)

#2 (Regular survey) Non-weight bearing resident experienced significant functional decline after sustaining avoidable spiral fractures to femur and both humerus bones during standing lift transfer. (record review, review of professional literature, and staff interview)

#3 (Regular Survey) – Three findings contributed to the "G" score as follows:

A. Avoidable admission to ICU for digoxin toxicity and sepsis due to lack of assessment of the resident's deteriorating condition. (record review and staff interview)

B. Recurring aspiration related to lack of implementation of planned preventative interventions. (observation, record review, review of professional literature, and staff interview)(Repeat deficiency – 3 residents, 7 observations).

C. Unresponsive diabetic resident not assessed, physician not called, and not provided the necessary responsive treatment/care. (Facility reported nurse for

slapping resident to try wake her up.) (record review, review of State Agency files, and staff interview)

#4 (Regular survey) Uncontrolled severe pain due to lack of timely assessment/diagnoses and treatment following near fall resulting in spiral fracture to arm. (record review, review of facility policy, and staff interview)

#5 (Regular survey) Two findings contributed to the "G" score as follows:

A. Avoidable hospital admission with acute respiratory failure due to transport to emergency department via transport service without provision of oxygen. (record review, professional literature, staff interview)

B. Failure of caregiver to report fall resulted pain and in delay in surgical treatment for hip fracture for four days.(Record review, facility policy, and staff interview)

#6 (Regular survey and complaint investigation) Two residents with history of aspiration pneumonia observed to cough/choke when fed while in a reclined position. (observation, record review, review of professional literature, and staff interview)

#7 (Regular survey) – Failure to assess and respond to repeated and documented complaints of mattress/bed discomfort resulted in unresolved pain, skin breakdown and unnecessary use of antianxiety medications. (observation, record review, and staff interview)

#8 (Regular Survey) Continuous unresolved pain due to lack of assessment and development of a responsive individualized pain management program. (record review)

#9 (Regular survey and complaint investigation) Two findings contributed to the "G" score as follows:

A. Failure to promptly recognize excessive bruising (21 X 23 cm) for a resident on anticoagulation medication therapy resulting in continued administration of anticoagulants, a hyper-therapeutic INR and critically low hemoglobin. (record review, information received from the complainant, review of facility policy, review of professional literature, and staff interview)

B. Resident experienced bowel impaction requiring manual extraction due to lack of an effective bowel management program and effective monitoring of bowel elimination function. (record review, review of facility policy/procedure, and staff interview)

#10 (Regular survey) Lack of an effective bowel management plan and monitoring of the resident's bowel function/pattern resulted in two episodes of a resident becoming impacted and subjected to manual extraction of stool. (record review, review of professional literature, review of facility standing orders, and staff interview)

#11 (Complaint investigation) Resident experienced avoidable uncontrolled pain, hospitalization, and wound debridement as a result of significant deterioration in a skin

wound. (record review, review of facility policy, information provided by the complainant, and staff interview)

#12 (Regular survey) Resident exhibited aggressive/anxious behaviors, expressed distress/pain, and received unnecessary psychotropic medication during three attempts to obtain a urine specimen via urinary catheterization without notification of the physician to determine the necessity of follow-up testing after antibiotic therapy. (record review and staff interview)

#13 (Regular Survey) – Avoidable impaired skin integrity/breakdown resulted in unnecessary pain/discomfort related to lack of provision care planned incontinence/skin care. (observation, record review, and staff interview)

F314 - Treatment/Services to Prevent/Heal Pressure Sores. "G" score deficiencies in five facilities as follows:

#1 (Regular survey) Four residents did not receive the necessary care and services, to promote healing of existing pressure sores, and prevent new pressure sores from developing (i.e. prompt dietary notification, accurate assessment, repositioning programs, notification of physician of worsening/changes). (observation, record review, review of facility policy, and staff interview)

#2 (Complaint investigation) The lack of timely/effective treatment, and lack of accurate monitoring of existing pressure sores for the need to alter current treatment resulted in three residents experiencing the development of avoidable pressure sores, with increase in size/depth and the development of infections in the pressure sores.(information received from the complainant, observation, record review, review of facility policy, and staff interviews)

#3 (Regular survey and complaint investigation) Two residents developed avoidable pressure sores, and worsening of existing pressure sores, including the development of infection, due to the lack of timely identification/assessment, treatment of skin integrity concerns/problems, and the lack of provision of preventative measures. A gel mattress was ordered on 7/30/2014, and observed not to be present on 8/27/2014. (observation, record review, review of facility policy, and staff interview)

#4 (Regular Survey) Failure to provide necessary preventative measures and timely assessment of existing/occurring pressure ulcers resulted in delayed treatment/healing of pressure ulcers and the need for surgical debridement. (observation, record review, review of professional reference, review of facility policy, and staff interview)

#5 (Regular survey and complaint investigation) Resident received a facility acquired pressure sore which continued to worsen, resulting in avoidable pain and infection, due to a lack of prompt evaluation and implementation of dietary interventions, lack of applying dressings as ordered, lack of frequent repositioning, lack of adequate personal hygiene, and delay in notification of physician for treatment alternatives. (observation, information from the complainant, record review, review of facility policy, review of professional reference, and staff interview)

F323 – Free of Accident Hazards/Supervision/Devices. "G" scores in nineteen facilities as follows:

#1 (Onsite revisit) "J" scored (immediate jeopardy) One resident experienced significant burns from spilled coffee. Facility indicated in the POC to the citation during the regular survey that they would evaluate all residents to determine ability to handle hot beverages. On the revisit, it was determined the evaluations were not completed. (record review and staff interview)

#2 (Regular survey) Two residents experienced falls resulting in major injuries (hip fracture and head injury) as a result of failure to ensure the provision of necessary assistance and supervision. (record review and staff interview)

#3 (Regular survey) Resident experienced fall resulting in facial injuries as a result of staff transporting resident in a unsafe manner. (observation, record review, review of facility policy, staff and confidential individual interview)

#4 (Regular survey) Three residents eloped from the special care unit multiple times due to lack of adequate supervision, a functioning alarm system, and adequate/effective monitoring and reevaluating interventions in place. (observation, record review, review of facility policy and staff interview)

#5 (Regular Survey) – Telephone call from a community member alerted the department of the elopement of resident from facility including crossing of a busy roadway due to lack of elopement risk assessment and responsive preventative care plan. (record review, policy review, and staff interview)

#6 (Complaint investigation) Two findings related to the "G" score as follows:

A. Failure of staff to utilize the appropriate chair resulted in an avoidable fall for one resident with resulting facial injuries; and

B. Failure to transfer a resident with a mechanical lift, per care plan, resulted in resident sustaining a laceration to the leg. (observation, record review, review of facility policy, and staff interviews)

#7 (Regular Survey) Failure to assess risks associated with side rail use and provide the resident with a safe environment, resulted in multiple incidents of side rail entrapment with injuries. (observation, record review, staff interview)

#8 (Regular Survey) Avoidable fall resulting in pelvic fracture due to lack of required assistance/supervision when resident requiring assistance left unattended in the bathroom. (record review, review of professional reference, and staff interview)

#9 (Regular survey and complaint investigation) During five observations, a resident, unable to bear weight, yelled out, moaned and complained of pain when staff transferred the resident utilizing a standing lift. The care plan stated assist of 2 with EZ stand. A Hoyer lift when refuses to hold onto the EZ stand. CNAs did not report pain to nurses. EZ stand observation

revealed straps were applied incorrectly, and feet not on foot plate. (observation, record review, review of policy, review of manufacturer's recommendations, and staff interview)

#10 (Regular survey) Unwittnessed avoidable fall resulting in a hip fracture and decline in physical function due to failure to reassess fall risk factors and implement effective interventions to prevent further falls and injury. (observation, record review, review of facility policy, and staff interview)

#11 (Regular survey) Resident spilled hot tea resulting in an avoidable burn and unnecessary pain and the facility failed to reassess capabilities or implement any interventions to prevent future burns. (record review and staff interview)

#12 (Regular survey) Avoidable burns and unnecessary pain/discomfort related to hot coffee from coffee dispensers. (record review and staff interview)

#13 (Regular survey) Due to lack of failure to follow plan of care, assess causative factors for falls experienced, and implement/monitor effectiveness of responsive safety/supervision interventions, a resident experienced multiple falls resulting avoidable head injury requiring emergency room care, staples to laceration, and unnecessary pain/discomfort. (observation, record review, review of policy, and staff interview)

#14 (Complaint investigation) Facility failed to investigate incident of resident experiencing unresponsive episode with near fall from standing lift, and additional unresponsive episodes during transfer for several days prior to physician notification. (information provided by complainant, record review and staff interview)

F325 – Maintain Nutrition Status. "G" scores in four facilities as follows:

#1 (Regular Survey) Severe avoidable weight loss X 3 residents due to failure to implement/evaluate the effectiveness of appropriate interventions to restore/maintain nutritional status. (observation, record review, review of facility policy, and staff interview)

#2 (Regular Survey) – Severe avoidable weight loss due to failure to implement and evaluate the effectiveness of current planned interventions. Weight on admission 127 pounds. 26.1 pounds (20%) weight loss occurred in less than 2 months. When resident's weight reached 109 pounds, hot chocolate was added to meals and chocolate milk at hs. When weight reached 101 pounds, nursing requested ensure plus pm & hs. This information was not on the dietary card and not monitored. (observation, record review, review of professional literature, and staff interview)

#3 (Regular Survey) Severe avoidable weight loss due to failure to provide required assistance with eating and implement appropriate interventions to restore/maintain nutritional status. (observation, record review, review of facility policy, review of professional reference, and staff interview)

#4 – (Regular Survey) Severe avoidable weight loss X 2 residents due to failure to implement and monitor the effectiveness of planned interventions. (observation, record review, review of facility policy, and staff interview)

F327 – Sufficient Fluid to Maintain Hydration. "G" score in one facility as follows:

#1 (Regular survey and complaint investigation) Dependent resident experienced dehydration and urinary tract infection resulting in hospitalization for sepsis due to lack of offering/providing/monitoring adequate fluid intake. (observation, record review, facility policy review, review of professional literature, and staff interview)

F328 – Treatment/Care for Special Needs. "G" score in one facility as follows:

#1 (Complaint investigation) Due to the lack of adequate monitoring and staff oversight, a resident requiring continuous oxygen experienced significant anxiety/fear after running out of oxygen on several occasions. (information provided by the complainant, observation, record review, resident interview, and staff interview)

F329 – Drug Regimen is Free of Unnecessary Drugs. "G" scores in one facility as follows:

#1 (Regular Survey) Avoidable fall with resulting femur fracture due to lack of assessment of behavior(s) and sleep patterns prior increasing the resident's risk for falls with an increase in hypnotic and antipsychotic medications. (observation, record review, facility policy review, professional reference review, and staff interview)

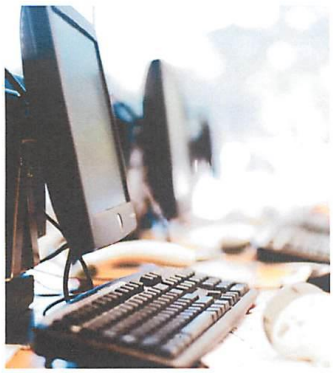
F333 – Residents Free of Significant Med Errors. "G" scores in one facility as follows:

#1 (Complaint investigation) Due to failure to properly identify resident prior to administration of an opiate pain medication patch to the wrong resident required admission to the emergency room. (record review, review of facility policy, review of professional literature, information provided by complainant, and staff interview.

Independent IDR

Independent Informal Dispute Resolution

MPRO



URAC
ACCREDITED
INDEPENDENT REVIEW

Charlene Kawchak-Belitsky, R.N., BSN, NHA
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MPRO:

Your Objective & Independent IDR Alternative

MPRO, a leader in health care quality improvement and record review for more than 25 years, is committed to providing the best in Independent Informal Dispute Resolution (IIDR) services for state agencies and health care providers through its URAC accredited IIDR program. Whether you are a state official looking for alternative solutions to your current IIDR process, or a health care provider seeking to have a fast, objective, quality, independent review of your disputed citations, MPRO can provide customized solutions to meet your needs – timely, affordable resolution of disputed citations.

IIDR Solutions

Our approach to IIDR is characterized by a rigorous decision-making process, highly qualified professional reviewers, established reviewer selection standards, internal reliability and on-going staff training to ensure reviewers have current knowledge of Federal and State regulations and practice standards.

MPRO's IIDR services integrate quality improvement principles, including internal auditing of our decisions to ensure consistent reliability and to identify educational opportunities. All MPRO services are supported by stringent confidentiality and security processes.

National Accreditations

MPRO is accredited by URAC as an Independent Review Organization (IRO) — a status we have maintained for more than 13 years. URAC standards ensure only appropriately trained, qualified, professional personnel conduct and oversee the review process; that a reasonable, timely and efficient process is in place; and that review decisions are based on current practice standards.

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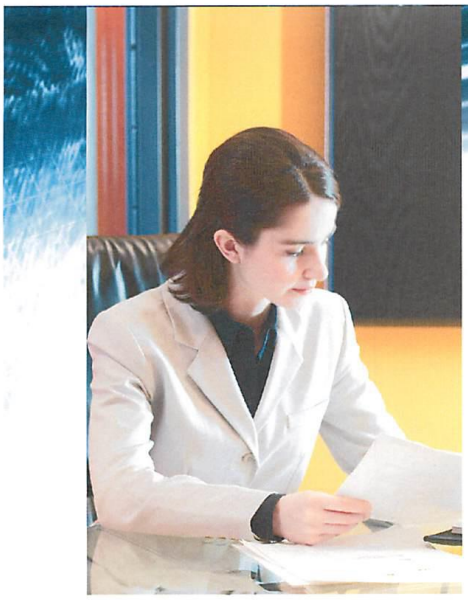

The MPRO Difference

Objective Review

MPRO believes an objective review process is fundamental to reaching a reliable, consistent determination for each cited deficiency. In compliance with URAC guidelines, MPRO ensures all IIDR review determinations are independent of individuals involvement with issuing the statement of deficiency, or providing services to the nursing facility in question. Strict adherence to URAC guidelines ensure no organizational or reviewer conflict of interest exists for each requested review. Each reviewer conflict of interest profile is examined and documented prior to making a review assignment.

Commitment to Quality Improvement

MPRO provides monthly quality improvement training for our reviewers and an innovative reporting and information management system.

Expert Reviewers & Training

Each of MPRO's IIDR reviewers is a qualified professional with the expertise to provide objective and thorough independent review. IIDR reviewers are either licensed registered nurses or other long-term care (LTC) professionals with extensive knowledge and understanding of LTC regulations and standards of practice.

MPRO IIDR Clients

As a result of MPRO's national reputation for quality IIDR reviews, MPRO has secured contracts with several state agencies to provide IIDR review services, including alternatives to the IDR reviews conducted by state survey agencies for health care providers. Once selected to conduct independent review, MPRO works with state stakeholders to educate providers on the review process and methods for preparing their case materials.

About MPRO

MPRO is a recognized leader in health care quality improvement and independent review services. For more than 25 years, MPRO has demonstrated a commitment to promoting quality health care and protecting and assisting health care consumers, providers and payers while creating solutions to health care challenges.

For additional information, contact:
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Updated June 2013

Informal Dispute Resolution Options

Example of Timelines for IDR Options Based on a October 1, 2015 Facility Exit Date

	Option 1	Option 2	Option 3	Option 4	Option 5
Enforcement Timeline Exit: October 1 – Day 0	Current SSA Review	MPRO/Final SSA Appeal CMS if Enforcement Action Imposed	Small Group to participate in initial review; Final SSA/Appeal to CMS if Enforcement Action	Combination of 1 and 2; or 1 and 3.	MPRO/Final SSA Third State Review Appeal to CMS if Enforcement Action Imposed
Def Write-up/Scoring and send to facility – up to 10 working days – October 15, 2015 – Day 15					
Facility PoC and IDR due 10 calendar days after receipt – October 25, 2015 – Day 25	IDR received by October 25, 2015 SSA review 10 working days Response to facility by November 6, 2015 – SSA Final Decision - Day 36	MPRO received IDR request on October 25, 2015 – 20 calendar days to review – November 14, 2015- Returned to SSA with recommendation – Day 44	Sm Gp received IDR on October 25, 2015 – 20 calendar days to review – November 14, 2015- Returned to SSA with recommendation – Day 44		MPRO received IDR request on October 25, 2015 – 20 calendar days to review – November 14, 2015- Returned to SSA with recommendation – Day 44
Correction requested by Day 35-45					
Revisit between Day 45-65		SSA 10 working days to review – December 1, 2015 – SSA Final Decision - Day 61	SSA 10 working days to review – December 1, 2015 – SSA Final Decision - Day 61		SSA 10 working days to review – December 1, 2015 – SSA Final Decision- Day 61
Day 75 – notify RO of compliance or non-compliance					Facility request a third state level review from Administrative Law Judge
Day 90 – Enforcement Imposed	Day 90 Enforcement Action Imposed – Appeal to CMS – Timeline unknown	Day 90 Enforcement Action Imposed – Appeal to CMS – Timeline unknown	Day 90 Enforcement Action Imposed – Appeal to CMS – Timeline unknown		
Day 180 – Possible Termination Action of not corrected					Administrative Law Judge estimated at 120 days – Day 181
Costs	No additional cost to Facility; other than legal fees related to appeal being facility responsibility.	Facility pays for MPRO services – Minimum $885/tag and more based on review time. Facility pays own legal fees if appeals to CMS	No additional costs to Facility as long a three member panel are on volunteer basis; other costs related to legal fees for appeal facility resp.	.	Facility pay for MPRO services – Minimum $885/tag and more based on review time, and pay for cost of Administrative Law Judge if department prevails.

Appendix G

NDDoH LTC Collaborative Workgroup IDR Subcommittee Meetings

December 2, 2015 and December 8, 2015

Topic: If an option is made available for facilities to request that an independent panel/ small group to review the IDR request prior to the State making its final determination:

December 2, 2015 Meeting Minutes:

1. How many people should be on the group?
   Group Recommendation: 3 members and 1 SSA employee in a non-voting advisory capacity to respond to questions.

2. Who should be on the group?
   Group Recommendation:
   1-NDLTCA Board Member or designee (not an ALF or BC member)
   1-NADONA Representative (Nurse)
   1-QIO/QHA
   1-SSA Representative (Non-Voting, Advisory Capacity only to respond to questions)

3. What qualifications would the individuals on the group need to meet?
   Group Recommendation: Each organization would make their own decisions regarding the representative to complete the review with consideration given to potential conflict of interest and that the individual must be actively working in the field at the time of the review. The reviewer would need to have completed the 2-4 hour training by the NDDoH related to the IDR review process (See below).

4. What training should reviewers receive prior to participating on a review?
   Group Recommendation: Department provide 2-4 hour orientation to the process, possibly update annually.

December 8, 2015 Meeting Minutes:

5. Who would coordinate the group, assign members, and facilitate the review?
   Group Recommendation: NDLTCA should coordinate the group, if willing.

6. Whose responsibility would it be to insure reviewers had no conflict of interest?
   Group Recommendation: Send out to find out who would volunteer, the individual would determine if they have a conflict of interest and if so should not volunteer, and then the president of the organizations providing the representative would have final determination if there was a conflict.

7. Whose responsibility would it be to ensure reviewers sign a business associate agreement (BAA) with the facility as they would be handling PHI?
   Group Recommendation: The NDLTCA would send out the name of the facility requesting the IDR and a BAA to be signed by the reviewer to the President of NADONA, the Chair of the NDLTCA Board and the QIO with the request for the name of the selected representative to complete an IDR. The name of the individual agreeing to participate on the review panel and a BAA by the individual

should be returned to the NDLTCA. As a part of the BAA, the reviewer should sign that all information be deleted if electronic or shredded if paper copy upon completion of the review.

8. Who would be responsible to document the review and submit the results to the state?
   Group Recommendation: Option 1: Request that the NDLTCA provide administrative support for the meeting. Or Option 2: Department of Health Advisory Representative would document the minutes from the call.
   The minutes would be sent to the members for approval. Hard copies should be shredded

9. What happens with the records once the review has been completed? Are the submitted to the State in their entirety with the recommendations resulting from the review?
   Group Recommendation: See Number 7 above.

10. What would be the timeline for completion?
    Group Recommendation: Ten working days.

11. What would the process look like?
    Group Recommendation:
    a) The facility requesting the preliminary review by the small panel would contact the NDLTCA (with a copy to the NDDoH) with their request within the 10 calendar days from the date they receive the CMS 2567 form.
    b) The NDLTCA would contact the president of NADONA, the Chair of the NDLTCA Board, and the QIO with the name of the facility requesting the review, and to request the name of the reviewer, and to have a BAA completed by the reviewer and returned to the NDLTCA.
    c) Each organization would submit the name of their selected reviewer, along with the signed BAA to the NDLTCA
    d) The NDLTCA would provide the facility and the SSA with the names of the reviewers and copies of the signed BAAs
    e) The Facility has the responsibility to send the hard copy documents of all information requested to be reviewed as a part of their IDR to the three reviewers and the Department of Health.
    f) The three member review panel can visit with each other during their independent review of the information prior to the group meeting. The information may not be discussed with other individuals, except that the panel members can reach out to experts as long as confidential information not provided. The name of the expert consulted needs to be included in the review panel's report.
    g) The NDLTCA would coordinate the time of the call for the panel review group to discuss their review and to come up with their recommendations.
    h) Staff from the NDLTCA would serve as the scribe for the group, with someone from the SSA also being present on the call to serve in an advisory, non-voting, capacity to respond to questions from the review panel members.
    i) The minutes and recommendations resulting from the call would be sent from the NDLTCA to the three review panel members for review, and approval.
    j) Once the review was completed, the approved meeting minutes and recommendations would be sent from the NDLTCA to SSA and the facility. Any additional information considered by the panel beyond what was provided by the facility would need to be included with the information sent to the SSA to be included in the SSAs final review.

k) Once the minutes of the meeting and recommendations have been approved by all review panel members and the minutes from the meeting and recommendation submitted, the hard copies used by the panel reviewers are to be shredded and the facility requesting the review notified that the documentation has been shredded consistent with the BAA.
l) The minutes from the meeting and panel recommendations would be considered by the SSA as the SSA makes final determination on the results of the IDR. Once the final determination is made by the SSA, the facility would be notified of the final results of the IDR review.
m) Steps a-j should be accomplished within 10 working days. Step k should be accomplished within a second 10 working days.

12. Would the group meet in person or via conference call?
    Group Recommendation: Conference call.

13. Is all work on the part of the reviewers volunteer and absorbed by their regular employer, or would they be paid by the facility? Renee: There should be a charge for the process. There should there be an honorarium to the reviewer.
    Group Recommendation: Discuss as a larger group. Possibly $500 for each deficiency IDR - $200 to the association and $100 honorarium for each reviewer.

14. Other?
    If a facility requests the small panel to review, all deficiencies they want to IDR should go to the small group. The option should not be available to split the request for an IDR review so that some tags are reviewed by the SSA, and some tags are reviewed by the Small Group Review Panel prior to the final review by the SSA.

    Education should be provided on the IDR options at a ND LTCA meeting/conference.

Documents to review prior to the meeting:

- 7212 – Informal Dispute Resolution; 7212.2 Purpose to provide Facilities an Opportunity to Informally Dispute Cited Deficiencies After a Survey; and 7212.3 Mandatory Elements of Informal Dispute Resolution
- 7213.6 – Qualifications of an Independent Informal Dispute Entity or Person(s)
- Information received from AHFSA members (other states) who use panels as a part of their IDR process

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, Colorado 80294

Western Division of Survey & Certification
Refer to: WDSC-RO8-JRC

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

November 9, 2015

Department of Health
Health Resources Section
Attn: Darleen Bartz, PhD., Chief
600 East Boulevard Avenue
Dept. 301 Bismarck, ND 58505-0200

Dear Dr. Bartz,

This is to clarify the referencing of F-Tags during the exit for Long-Term Care (LTC) Certification surveys. The Centers for Medicare and Medicaid Services (CMS) has provided guidance to surveyors that F-Tags should not be provided in reference to issues determined to be out of compliance at the exit conference.

The State Operations Manual (SOM) provides a process and protocol to which surveys are conducted. The exit conference is both a courtesy to the provider as well as a way to expedite the provider's planning ahead of the formal CMS-2567 report. The CMS-2567 is, in fact, the official notification by CMS to the provider of deficiencies cited, with supporting evidence.

Appendix P of the SOM, under the instructions for Task 7, "Exit Conference states that the exit conference is to *"inform the facility of the survey team's observations and preliminary findings*". These preliminary findings are subject to the standard review processes and the final assignment of F-Tags, by federal protocol, when the CMS-2567 report is finalized by the agency.

The SOM guidance states, "*During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.*" Additionally, the guidance states, "*Provide information in a manner that is understandable to those present, e.g., say the deficiency "relates to development of pressure sores," not "Tag F314".*

The 1864 Agreement provides CMS with the authority to designate the content of the survey process to be followed by the States. The 1864 Agreement is the agreement between CMS and the State survey agency to carry out the provisions of Sections 1864, 1874, and related provisions of the Social Security Act. Article II of the 1864 Agreement specifies the functions to be performed by the State. Article II, A.1. (c), reads that the State is "*responsible for surveying for the purpose of certifying to the Secretary the compliance or non-compliance of providers and suppliers of services and resurveying such entities, at such times and manner as the Secretary may direct.*"

As we discussed, CMS is requiring that the State of North Dakota State Survey Agency follow the directed policy and guidance and not provide F-tags when presenting preliminary survey findings to providers during the exit conferences of Long-Term Care Surveys.

Sincerely,

Steven D. Chickering,
Associate Regional Administrator
Western Division of Survey and Certification

Copies via e-mail to:

Thomas E. Hamilton, Director, Survey and Certification Group
Karen Tritz, SCG, CCSQ
David Wright, Deputy Regional Administrator, CQISCO

Appendix I

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 16-11-ALL

DATE: March 11, 2016

TO: State Survey Agency Directors

FROM: Director Survey and Certification Group

SUBJECT: Exit Conferences - Sharing Specific Regulatory References or Tags

Memorandum Summary

- **Advance Guidance – Procedures for Conducting the Exit Conference:** The Centers for Medicare & Medicaid Services **(**CMS) is clarifying guidance to surveyors regarding the procedures for conducting the exit conference in the review of compliance with Medicare or Medicaid Conditions of Participation, Conditions for Coverage, and Requirements for Participation.

- **Review Exit Conference Procedures:** Please review with surveyors the exit conference procedures for conducting the federal surveys to ensure consistency of this process across States.

Background

The CMS has received questions regarding what degree of specificity surveyors should give during the Exit Conference to Medicare/Medicaid providers and suppliers regarding deficiencies found during the conduct of federal surveys. This policy memorandum is relevant to all surveyors conducting Federal surveys and for all types of Federal surveys. To address these questions and provide additional clarity and ensure uniformity in the survey procedures, CMS has revised the State Operations Manual (SOM), Chapters 2 and 5, and Appendix P. A list of all revised Sections can be found at the end of this policy memorandum. In the next few months, CMS will re-issue this memorandum to include other affected Appendices (e.g., Appendix I)

The Exit Conference during the onsite survey is both a courtesy to the provider and a way to expedite the provider's planning ahead of the formal receipt of the survey findings in the Form CMS-2567, Statement of Deficiencies. The purpose of the Exit Conference is to informally communicate preliminary survey team findings and provide an opportunity for the exchange of information with the provider's or supplier's administrator, designee or other invited staff. The findings or information conveyed at the Exit Conference

are preliminary in nature and are subject to change pursuant to the State and CMS supervisory review processes. Additionally, an Exit Conference is not always guaranteed, as is noted in section 2724 of the SOM.

Long Term Care (LTC) Providers (Nursing Homes)

For LTC providers, CMS has invested considerable effort to add to the SOM more explanations and resource material under many deficiency tag codes that can be of particular use to a facility in understanding relevant deficiencies and preparing remedial action. If the provider asks for the specific regulatory basis or the specific tag code, the surveyors should generally provide this information (except as noted below), but must always caution the facility that such coding classifications are preliminary and are provided only to help the provider gain more insight into the issues through the interpretive guidance. If the facility does not specifically ask for the regulatory basis or tag, the survey team may use its own judgment in determining whether this additional information would provide additional insight for the facility.

However, if the survey team is still deliberating which tags will be most pertinent, the survey team must not speculate at the exit conference as to the specific tag coding that will be applied. For example, the team may still be deliberating whether the finding was a care planning deficiency or staff training deficiency. Similarly, the team may believe that additional consultation should occur with other State personnel (e.g., a pharmacist) before a specific tag number is assigned to the deficiency finding. In these cases, the survey team should describe the general area of non-compliance without identifying a specific tag code. This is a judgment to be made by the survey team onsite, so in preparation for the exit conference the team should deliberate as to the degree of detail that will be appropriate. This is a survey-specific decision based on the evidence gathered.

As described below, States must follow the federal process. State licensure laws do not override the procedures outlined in the federal survey process. *States are not permitted to have blanket policies that differ from the policy described in this section. For example, States may not require surveyors to always provide certain information during the Exit conference.*

Under no circumstances, however, would the surveyors provide the Scope and Severity of a given deficiency finding (unless it is an immediate jeopardy), as such finer degree of possible detail should await supervisory review. Instead, survey teams may describe the general seriousness (e.g., harm) or urgency that, in the preliminary view of the survey team, a particular deficiency may pose to the well-being of residents. If a provider asks whether the noncompliance is isolated, pattern, or widespread, the surveyor should respond with the facts (i.e., noncompliance was found affecting X number of residents).

Non-Long Term Care Providers and Suppliers

For non-LTC providers and suppliers, if the provider/supplier asks for the specific regulatory basis for the noncompliance findings, the surveyors should generally provide the regulatory grouping to the extent that the team is not still deliberating which part of the regulation is most pertinent. Consistent with existing CMS policy, the survey team should avoid identifying the specific tags, as the tag codes often identify the Condition- or Standard-level classification for most non-LTC deficiencies. Additionally such specific details should wait supervisory review. This has been CMS' long-standing policy, and we will continue this policy for non-LTC providers and suppliers.

Clinical Laboratories (CLIA)

For laboratories, given the complexity of the regulations and nature of the survey, the surveyors must indicate to the laboratory that the specific regulatory reference will be found in the Form CMS-2567 report that will be issued to them. The laboratory is informed that the information discussed in the exit interview is preliminary and the lab management will have an opportunity at the exit interview to talk in general about the issues that were found.

Life-Safety Code (LSC)

For LSC surveys, the survey team may follow the procedures for either non-LTC or LTC, depending on the degree to which, in the judgment of the team, the tag codes are important in helping the provider/supplier to understand the nature and location of the deficiency, and the corrective actions that would be necessary. Facility representatives are typically invited to accompany life safety surveyors during building tours, to improve familiarity with preliminary findings and exit conference proceedings.

Additional Considerations

We believe that the attached changes in the SOM will provide additional guidance for surveyors about what to communicate regarding the deficiency findings and create a common set of expectations for States and providers/suppliers. There are two related considerations described below that provide additional context for these changes.

First, the integrity of the State and CMS post-survey quality review process is central to having well-supported, evidenced-based deficiency findings that appropriately establish the level of harm or potential for harm to the patient/resident. CMS will evaluate this policy on an ongoing basis. If, we find that providing this level of detail undermines that process or results in providers/suppliers trying to unduly pressure surveyors, or influence the objectivity and fairness of the survey process, we will re-evaluate the policy.

This policy memorandum also clarifies that States must not leave draft CMS-2567 forms onsite before they are finalized. This type of activity undermines the survey and certification process by shortening the time for the investigation and limiting the quality assurance process for the review of the CMS-2567 forms.

States are required to follow the federal survey process as written in the SOM. States are not permitted to establish additional processes for the federal surveys (such as conducting a “pre-exit conference” which provides deficiency information that the federal exit conference prohibits). For questions related to additional processes, States must consult with their CMS Regional Office. These actions would be in violation of the 1864 Agreement (i.e., Section 1864 of the Social Security Act) which provides CMS with the authority to prescribe the survey process to be followed by the States in their review of federal Medicare/Medicaid requirements. Article II, A.1. (c) of the 1864 Agreement specifies the functions to be performed by the State. The State is "responsible for surveying for the purpose of certifying to the Secretary the compliance or non-compliance of providers and suppliers of services and resurveying such entities, at such times and manner as the Secretary may direct."

Contact: We would ask that States share this memorandum with all surveyors and review the Exit Conference procedures with them. Any questions on this memo can be sent to DNH_TriageTeam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

Thomas E. Hamilton

Attachment:
SOM Revisions
Chapter 2, Sections 2724 and 2727
Chapter 5, Sections 5080.2, 5300.5, and 5340
Appendix P, Task 7

cc: Survey and Certification Regional Office Management

Appendix J

Root Cause Analysis related to G-Level Citations Discussion – February 1, 2016

1. What is the issue that you want to research?
   - Need to define the purpose for the research study
   - Are there common characteristics when a G-level citation is cited?
   - Explore each G-level deficiency cited related to common characteristics - things that the facility can work on.

   Discussion:
   - Need to have a clear sense of purpose - otherwise you just collect data that does not answer the question at hand.
   - Need to focus on what is causing the problem - more to do with facility information.
   - Need to define the issue and be willing to go where the information takes you.
   - Two buckets - the facility's role in the citation; and the whole system of surveillance - including surveyor training; or is it a combination of both?
   - What are the root causes that caused the increased citations?
   - Also, if they have decreased, why - more response from the facility or a change in how the surveillance is being completed.
   - What has caused the dramatic shifts?
   - Facilities put QA in place to respond, facilities communicate between each other.
   - Need to go through a cycle of the 80 facilities.
   - Three buckets of evaluation - Formative - to identify the questions; Process evaluation - once you have defined your theories - form your hypothesis; Outcome evaluation - what is the outcome - G-level citations
   - Barb - A root cause analysis may not be the best approach
   - Pam - respect all staff from the department. Think needs it to be approached from the facility perspective and the survey perspective.
   - Facilities need to look at how things are now - they need to work on correcting and keeping the corrections in place.
   - Facilities don't want the G-level citations because of the 5 star ratings - need to focus on the residents
   - The five star rating is a reality, we need to deal with it - We care for our residents.
   - When we talk about our deficiencies in the facility, we talk about how it impacts our residents, how do we best care for the resident.

2. What information should be explored?
   - All 2567's and plans of correction
   - Resident Age, Diagnosis, Acuity if there is a G-level citation
   - Use of Temporary Staff - Would like to eliminate the use of temporary staff - do not have the day to day control or knowledge.
   - Implementation of the EHR - positive or negative impact?
   - Licensed nurse knowledge of residents
   - Changes in leadership staff in the facility - administrators and DONs

- Dynamics of surveyor team members
- Time of year - cycle
- How many facilities are completing a Root Cause Analysis on deficiencies cited

Discussion:

- May be difficult to narrow down to know what information is needed.
- It would be helpful for the facilities to do a root cause analysis of their own G-level citations.
- When a G-level is cited, some facilities do a root cause analysis on regarding why the citation occurred.
- Emphasis on the five star rating and bundle payment has made receiving a G-level more impactful on the facility - this is a driving factor on why facilities do not want G-level
- Having a G-level citation can drop you to a 2 star level in the 5-star rating.

3. What information can be accessed?
   - CMS FOIA Request - Analysis by surveyor, how many tags and what tags and the level were cited by each surveyor (de-identified) - is this information relevant?
   - Linda - FOIA goes to Baltimore and they let the regional office know if they can release information. So far the RO has not received requests for CO.
   - Shelly did receive the state performance information on all states in the region for the last 3 years and did receive this information. It was a huge file. It was sent out to members.
   - If cited for an issue, the facility should do a root cause analysis regarding why it is cited so that corrections can be made. Facilities would guide themselves on how to correct.

4. Who should complete the research/root cause analysis?
   - QHA
   - Dr. Dwelle indicated we need someone who can do Qualitative Research, Laura Hand - UND - Public Health Training Program - to complete Formative Evaluation
   - Centers for Rural Health

5. How will the root cause analysis be funded?
   - CMS would not it.
   - NDDoH would most likely not have general funds.
   - Not sure where the NDLTCA is at on funding for something such as this.
   - Barb - there are some small grants that may be available by the Consensus Council to fund issues such as this.
   - Dr. Dwelle - meet with folks from UND - Shelly, Terry, Arvy, Administrators - to see if we could get a proposal from them including the cost for them to complete the research.
   - Londa would set up this meeting with UND

Appendix K

NORTH DAKOTA
DEPARTMENT *of* HEALTH

HEALTH RESOURCES SECTION
600 East Boulevard Avenue, Dept. 301
Bismarck, N.D. 58505-0200

To: Skilled Nursing Facility Administrators and Directors of Nursing

FROM: Bruce Pritschet, Director Division of Health Facilities Bruce Pritschet

DATE: March 22, 2016

TOPIC: Surveyor Communication with Medical Director and Resident Primary Care Providers

PLEASE SHARE THIS MEMORANDUM WITH YOUR MEDICAL DIRECTOR AND ALL RESIDENT PRIMARY CARE PROVIDERS AT YOUR FACILITY

The state survey agency is passing along some information, intended for physicians and mid-level practitioners, who provide medical services to residents of skilled nursing facilities (SNFs).

In an effort to gather more accurate and consistent resident findings during an onsite survey, our Health Department survey staff may be contacting you, the medical provider. The surveyor will be asking questions specific to a sampled resident under your care to better understand and verify the medical goals and plans identified for the resident. The contact will most often be by phone and will happen when concerns are identified that rise to the level of actual harm relevant to a sampled resident under your care.

Examples of care concerns you may be contacted regarding may include:

- The care and services provided to the resident
- Pressure Ulcers
- Indwelling Catheters
- Nutritional Status
- Unnecessary Drugs

We do not anticipate the phone call will last more than a few minutes and we have asked the surveyors to be prepared to ask specific questions regarding findings that may rise to the level of harm.

Thank you in advance for your participation in the survey, as we all strive to ensure the best care for the residents of our skilled nursing facilities.

Appendix L

Surveyor/Facility Communication During the LTC Survey Process

Throughout the survey, surveyors will be communicating and asking questions of staff – This is done to obtain information, recognizing that every facility operates differently.

Surveyors are to maintain an open and ongoing dialogue with the facility during the survey process. This provides the facility with the opportunity to provide additional information when considering any alternative explanations before making deficiency decisions.

However, this does not mean that every negative observation is reported to the facility on a daily basis. Moreover, if the negative observation relates to a routine that needs to be monitored over time to determine whether a deficiency exists, the surveyor is instructed to wait until a trend has been established prior to notifying the facility of the problem. There may be rare instances when notification of an issue does not occur until the exit conference, dependent upon when the issue was identified and when the investigation was completed.

Several tasks in the survey process direct the surveyors to interview various direct care staff members within the facility. The surveyor will interview staff members who know the residents such as the CNAs and Licensed Professional Staff. Surveyors may also ask staff members who are knowledgeable regarding specific documentation on concerns identified.

In addition to this communication, the team leader will try to have a meeting with facility leadership staff on a daily basis, after the first day of survey if appropriate/applicable.

Strategies for Facility Communication During a Survey

Facility leadership should inform their staff members:

- Open communication between the facility staff and surveyors is desired and needed.
- They may be asked questions and interviewed by surveyors during the survey.
- TO BE SURE AND PROVIDE SURVEYORS WITH ANY ADDITIONAL INFORMATION REQUESTED OR ANYTHING THAT WOULD CLARIFY AN ISSUE.
- They should feel free to:
  - Ask questions anytime
  - If they don't understand our survey process, visit with the team leader

If the facility has questions during the survey –

- Our management is requesting you visit with the team members and/or Team Leader that are at the facility first.
- If the concern is not able to be resolved, facility Administrator/DON can contact the Health Facilities Long Term Care Leadership team at their office in Bismarck.

Communication:

- Most communication/requests for additional information are completed by each surveyor on the issues they identify with Dept heads/Supervisors/Charge nurses – Please ask these facility staff members to share this information with the Administrator &/or DON.
- It is recommended that the Administrator and/or DON check with the survey team each day to see if there is additional information needed by the team to facilitate the survey process.

Appendix M

ND Department of Health and Centers for Medicare and Medicaid

Long Term Care Provider Update

June 29, 2016

9:00 am – 4:00 pm

9:00 am	Welcome and Review of Agenda
9:15 am	NDDoH LTC Collaborative Workgroup Update – Darleen Bartz, PhD.
10:15 am	Break,
10:30 am	North Dakota Issues - Centers for Medicare and Medicaid Services (CMS) - Robert Casteel and Captain Linda Bedker

- LTC Complaints;
- Resident Dumping Issues in LTC; and
- CMP Imposition in North Dakota

11:30 am	Lunch on your own
1:00 pm	CMS Central Office Update – Karen Tritz, CMS

- New CMS LTC Survey Process;
- Payroll Based Journal;
- Nursing Home Compare;
- Five Star Ratings;
- CMS 2016/2017 LTC Action Plan, and
- Q & As

3:00 pm	Break
3:15 pm	Western Division Data – Steve Chickering, CMS
3:45 pm	Q & As
4:00 pm	Conclude

Appendix N

Summary of Action Steps and Responses

Action Step 1: During the March 5, 2015 meeting, identify the five key issues to be focused upon by the Workgroup.
Response to Action Step 1: The five key issues were identified by the Workgroup members during the March 5, 2015 meeting in the following priority order as follows:

1. High Number of G-level Citations
2. Objectivity and Fairness of the IDR Process
3. Subjectivity in the Survey Process
4. Sufficient Time to Discuss Findings at the Exit Conference
5. Increased Potential for a Citation when Caring for Behaviorally Difficult Patients

Action Step 2: During the April 9, 2015 meeting, the request was made for S&C letters that pertain to LTC to be emailed from the SSA to Shelly Peterson to distribute to her member facilities.
Action Step 2 Response: It was decided that the Health Facilities Division Director or designee would review the new CMS S&C letters each Friday when working, and any S&C Letters that related to LTC providers would be forwarded to Shelly Peterson, who would then disseminate the letters to her LTC member facilities.

Action Step 3: During the April 9, 2015 meeting, the Workgroup recommended that training be provided to survey staff related to scoring considerations for the most frequently cited deficiency citations.
Response to Action Step 3: Similar training had already been provided to survey staff in March 2015 related to scoring considerations for some of the most frequently cited deficiency citations. Training in this area will be ongoing.

Action Step 4: During the April 9, 2015 meeting, the Workgroup members identified a need to further explore the possibility of having a Root Cause Analysis completed to see if the root cause(s) of the G-level citations can be identified. Also, explore options regarding who could complete an un-biased analysis.
Response to Action Step 4: During the July 24, 2015 meeting, the Workgroup identified information that should be considered if a root cause analysis was completed related to G-level citations. Suggestions included: CASPER reports; higher acuity residents; high number of residents with pressure sores; high number of hospital admissions and readmissions; residents with mental health or behavioral issues; availability of psychiatric services; turnover of administrative staff, administrator, director of nursing, and unit supervisors; types of residents and staffing needs; reimbursement system support care needs; behavioral residents and staff time needed to respond; residents with co-morbidities; hospital push back to discharge patients before they are ready; increased requirements for EMR; frequency and availability of providers coming to facility to see patients; and lack of physicians and use of Locums.
Response to Action Step 4: During the February 1, 2016 meeting, the Workgroup again discussed the potential of a Root Cause Analysis Related to G-Level Citations in North Dakota. The results of the discussion are located in Appendix J.
Response to Action Step 4: During the April 4, 2016 meeting, it was reported that workgroup members met with Laura Hand February 22, 2016 to discuss possible research study. Bruce Pritschet sent screen shots from PDQ to Laura to review for possible data collection. No funding

source yet identified. Laura Hand sent an email to the NDDoH on March 31, 2016 indicating that she did not believe that she was the right person for the project, as she had reached the conclusion that the project required someone leading/designing it who was familiar with either the facility side or the inspection side, and she had not experience with either. Therefore, she declined the research study opportunity.

Action Step 5: During the April 9, 2015 meeting, the Workgroup requested that research be completed related to what federal information can be accessed for use in a root cause analysis. Also, the Workgroup questioned how access to federal information could be requested.
Response to Action Step 5: During the May 11, 2015 meeting, a report was provided related to access to federal information. The Social Security Act, the Code of Federal Regulations, the CMS agreement with states, 42 CFR § 488.26 Determining Compliance, and other CMS information was reviewed related to what information would be releasable to the workgroup or public from the State Survey Agency (SSA). The Workgroup would need to submit a Freedom of Information Act request to CMS to access data from the CMS database. Information that is on the NDDoH website (deficiency statements and plans of correction) is publically accessible as well as information on CMS Nursing Home Compare website.

Action Step 6: During the July 24, 2015 meeting, the Workgroup recommended the Department of Health send a letter to SNF/NF facilities that they could share with their physicians and medical directors to let them know that there may be occasions during the survey when a surveyor will call them to discuss quality of care issues that raise to the level of harm.
Response to Action Step 6: During the April 4, 2014 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, shared a memo which had been sent out to LTC facilities on March 21, 2016 to share with their medical directors and resident primary care providers. The memo discussed that surveyors may be contacting them during the survey of a facility to discuss quality of care issues that raise to the level of harm that have been identified during the survey. Training was provided to LTC survey staff in March 2016.

Action Step 7: During the July 24, 2015 meeting, the Workgroup requested that Bruce Pritschet and Lucille Rostad visit with surveyors related to incorporating physician and/or medical director interviews as needed into the survey process for quality of care citations which rise to the level of actual harm.
Response to Action Step 7: During the April 4, 2016 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, reported that training had been provided to LTC surveyors in March 2016 related to incorporating medical provider interviews into the survey process for quality of care findings with actual harm.

Action Step 8: During the August 12, 2015 meeting, Steve Chickering, CMS, agreed to set up a meeting between Dr. Terry Dwelle and Karen Tritz, CMS CO LTC Program Manager, to discuss concerns related to the survey process.
Response to Action Step 8: A conference call took place between Karen Tritz, CMS, Dr. Terry Dwelle, and Darleen Bartz on October 7, 2015 to discuss concerns regarding the survey process that had been identified and access to federal information.

Action Step 9: During the August 12, 2015 meeting, Steve Chickering, CMS, identified that he planned to contact Karen Tritz, CMS CO LTC Program Manager, to identify a time that she could present to LTC facilities in North Dakota regarding upcoming changes in the survey process.

Response to Action Step 9: During the November 2, 2015 meeting, Steve Chickering, CMS, reported that he wants to move forward with the CMS and Department of Health provider presentation – a date needed to be confirmed on this. Steve would work with Karen Tritz, CMS Central Office and Evan Schulman to see when they would be available.
Response to Action Step 9: During the May 26, 2016 meeting, Darleen Bartz provided an update on the CMS Presentation to ALL LTC Providers. The date will be June 29, 2016 – Shelly had sent out a save the date to the industry. The location will be at the Heritage Center. Darleen reviewed the agenda and presenters. Darleen will present a summary of the work that has been completed by the Collaborative Workgroup. Robert Casteel and Linda Bedker, CMS Denver Regional Office will present on LTC complaints, resident dumping issues, and CMP imposition in North Dakota. Karen Tritz, LTC Program Manager, CMS Central Office will present on the new LTC survey process, payroll based journal, nursing home compare, the five star ratings, and the CMS 2016/2017 LTC Action Plan. Steve Chickering, CMS Western Division, will provide a report on the CMS Western Division Data for 2015. There will be some time set aside for questions. The workgroup members thought the agenda looked good. The registration for the presentation will be emailed out to the industry in the next week or as soon as possible. Please refer to Appendix M for a copy of the agenda.

Action Step 10: During the August 12, 2015 meeting, Steve Chickering, CMS, indicated he would check into whether or not surveyors could provide facilities with a list of tags/release of F-tags at the exit conference and get back to the Workgroup.
Response to Action Step 10: During the November 2, 2015 meeting, Steve Chickering, CMS, reported that the guidance he had received from CMS Central Office was not to give the F-tags during the exit conference. He indicated that from this point forward, this was the guidance being provided to the North Dakota SSA and to other States. Steve indicated that if CMS' stance changes, he will let the Workgroup know.
Response to Action Step 10: During the February 1, 2016 meeting, the letter received from CMS related to release of preliminary F-tags at the facility exit conference was reviewed. Please refer to Appendix H for a copy of this letter. The letter required "the State of North Dakota State Survey Agency follow the directed policy and guidance and not provide F-tags when presenting preliminary findings to providers during the exit conference of Long Term Care Surveys."

Action Step 11: During the September 8, 2015 meeting, the Collaborative Workgroup discussed strategies to foster good communication by facility staff members and surveyors during the Survey Process. The NDDoH Division of Health facilities management staff should explore strategies to facilitate communication during the survey process.
Response to Action Step 11: During the April 4, 2016 meeting, Bruce Pritschet, NDDoH Health Facilities Division Director, shared the one sheet handout that had been developed entitled Surveyor/Facility Communication during the LTC Survey Process. Bruce reported that surveyors had been provided training on communication with the facility in March 2016. This handout would be provided to LTC facilities during the entrance conference with recommended strategies to be used by both the survey team and facility to improve communication during the survey process. Please refer to Appendix L for the one page handout on communication which will be provided to facilities during the entrance conference.

Action Step 12: Shelly Peterson, NDLTCA President, was tasked with obtaining additional information related to MPRO.

Response to Action Step 12: Shelly Peterson provided an update during the September 8, 2015 meeting on the information that MPRO had shared in their presentation to the Long Term Care Administrators. The LTC Administrators would be willing to have an option available for a third party review; however, cost was a concern. Shelly reported she was not able to get cost information from MPRO, however, reported they seemed like a creditable and knowledgeable option.

Action Step 13: During the September 8, 2015 meeting, Darleen Bartz, NDDoH, was asked to reach out to MPRO to obtain information related to the cost of having them complete third party review. In addition, Darleen is to reach out to other CMS Region 8 states to find out what costs they incur related to the IDR process used in their states.
Response to Action Step 13: During the November 2, 2015 meeting, Darleen Bartz, NDDoH, presented information related to the costs associated with MPRO completing a preliminary IDR review. The base fee per tag is $160 with an additional hourly rate of $145 per hour. Each tag takes an average of 5 hours dependent upon information submitted. Fees can vary greatly. Darleen also presented information gathered from the six states in CMS Region 8 related to IDR costs incurred by their State Survey Agencies related the IDR process. All six states reported NO additional costs related to completion of the IDR process.

Action Step 14: During the November 2, 2015 meeting**,** Steve Chickering, CMS, was asked to see what information he could provide related to state performance standards for CMS Region VIII and North Dakota.
Response to Action Step 14: During the November 2, 2016 meeting, Steve Chickering, CMS, stated he was willing to work on the FOIA request for State Performance Standards for Region VIII.
Response to Action Step 14: During the February 1, 2016 meeting, Shelly Peterson reported that she had received the information from CMS related to the Region VIII State Performance Standards.

Action Step 15: During the November 2, 2015 meeting, a subcommittee of Workgroup members were identified to meet and discuss the small group IDR preliminary review concept, and to report back at the next meeting with a proposal regarding how a small group preliminary review of an IDR request would work.
Response to Action Step 15: During the February 1, 2016 Workgroup meeting, a report was provided from the Small Group IDR Sub-Committee. Please refer to Appendix G for a copy of the minutes of the December 2 and December 8, 2015 meetings of this Subcommittee which outline what a Small Group Preliminary IDR process would look like.

Action Step 16: During the November 2, 2015 meeting, the decision was made to discuss the concerns regarding CMS' directive to no longer release preliminary F-tags during the Long Term Care Exit Conferences with the State Health Council and with our delegation to Washington, D.C. to see if a change could be made regarding this discussion.
Response to Action Step 16: CMS released S&C: 16-11-ALL: Exit Conferences – Sharing Specific Regulatory References or Tags in response to the concerns that were brought to CMS' attention by Sen. Hoeven, the NDLTCA and Dr. Dwelle and Arvy. The workgroup was pleased with the outcome. Please refer to Appendix I for a copy of the S&C.

Action Step 17: During the February 1, 2016 meeting, the Workgroup requested that the NDDoH reach out to MPRO to develop a contract with them to complete the preliminary review

of an IDR request if that option was selected by the facility, with the understanding that the facility would pay MPRO for the cost of the preliminary review.
Response to Action Step 17: During the April 4, 2016 meeting, Darleen Bartz, NDDoH Health Resources Section Chief, reported that she had reached out to MPRO regarding completion of preliminary IDR reviews prior to the State Survey Agency final IDR review as an option for facilities. The cost of the preliminary review would be covered by the facility requesting the review. MPRO felt they could take on this workload with a tentative date of July 1, 2016. Specific contract details needed to be worked out.
Response to Action Step 17: During the May 26, 2016 meeting, the workgroup indicated that they were comfortable with the Department moving forward with the contract with MPRO with no further updates to the workgroup.

Action Step 18: During the February 1, 2016 meeting, the Workgroup recommended that the NDDoH provide training for the LTC facilities related to the IDR options that would become available tentatively July 1, 2016 which include: the ND SSA IDR process; or option for preliminary review by MPRO followed by final state level review by the SSA. Shelly indicated the soonest training could be scheduled was during the NDLTCA 2016 Fall Conference.
Response to Action Step 18: During the May 26, 2016 meeting, the workgroup discussed that training by the department on the IDR process and options available should take place at the NDLTCA Fall Conference. The department agreed to provide training on the IDR process and options at the conference.

Action Item 19: During the April 4, 2016 meeting, the workgroup decided to form a subcommittee to discuss mental health issues in LTC and present the results of their discussion to the group meeting on this topic to try mental health issues in LTC included in what is to be presented to the legislature. Karla Backman, State Ombudsman, was willing to lead this subcommittee. Additional members were identified to work with Karla. The subcommittee was asked to report back at the May 26, 2016 Meeting.
Response to Action Step 19: During the May 26, 2016 meeting, Karla Backman reported that the subcommittee had met on April 18, 2016. The subcommittee discussed mental and behavioral health issues in long term care and started putting talking points together. The subcommittee has another meeting scheduled for June 16, 2016. The subcommittee plans to discuss with Pam Sagness, DHS, who is taking a lead on addressing mental health issues with the legislature next session.
Response to Action Step 19: During the May 26, 2016 meeting, the workgroup recommended that the Mental and Behavioral Health Subcommittee report back on their work at a NDDoH LTC Advisory Committee future meeting.

Action Step 20: Dr. Dwelle and Darleen Bartz, NDDoH, would call Dr. Goldstein sometime after the April 4, 2016 meeting to discuss the research project on G-level citations and report back at the next meeting.
Response to Action Step 20: During the May 26, 2016 meeting, the workgroup discussed the G-Level Citation Research Project and questioned the benefit or ability to continue to pursue this research.. No funding source was identified for completion of the research. The number of G-Level citations in 2015 and 2016 are close to that of the region and nation. And, with the state funding cuts and the resultant negative impact this would have on staffing in facilities, the potential for increased G-Level citations was identified. After discussion, all workgroup members present agreed the G-Level Citation research project should be placed on hold.

Action Step 21: During the May 26, 2016 workgroup meeting, members discussed strategies for increasing the number of responses to post survey evaluations by providers. The workgroup members determined that it may be helpful to provide the post survey evaluations to the Directors of Nursing in addition to the Administrators.

Response to Action Step 21: Beginning July 1, 2016, the post survey evaluations will be provided to both the LTC Directors of Nursing and Administrator for completion.