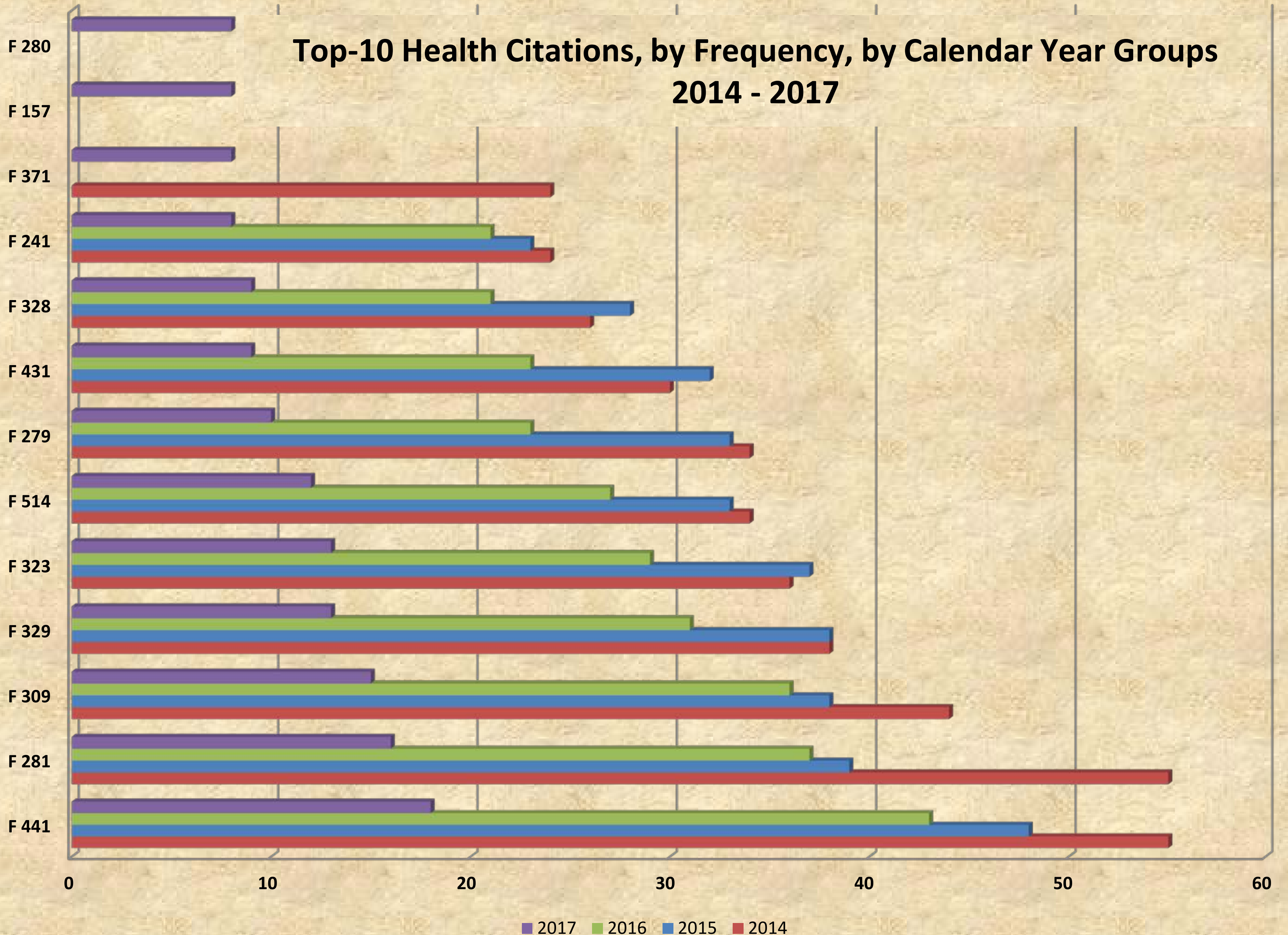
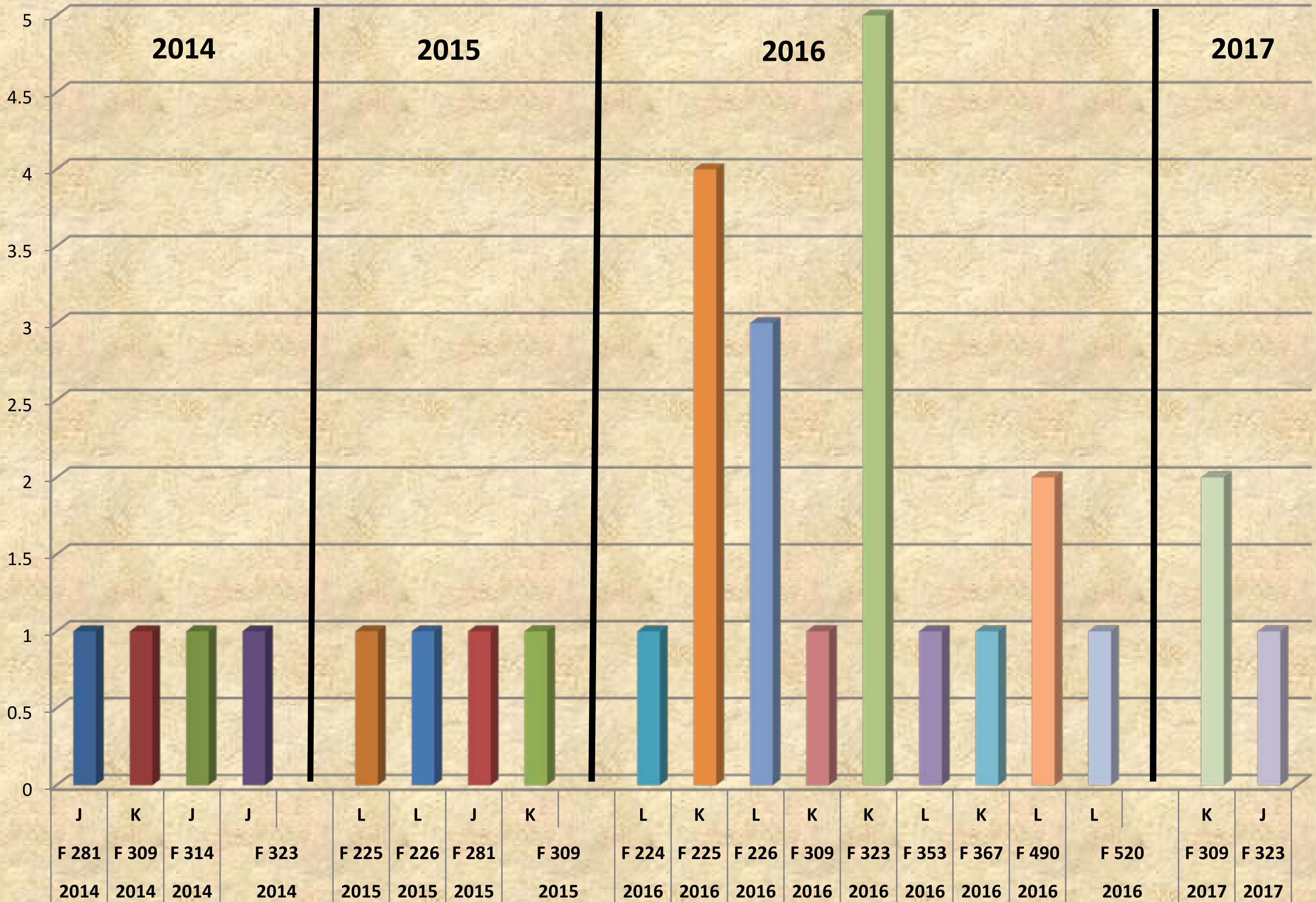
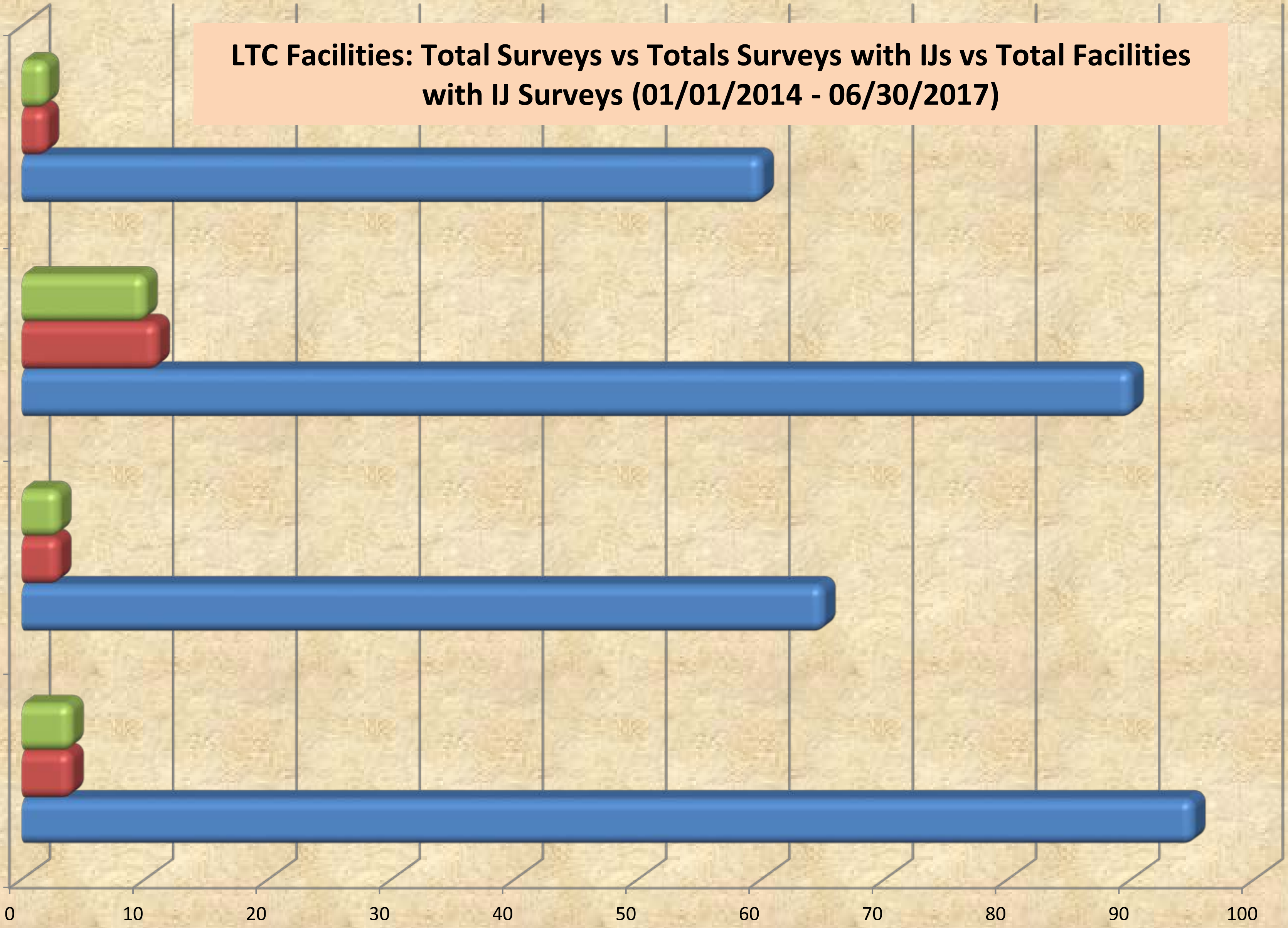
IHCA

BFS 2017


Top-10 Health Citations, by Frequency, by Calendar Year Groups
2014 - 2017
F 280
F 157
F 371
F 241
F 328
F 431
F 279
F 514
F 323
F 329
F 309
F 281
F 441
0
10
20
30
40
50
60
2017
2016
2015
2014



IJ-Tag Frequency, by Tag, by Calendar Years 2014 - 2017
2014
2015
2016
2017
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5
5
J F 281 2014
K F 309 2014
J F 314 2014
J F 323 2014
L F 225 2015
L F 226 2015
J F 281 2015
K F 309 2015
L F 224 2016
K F 225 2016
L F 226 2016
K F 309 2016
K F 323 2016
L F 353 2016
K F 367 2016
L F 490 2016
L F 520 2016
K F 309 2017
J F 323 2017


LTC Facilities: Total Surveys vs Totals Surveys with IJs vs Total Facilities with IJ Surveys (01/01/2014 - 06/30/2017)
2017
2016
2015
2014
0
10
20
30
40
50
60
70
80
90
100
Facilities with IJ Tags
Surveys with IJ
Total Surveys

IDR Data for 1/1/16-6/30/17

19 requests for IDR

(18 different facilities)

Tags requested and frequency of request

157 =1

224 =2

226 =3 (Tied for second)

247 =1

248 =1

250 =3 (Tied for second)

309 =3 (Tied for second)

314 =2

315 =2

318 =1

323 =6 (*Most Frequent)*

325 =1

329 =2

425 =1

490 =1

520 =1

IDR Results

Month & Year	Facilities heard	F-Tag(s)	Outcome	Type of review
06/01/2017	1	314	No Change	Panel
04/01/2017	1	520	Withdrawn	Panel
03/01/2017	1	314	S/S Changed	Desk Review
01/01/2017	2	224	Moved to 281	Desk Review
		226	Moved to 281	Desk Review
		323	No Change	Panel
12/01/2016	2	157	Deleted	Desk Review
		247	Deleted	Desk Review
		250	No Change	Panel
		309	No Change	Panel
11/01/2016	2	323	Panel recommended deleting. CMS upheld citation and S/S	Panel
		248	Deleted	Desk Review
		250	No Change	Panel
10/01/2016	1	315	Moved to 309	Panel
		425	Moved to 309	Panel
09/01/2016	1	309	No Change	Panel
		329	No Change	Panel
08/01/2016	2	325	No Change	Panel
		315	Panel recommended deleting. CMS upheld citation with reduction in S/S	Panel
07/01/2016	2	329	No Change	Panel
		323	No Change	Panel
06/01/2016	1	309	Deleted	Desk Review
		323	Deleted	Desk Review
05/01/2016	1	224	Deleted	Desk Review
		226	S/S Changed	Panel
		353	Example Removed, No Change in S/S	Panel
04/01/2016	1	226	Example Removed, No Change in S/S	Panel
		490	Example Removed, No Change in S/S	Panel
02/01/2016	1	250	Withdrawn	
		318	Withdrawn	
		323	Withdrawn	

IDR Results

Withdrawn (*tags 250, 318, 323, & 520*)	4	12.9%
No Change (tags 250 (x2), 309 (x2), 314, 323 (x2), 325, & 329 (x2)	10	32.3%
Tag Moved (tags 224→281, 226→281, 315→309, & 425→309)	4	12.9%
Example Removed, No Change in S/S (tags 226, 353, & 490)	3	9.7%
Panel recommended deleting. CMS upheld citation and S/S (tag 323)	1	3.2%
Panel recommended deleting. CMS upheld citation with reduction in S/S (tag 315)	1	3.2%
S/S Changed (tags 226 & 314)	2	6.5%
Deleted (tags 157, 224, 247, 248, 309, & 323)	6	19.4%

- No facilities has a survey interval of greater than 15.9 months.
- We are still using contract survey staff.
- 100% of facilities are or have been enrolled in E-POC. The challenge is for facility administrators to maintain their user ID and passwords and to have someone to act on their behalf when they are out of the facility.
- The LTC Providers Reporting Portal is doing ok. Challenge is to keep facility administrators current and for administrators to keep assigned users current.
- Complaints received (intakes) from January 1, 2016 to present: **180**
- Substantiated intakes from January 1, 2016 to present: **69** (*38.3%*)

Fire Safety Top 3 citations & how to avoid them

#1 – Fire/Smoke door assemblies and certain egress doors: Must be inspected annually per NFPA 80, *Standard for Fire Doors and Other Opening Protectives, 2010 edition*, and NFPA 105, *Standard for Smoke Door Assemblies and Other Opening Protectives 2010 Edition*

A. **Painted or missing fire door labels**: The label found on the edge, or top, of a fire door and in the rabbet of a fire-rated frame may be made of metal, paper, or plastic, or may be stamped or die-cast into the door or frame. Labels must be visible and legible.

B. **Poor clearance dimensions around the perimeter of the door in the closed position:** The maximum clearance allowed by NFPA 80 between a fire door and the frame at the head, jambs, and meeting stiles of pairs is 1/8 inch for wood doors, and 3/16 inch for hollow metal doors. The maximum clearance at the bottom of the door is 3/4 inch between the bottom of the door and the top of the flooring or threshold.

For doors that have clearances which are larger than allowed by NFPA 80, there are gasketing products in development which may be allowed by the listing agencies as an alternative to replacing the door. Shimming the hinges with metal shims may help to correct the problem, and there are metal edges available which are listed for use when a door needs to be increased in width to reduce the clearance.

C. **Auxiliary hardware:** Items that interfere with the intended function of the door. These auxiliary items may include creative ways of holding open the door or providing additional security. In many cases, the auxiliary items create an egress problem. Examples include additional locks or surface bolts. Egress doors must unlatch with one operation.

How to Avoid Deficiencies:

The new requirements for the annual inspection of fire and egress doors have drawn attention to the condition of existing doors and the potential failure of these doors to perform in a fire or emergency. Fire and egress doors are required to be properly maintained. Inspecting the doors in your facility and repair or replace the deficient components. Written documentation of fire door inspections must be kept for review by the authority having jurisdiction. Inspections may be conducted by an individual who is knowledgeable about the type of doors being inspected. If you seek additional education and training for fire door inspections, there are several online training programs available, including:

- The Door Hardware Institute's Fire and Egress Door Assembly Inspection Program (FDAI) at www.dhi.org/INDUSTRY/fdai/index.php
- The International Fire Door Inspector Association (IFDIA) at www.ifdia.org/elearning
- I Dig Hardware/I Hate Hardware at www.idigHardware.com

#2 - Above Ceiling Inspections:

Unsealed Penetrations: Gaps and holes from penetrations allow easy access for fire and smoke to spread quickly throughout the building. This will put your building and everyone inside at risk in during a fire emergency.

How to Avoid Deficiencies:

Fire-stopping above the ceiling will help prevent fire and smoke from spreading throughout the building. An above-ceiling permit program would be very helpful as well as holding the contractors or communication companies accountable for the work they perform above the ceiling.

#3 – Alcohol Based Hand-rub Dispensers (ABHRD):

Testing and Documentation:

Facilities are required to test the dispenser every time a new refill is installed and document.

The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. The dispenser shall be tested in accordance with the manufacturer’s care and use instructions each time a new refill is installed.

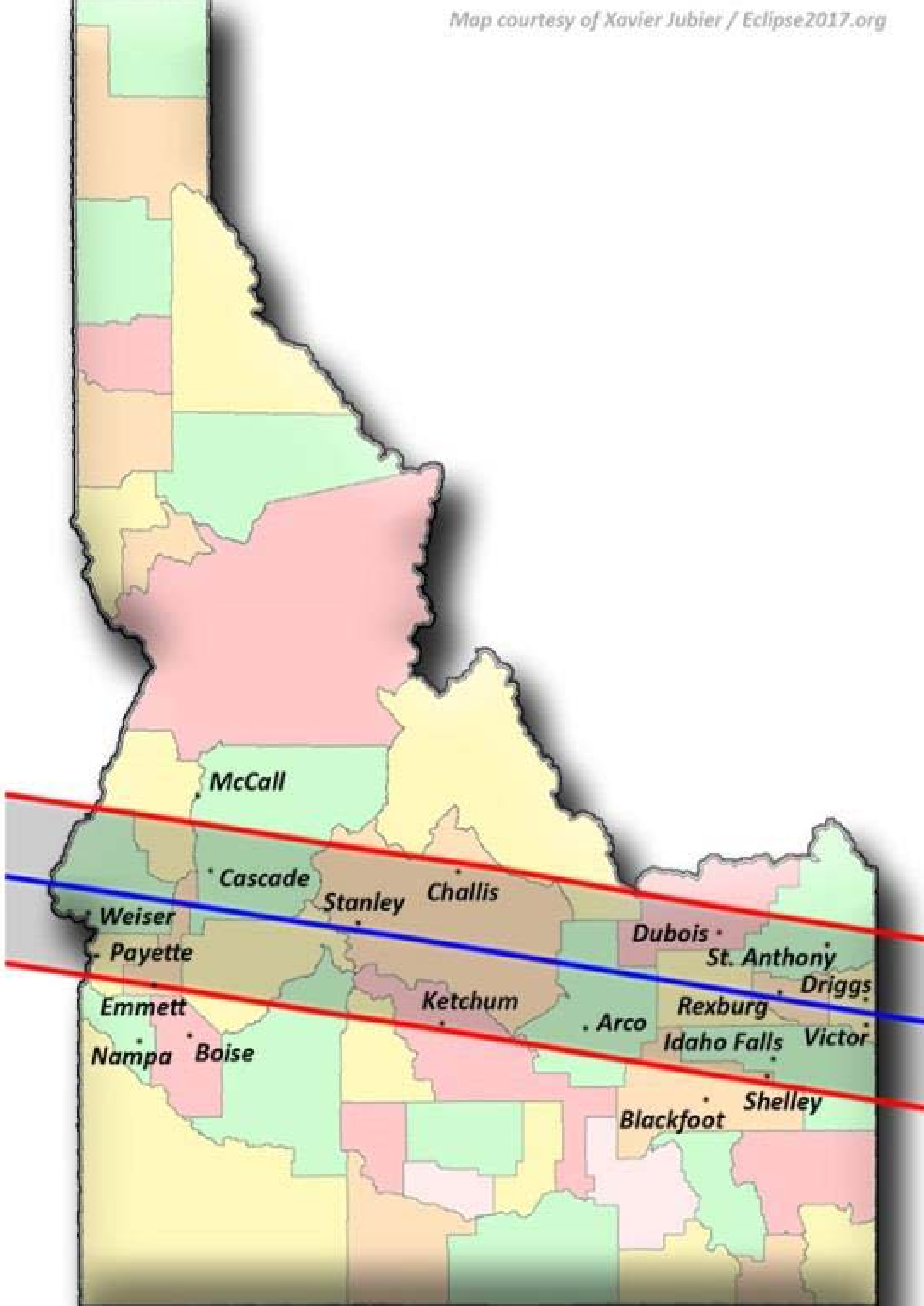
How to Avoid Deficiencies:

A quick inspection of the installed ABHRD should be conducted on a daily basis by all staff. The staff should report any deficiencies they see to whoever is in charge of the maintenance program; this would include leakage, or failure of the dispenser. The person in-charge of the maintenance program should conduct a monthly check for all ABHRD in the facility for faulty equipment and also document this as well as document every time an ABHRD is replaced and a test is provided to ensure proper usage.

Fuel Testing for Generators

NFPA 110 requires a fuel quality test to be performed annually using the approved ASTM standards.

This is new to the code and normally the company that tests the generators conducts this service



Map courtesy of Xavier Jubier / Eclipse2017.org
McCall
Cascade
Stanley
Challis
Weiser
Payette
Dubois
St. Anthony
Driggs
Emmett
Ketchum
Rexburg
Arco
Idaho Falls
Victor
Nampa
Boise
Shelley
Blackfoot

Potential Issue

- Solar Eclipse (August 21, 2017)
  - Washington County already seeking disaster declaration due to crowding, lack of resources, and extremely limited driving conditions
  - Path of totality to cover much of southern Idaho, expecting 500,000 to 1 million visitors over a two to four day period
  - Expect delays in emergency responses, products, normal transportation (up to 12 times longer), and staffing issues

When is your weekly food supply delivered? May want to reschedule.
When are you medications delivered? May want to reschedule.
What about the timing and supply of oxygen and DME.
Are your transportation vehicles filled with gasoline?
Do you have plans if there is a power outage? Will your generator support basic services.
Staffing, travel time, day care…
Consider rescheduling non-urgent MD visits.
Some local businesses may not be operating the 21st, make sure you have what you need.
Are you working with the local emergency preparedness folks?

EMEREGENCY PREPAREDNESS

The final rule addresses the three key essentials that are necessary for maintaining access to healthcare services during emergencies:

- Safeguarding human resources
- Maintaining business
- Continuity and protecting physical resources

Four core elements that is central to an effective and comprehensive framework of emergency:

- Risk assessment and emergency planning:
- Policies and procedures:
- Communication plan:
- Training and testing:

We encourage facilities to engage and collaborate with their local partners and healthcare coalitions in their area for assistance.

Emergency Plan: Based on a risk assessment, using an all- hazards approach, update plan as needed and must be reviewed and approved annually

Policies & Procedures: Based on risk assessment and emergency plan. Must address: subsistence of staff and patients, evacuation, sheltering in place, tracking patients and staff

Communications Plan: Complies with Federal and State laws. Coordinate patient care within facility, across providers, and with state and local public health and emergency management

Training & Exercise Program: Develop training program, including initial training on policies & procedures. Conduct drills and exercises: Full-Scale Exercise annually and additional exercise for some facility types

What is New?

- Annual Hazard Vulnerability Assessment
- Annual Full Scale exercise that is community based
- Additional Exercise- Tabletop
- Tracking on-duty staff during evacuation
- Train volunteers and those under service contracts
- Name & contact information for volunteers
- Share information from your facility emergency plan with residents and their families/representatives
- Integrated Healthcare System

HAZARD VULNERABILITY ASSESSMENT

- Annual facility specific risk assessment
- Incorporates community based risk assessment
- Review and update annually
- Basis for your plan

ANNUAL FULL-SCALE EXERCISE

- Conduct one FULL SCALE EXERCISE annually
- Participate in a community based exercise
- Actual events count but you MUST DOCUMENT
- Conduct an additional exercise of the facilities choice - can be a tabletop exercise
- SNFs- conduct unannounced procedure drills

WHAT IS A FULL SCALE EXERCISE

- Activating plans
- Staff participation to demonstrate knowledge of emergency procedures
- Moving people and equipment

REAL LIFE EVENT CAN BE USED INSTEAD OF EXERCISE

If your facility experiences an actual natural or man-made emergency or disaster that requires activation of the emergency plan

Annual requirement for testing is not measured by calendar year but will be measured from the date of the last actual emergency event or the date the exercise/testing took place

DOCUMENTATION

Exercise or real event must be documented

Remember to include:

- After Action Report /Improvement Plan
- Photos
- Sign-in Sheets
- Forms used during exercise or event
- Updates to your emergency plan following

ADDITIONAL EXERCISE- TABLETOP

- Tabletop exercise includes a group discussion led by a facilitator
- Uses a narrated, clinically relevant emergency scenario
- Participants answer questions based on a scenario and your emergency plan

EMERGENCY POWER/GENERATOR

- Generator must be located in accordance with the location requirements found in Health Care Facilities Code, Life Safety Code and NFPA 110
- Facility must implement emergency power system inspection, testing and maintenance requirements
- Maintain an onsite fuel source to power emergency generators
- Must have a plan for how it will keep emergency power systems functioning during the emergency, unless it evacuates

HOW WILL THE RULE BE ENFORCED?

November 15, 2017- surveying for compliance begins

Facilities found to be out of compliance with the requirements will follow the same enforcement process as with any other CoP/CfC that is found to be out of compliance

These new regulations are a condition or requirement to participate in Medicare

CMS S&C Letters

- Payroll-Based Journal Update—17-25
- SQC Changes and Transfer Discharge Requirements—17-27 NH
- Requirement to Reduce Legionella Risk—17-30, revised 06-09-17
- Appendix Z—Emergency Preparedness final rule and IG and Survey Procedures—17-29
- INFORMATION TO ASSIST PROVIDERS AND SUPPLIERS IN MEETING THE NEW TRAINING AND TESTING REQUIREMENTS OF THE EMERGENCY PREPAREDNESS REQUIREMENTS FOR MEDICARE & MEDICAID PARTICIPATING PROVIDERS AND SUPPLIERS FINAL RULE —17-21 ALL
- Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool—17-37 NH