

STATE OF COLORADO

John W. Hickenlooper, Governor
Christopher E. Urbina, MD, MPH
Executive Director and Chief Medical Officer



Dedicated to protecting and improving the health and environment of the people of Colorado

4300 Cherry Creek Dr. S. Laboratory Services Division
Denver, Colorado 80246-1530 8100 Lowry Blvd.
Phone (303) 692-2000 Denver, Colorado 80230-6928
Located in Glendale, Colorado (303) 692-3090

<http://www.cdph.state.co.us>

Colorado Department
of Public Health
and Environment

Long Term Care Advisory Meeting November 1, 2011 9:30 - 11:30 a.m. CDPHE Campus, Building A Sabin-Cleere Room

Call to Order: Deputy Division Director Jennifer McCants welcomed attendees and called the meeting to order at 9:31 a.m.

I. CDPHE Updates

Staff Changes: Jennifer McCants introduced Jane Garramone, RN, who has worked with the program for more than 10 years, and she is going to be the interim long term care program manager. Kristy Flodquist will be going into the field to conduct complaints, revisits. Surveyor Jo Tansey will be the interim complaints supervisor, and you can contact her with issues related to complaints at 303-692-2863. Kim McClain, a long-term care supervisor will be going out in the field in December to conduct complaints and revisits. There are a lot of changes going on in the division and we're thankful Kristy and Kim will be remaining with the program

Feeding Tubes in Nursing Homes: Jane Garramone reported that in early September, CMS sent a new transmittal to the state survey agencies on the use of feeding tubes in nursing homes. In short, F321 has been combined into F322 and, according to CMS; the changes were made to provide nursing home surveyors with guidance to determine compliance with use of feeding tubes by nursing homes. The revision is effective on November 30, 2011.

There will be two positions opening up for the Informal Dispute Resolution (IDR) Committee, one in December and one in January. To qualify, you must have spent six months in your current position, and you may be any of the following: administrator, director of nursing (DON), clinical coordinator, or consultant. If you are interested, please send a resume to Elaine Sabyan at 303-692-2815.

I. Agency Reports

a. **Culture Change Coalition:** Colorado Culture Change Executive Director Penny Cook reported that their next program is on pay-for performance and is being held Friday, November 18 at the Wheat Ridge Recreation Center. There will be 10 tables on quality of life domains for the pay for performance application. And the homes that did well in those domains will be presenting. You can walk around and learn from them. The application has changed a little bit and you'll learn about that. On Jan 27 we're having a half-day session with charge Kay Van Norman and she's presenting a program on removing the unseen barriers of culture change, looking at our own perceptions of people that are aging and how that affects the work that we do. All different care settings, home care, assisted living, adult day, and personal caregivers.

Networks for the coalition that have been meeting throughout the state. One of Penny's goals is to get the networks up and running again. The southern network will meet this Friday in Pueblo, Northeastern Network is meeting quarterly either at Eben Ezer or Devonshire Acres and their next meeting in Jan 13; the Northern Network is up and running again and they're planning for a presentation with guest speaker in February. Western network is still trying to get going.

b. **Culture Change Accountability Board:** Shelley Hitt reported that the Board received seven applications for grants this year totaling a little over \$109,000 in requests. The Board, which has about \$55,000 to distribute, is in

the process of making recommendations for that funding. The four vacancies on the Board have been filled with diverse representation.

c. State Ombudsman Report: Shelley Hitt reported that the Legal Center's Older Americans' Team comprised of Ms. Hitt, ombudsman Vinni Ferrara and elder law attorney Mary Catherine Rabbitt. Ms. Hitt said that she has reduced her work hours and Ms. Rabbitt has picked up those hours. Ms. Rabbitt has worked with issues around financial elder abuse, and Medicaid planning issues and problems transfer of assets. Legal assistance is one of the priority services of the Older Americans Act and Ms. Rabbitt works with the 16 area agencies on aging to provide training and supervision. You can reach any team member at (303) 722-0300.

d. Ombudsman Program: Ombudsman Program Manager Shannon Gimble made two announcements. First, she introduced Carrie Glenny, the new nursing home ombudsman; her territory is mostly Adams County with a few other facilities close to Adams county lines. Second, effective October 1, 2011 the volunteer ombudsman program at DRCOG has been discontinued. Ms. Gimble assured providers that every facility will have an ombudsman.

II. Presentations

a. Influenza Guidelines for Long-Term Care Facilities: Ken Gershman, MD, MPH, from CDPHE's Communicable Disease Epidemiology Program gave a presentation on how influenza is spread, goals and components of flu surveillance, influenza vaccine, influenza testing, responding to an outbreak, and antiviral meds for treatment of prophylaxis of influenza. (Please see attached presentation.)

b. Waste Management for Health Care Facilities: Lillian Gonzales from Solid and Hazardous Waste Program in the Hazardous Materials and Waste Management Division explained that hazardous waste and solid waste rules fully apply to health care facilities. In 2012 the program expects to begin reaching out to nursing homes to make inspections and enforcement to ensure they have systems in place to collect/dispose of their pharmaceutical waste properly. There are two key requirements in your facilities from a hazardous waste perspective: (1) know which pharmaceuticals are hazardous wastes (2) any pharmaceutical wastes that *are* hazardous waste have to go to a permanent hazardous waste facility. The most common hazardous waste violation that they're seeing is that facilities are putting medication waste in sharps containers. The good news is that most providers are *not* putting medication waste down the drain, as was the norm even three-four years ago. One *big* exception to medication waste going down the drain is for narcotics. For narcotics, even if they are hazardous waste, CDPHE and the Hazardous Waste Program defer to the Drug Enforcement Agency's requirements and recommendations for disposal of narcotics. Staff understands that there is a diversion issue with narcotics and that in this special situation some narcotics are put down the drain.

CDPHE began stakeholder meetings on hazardous waste disposal and compliance assistance inspections at Front Range hospitals in 2008, and began regular inspections in these hospitals in 2009. In December 2010, inspections at rural hospitals in NE Colorado began, and since coming aboard in January 2011, Ms. Gonzales has been conducting inspections and working with rural hospitals on managing their pharmaceutical waste and other waste. In June, 2011, the first health care waste management training session for rural hospitals was held. She explained that the hazardous waste penalty maximum is \$25,000/day per violation. She said that proper disposal helps manage risk to hospital, employees, contractors, and environment. For 2012 and beyond, they'll be looking to set up a stakeholder process for long-term care facilities late in 2012 and will start taking a good look at the typical disposal situation is right now. Providers can help educate program staff on what the current status is and by working together, we can figure out something that will allow your focus to be on patient care and yet still find a way to dispose of your medications properly. Other health care facilities to be subject to future inspections include retail pharmacies, veterinary healthcare, and dental care facilities. (Please see attached presentation on waste management for health care facilities.)

c. What to Have Ready For Your QIS Recertification Survey: Supervisor Kristen Gurney reported that a group of surveyors got together to talk about how to expedite the surveys, make them a little more efficient, and get out of the buildings a little quicker. One of the educating providers on what you can do to speed up the process and get prepared. (Please see handout on survey preparation).

- The two most important things surveyors need to start the survey quickly are (1) an alphabetical resident census list with room numbers on them. Please make a note if someone's out for dialysis, on pass, at a day program, etc. Otherwise surveyors spend time tracking down these residents and they're out of the building. (2) New admission form, which surveyors provide upon entrance; it has the date listed on it and surveyors want all residents admitted after that date that are still residing in the facility.
- Then we start Stage 1. Record review we're going to look at a 6 month history of weight records. If they're not in the chart, please let us know where they are. We're also going to looking at skin assessments. If they're kept in a separate binder, in a treatment book, please tell surveyors where you keep them.
- Resident council president or active member we can interview with a room number. We can do this while reconciliation is happening
- Within four hours of entrance surveyors need a worksheet listing the PASSR Level II recipients, those on ventilators, dialysis, and hospice end of life services (look for form attached to entrance conference worksheet). PASSR II level II services. The second page is only to be filled out if you have residents receiving dialysis in your facility. Surveyors also do closed record review (admissions sample record review) and they're looking at things that happen within 30 days of admission into the facility, e.g., skin assessments and weight record within 30 days after admission; if they're in the closed record perhaps you may flag where surveyors can find the weights and skin assessments so they don't have to go through all the charts. If they're not in the closed record and are in computer, please have it ready for surveyors.
- Surveyors conduct stage one interviews with floor nurses and ask the same questions for every resident. One question is, "Has the resident fallen or sustained a fracture in last 30 days?" This is the only one that nurses have to go back through records; it really helps us if you keep a running tally of anyone who's fallen or sustained a fracture and when it happened, so that they can refer to a sheet instead of looking through nurses notes and incident reports, etc
- Some providers have prepared a QIS survey binder. You can refer to your entrance worksheet which tells you what we request when we get to the facility. It would be helpful if you would start preparing this info and having it ready for us. We're working hard to expedite the process, make it more efficient, effective, etc. without impacting life in the facility.

Q: How many QIS surveys have you done?

A: We've done 80 in Federal Fiscal Year 2011 (between 10/1/2010 and 9/30/2011).

Q: Is the timeframe shortening for surveys?

A: Our average is still about 6 days; some are done in 3-4 days. It depends on how many areas trigger; how many closed records the computer pulls for surveyors to review, whether the residents are interviewable. There are a lot of factors

d. Summary Sheet for Distribution of S&C Letter 11-30, Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility: Jennifer McCants reviewed a worksheet for the crime reporting, which also went out on the web portal, so many providers may have already opened it. The worksheet was developed in collaboration with the LTC program, occurrence programs, non-long-term care program, hospice, Teresa Bradbury in the Attorney General's office. Covered individuals have to report any reasonable suspicion of a crime for a resident that lives in a LTC; this applies if facilities receive at least \$10,000 in federal funds annually. Crimes have to be reported to at least one law enforcement agency and the state agency. Facilities should develop policies and procedures so you have your own internal processes in place. This is new: *in the event results in serious bodily injury, a report must be made within 2 hours* (used to be 24 hours per occurrence reporting guidelines.) Covered individuals are subject to civil money penalties if they fail to report in accordance with this act. Right now there's not an enforcement agency. Covered individuals must be notified on an annual basis by the facility as far as reporting obligations. The state agency then follows CMS protocol for investigating and reporting incidents, however, there is not a new tag to cite.

Staff would like you to continue to report occurrences to the occurrence reporting system within 24 hours, unless it meets the requirements for serious bodily injury. The occurrence intake phone number is 303-692-2900. Hospices in LTC and ICRMRs also fall under the parameters of the long-term care facility, according to the document. Surveyors will continue to investigate complaints with existing CMS and state policies and procedures. Under abuse regulations tags F223-226, there are already requirements for reporting.

Covered individuals who must report serious bodily injury include owner, operator, employee, manager, agent contractors of your facilities. Law enforcement includes a lot of different agencies, police, sheriff, detectives, public safety officers, corrections, medical examiners, coroners, APS, Medicaid fraud. However, your first contact would be your local police or sheriff.

Serious bodily injury is defined as an injury with extreme pain, substantial risk of death, involving protracted loss or impairment of function of a bodily member organ, mental faculty or requiring medical intervention such as surgery, hospitalization or rehabilitation. Reasonable suspicion of a crime is someone who could articulate the facts that indicate a suspicion based on observation, information from someone else, training, experience. Some examples of serious bodily injury might include fractures of femur, hip, facial, large or deep lacerations, closed or open head injuries, spinal cord injuries, and significant burns, severe abrasions of bruising, pattern of multiple injuries, rape or reasonable suspicion of rape or penetration, suspicious arson resulting in death.

If you have reported what could be a crime as an occurrence, you don't need to also report it to the complaint line. Ms. McCants is working with Teresa Bradbury, who is planning to do some education with the police departments because staff knows that interfacing with police and reporting to them and whether or not they will respond. Know we need to do more education.

e. F 431, Controlled Substances: Alan Miller, RPh, MS, CGP, director of clinical services for Omnicare of Golden, reviewed a short tag F431, which is *labeling, storage and controlled medication*. The facility is in compliance with F431 if:

1. The facility safeguards medications by locking the medications, limiting access, and disposing of medications appropriately;
2. Medications are stored under proper temperature controls and in accordance with manufacturers' specifications;
3. Medication labeling identifies, at a minimum, the medication's name, strength, expiration date when applicable, and lot number, and provides instructions as necessary for safe administration;
4. Schedule II medications are stored in separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and
5. Controlled medications are reconciled accurately

The issue that has come up is related to the refrigerator. However, Mr. Miller knows of no Schedule II medications that are kept in the refrigerator. Two caveats: (1) if you work with hospice and they have a refrigerator E-Kit with Roxinol that says on the outside "refrigerate" then you have a schedule II controlled substance there and it has to be double locked.

There has also been an issue about little lock boxes in the refrigerator that aren't permanently attached. However, (if you look at the regulations), there isn't a need to do this because there aren't going to be any Schedule II controlled substances in there. (2) Except when the facility uses single units. Sometimes you may have a Lorazepam E-Kit. Lorazepam comes in 2 vials, which is called a *unit dose*. As it says in #4, unit dose is excluded because the quantity stored is minimal.

Mr. Miller's recommendation is: if you have a refrigerator and it's in your bedroom – which is locked – it's considered one lock. If you want to put a lock on your refrigerator that's two locks. Even if you have a Lorazepam in the refrigerator, it's covered. Even if you have a third unsecured box in the refrigerator it

shouldn't be a problem because you don't need three locks. Lorazepam is a Schedule IV drug; there's nothing in F431 that says anything about double locking Schedule IV drugs. There's been some confusion about this. (Please see attached presentation.)

II. Next Meeting: The next meeting will be on January 3, 2012.