TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

Office of Inspector General

Updates

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Introduction

- New IG
- New Healthcare Folks
- High Standards
- Staffing Updates

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Legislation & Regulations

- Legislation Implementation
- State Health Plan
- PCH Regulation

3

ALC Updates

- Moving closer to the transition
- Internal interactive software
- Building Code
- KBN Regulation

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KY CMP Grant Fund

The CHFS Office of Inspector General (OIG), is responsible for the oversight and administration of the CMPRP Grant Fund and seeks innovative projects that support, protect and benefit CMS certified nursing facility (CNF) residents.

- A Civil money penalties (CMP) is a monetary penalty CMS may impose against CNFs for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities (CFR 42 §488.430).
- A portion of the CMPs collected are returned to the state and must be reinvested to support projects that benefit CNF residents and that protect or improve their quality of care or quality of life.
- The improvement initiatives must be outside the scope of normal facility operations and cannot be used to fund goods or services that the applicant already offers or is required to provide by state or federal law or regulation.

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KY CMP Grant Fund | Funding Limits

- **Resident or Family Councils -** Maximum $5,000 per CNF (one-time funding)
- **Consumer Information -** Maximum $5,000 per CNF (one-time funding)
- **Training to Improve Quality of Care -** Maximum $5,000 per CNF per year (max of $15,000 for a 3-year project)
  NOTE: The maximum allowable amount for training per year is the total allowed for any and all training during a year. Funding is dependent upon each state's balance of CMP funds available. CMS will also work with states separately on state-sponsored trainings, and these training will not impact each facility's maximum amount (e.g., a facility can attend a state-sponsored training and still apply for $5,000 for training).
- **Activities to Improve Quality of Life -** Maximum $5,000 per CNF per year (max $15,000 for a 3-year project)
  Note: CMS will not fund complex, high-cost technology, such as virtual reality, artificial intelligence, or simulation projects
- **CMS Developed Global Public Health Emergency (PHE) Applications**
  Communicative Technology - Maximum $3,000 per CNF (one-time funding)
  Visitation I - Maximum $3,000 per CNF (one-time funding)
  Visitation II - Maximum $3,000 per CNF (one-time funding)

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KY CMP Grant Fund | Applications

- Kentucky has a rolling deadline – applications can be submitted to the OIG anytime.
- All requests for use of CMP funds must be made electronically, to the OIG, using the most recent CMP application posted on OIG's CMP Website at: https://www.chfs.ky.gov/agencies/os/oig/Pages/cmpfunds.aspx
- A list of currently funded projects can be found at OIG's CMP website

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KY CMP Grant Fund | Contact Information

Lena Mullins-Datko
CMP Coordinator/Grants Administrator
lena.mullinsdatko@ky.gov
502-564-5771

Available for:

CMP Training/Technical Assistance, Application assistance, CMP questions in general

Application forms and additional information can be found at:
https://www.chfs.ky.gov/agencies/os/oig/Pages/cmpfunds.aspx

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KY CMP Grant Fund | Current Projects

Promoting Health Across the Lifespan Among Kentucky Certified Nursing Facility Residents Through Bingocize®, an Evidence-based Health Promotion Program

- University of Kentucky Research Foundation
- Bingocize® is an evidence-based program that mixes exercise, health education, and bingo to help overcome health problems in participants across the entire spectrum of care. The project aims to build capacity across the state through new and/or expanded community-engaged CNF and university partnerships to enhance the opportunity to improve quality of life (QOL) among residents of 30 Kentucky CNFs.

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KY CMP Grant Fund | Current Projects

Stories In Mind

- Frazier History Museum
- Goal: To combat feelings of loneliness and isolation in residents at 9 CNFs by providing meaningful engagement through weekly, recurring cultural fine arts programs using historical artifacts from the Frazier History Museum. The project will provide opportunities to create meaningful connections between residents, family members and staff as well as encourage verbal communication, calmer behavior, and improve resident attitudes and general demeaner.

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Thank You

David Lovely, Acting Inspector General
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Office of Inspector General
Division of Healthcare
2024

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INTRODUCTION

Carrie Storms, RN,

Division of Healthcare (DHC) Director

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INTRODUCTION

Tricia Steward, BSH, QIDP

Staff Assistant

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CMS Press Release 4-22-2024:

Biden-Harris Administration takes historic action to increase access to quality care, and support to Families and Care Workers.

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CMS PRESS RELEASE: 4-22-2024

"Minimum Staffing Standards for Nursing Homes" establishes for the first time, national minimum staffing requirements for nursing homes to improve the care that residents receive and support workers by ensuring that they have sufficient staff.

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Minimum Staffing Standards

Sections 1819 and 1919 of the Social Security Act (the Act) set out regulatory requirements for Medicare and Medicaid long-term care facilities, respectively. Specific statutory language at sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act permits the Secretary of the Department of Health and Human Services (the Secretary) to establish any additional requirements relating to the health, safety, and well-being of residents in skilled nursing facilities (SNF) and nursing facilities (NF), as the Secretary finds necessary.

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Minimum Staffing Standards

This provision and other statutory authorities set out in section 1819 and 1919 of the Act provide CMS with the authority to issue a regulation revising the existing requirements and to mandate a staffing minimum for nursing care.

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Minimum Staffing Standards

Centers for Medicare & Medicaid Services issues final rules to fulfill the President's commitment to Support family caregivers boost compensation & job quality for care workers, expand & improve care options, and improve the safety & quality of care in federally-funded nursing homes.

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Federal Register (final rule)

Medicare and Medicaid Programs: Minimum Staffing Standards for Long-term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Scheduled Publication Date 5-10-2024

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Federal Register

Federal Register online at:

https://govinfo.gov

or

https://federalregister.gov

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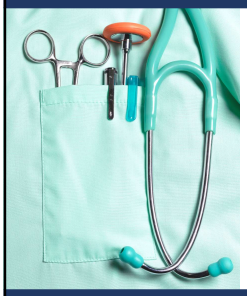
Federal Register



Revising §483.35(b) to require an RN to be onsite 24-hours per day and 7 days per week (24/7 RN)

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Federal Register

Specifying that facilities must provide, at a minimum, 3.48 total nurse staffing hours per resident day (HPRD) of nursing care, with 0.55 RN HPRD and 2.45 NA HPRD.

Revising the existing Facility Assessment requirements at §483.70(e) to a standalone section at §483.71.

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Implementation

CMS fully expect that LTC facilities will be able to meet requirements but recognize that external circumstances may temporarily prevent a facility from achieving compliance despite a facility's demonstrated best efforts.

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Implementation

CMS announced a national campaign to support staffing in nursing homes, CMS will work to develop programs that make it easier for individuals to enter careers in nursing homes, investing over $75 million in financial incentives such as tuition reimbursement.

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Implementation

In addition, the implementation of the requirements in the final rule are phased-in to allow facilities the time needed to prepare and comply with the new requirements.

Specifically, to recruit, retain, and hire nurse staff as needed.

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Implementation

Finally, the rule also finalizes requirements that will allow for hardship exemption in limited circumstances.

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Final Rule: Staggered Implementation

To give LTC facilities time to achieve compliance implementing in 3 phases over 3-year period for **non-rural facilities.**

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Implementation: Non-Rural Facilities

- **Phase 1**
  - Within 90 days of the final rule publication, facilities must meet the facility assessment requirements.
- **Phase 2**
  - Within 2-years of the final rule publication, facilities must meet the 3.48 HPRD total nurse staffing requirements AND the 24/7 RN requirement.
- **Phase 3**
  - Within 3-years of final rule publication, facilities must meet the 0.55 RN AND 2.45 NA HPRD requirements.

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Implementation: Rural Facilities

- **Phase 1**
  - Within 90 days of the final rule publication, facilities must meet the facility assessment requirements.
- **Phase 2**
  - Within 3-years of the final rule publication, facilities must meet the 3.48 HPRD total nurse staffing requirement AND the 24/7 RN requirement.
- **Phase 3**
  - Within 5-years of the final rule publication, facilities must meet the 0.55 RN and 2.45 NA HPRD requirements.

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Permitting Regulatory Flexibility

LTC facilities may qualify for a temporary hardship exemption from the minimum nurse staffing HPRD standards and the 24/7 RN requirement only if they meet following criteria:

- **Geographic staffing unavailability,**
- **financial commitment to staffing, and**
- **good faith efforts to hire.**

For example: The facility is located in an area where the supply of RN, NA, or total nurse staff is not sufficient to meet area needs.

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Temporary Hardship Exemption

- If the combined licensed nurse & NA to population ratio in its area is a minimum of 20% below the national average.
- If the RN to population ratio in its area is a minimum of 20% below national average, exemption from the 0.55 RN HPRD and from RN onsite 24-hours per day for seven days a week.
- The facility may receive an exemption from the 2.45 NA HPRD requirement if the NA to population ration in its area is a minimum of 20% below the national average.

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Temporary Hardship Exemption

Eligible LTC facilities that meet the criteria will receive a temporary hardship exemption by completing the following:

- Provide documentation of good faith efforts to hire and retain staff.
- Provide documentation of a financial commitment to staffing, including the amount the facility expends on nurse staffing relative to revenue.

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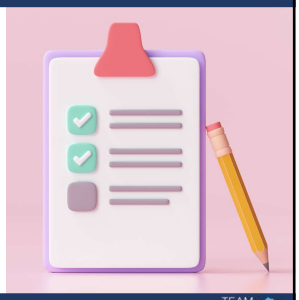
Temporary Hardship Exemption

Prior to being considered for exemption, the LTC facility must be surveyed for compliance with the LTC participation requirements.



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Office of Inspector General
Division of Healthcare

Top 10 Cited Health Deficiencies

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Top 10 Cited Health Deficiencies

F884 Reporting National Health Safety Network

- Cited 341 times

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Top 10 Cited Health Deficiencies

F656 Develop/Implement Comprehensive Care Plan

- Cited 61 times

F689 Free of Accident Hazards/Supervision/Devices

- Cited 57 times

F600 Free from Abuse/Neglect

- Cited 42 times

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Top 10 Cited Health Deficiencies

F880 Infection Prevention & Control

- Cited 31 times

F761 Label/Store Drugs and Biologicals

- Cited 23 times

F812 Food Procurement, Store, Prepare, Serve-Sanitary

- Cited 19 times

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Top 10 Cited Health Deficiencies

F657 Care Plan Timing & Revision

- Cited 18 times

F550 Resident Rights/Exercise of Rights

- Cited 13 times

F684 Quality of Care

- Cited 10 times

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Top 10 Life Safety Code Deficiencies

K372	Subdivision of Building Spaces – Smoke Barrier	31
K321	Hazardous Areas – Enclosure	29
K920	Electrical Equipment – Power Cords and Extension	26

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Top 10 Life Safety Code Deficiencies

K918	Electrical Systems – Essential Electric Systems	23
K353	Sprinkler System – Maintenance and Testing	19
K363	Corridor – Doors	19

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Top 10 Life Safety Code Deficiencies

K914	Electrical Systems – Maintenance and Testing	13
K351	Sprinkler System – Installation	13
K374	Subdivision of Building Spaces – Smoke Barrier	12
K712	Fire Drills	11

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Office of Inspector General - Division of Healthcare

State Operations Manual (SOM)

Chapter 5 – Complaint Procedures

(Revised 2-10-2023)

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SOM Chapter 5 | Complaint Procedures

5010 – General Intake Process (Implementation 10-24-22)

A complaint is an allegation of noncompliance with Federal and/or State requirements.

An allegation is an assertion of noncompliance with Federal health and safety regulations.

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SOM Chapter 5 | Complaint Procedures

5060 – ASPEN Complaints/Incidents Tracking System (ACTS)
(Implementation 10-24-22)

The SA collects information related to complaints and facility-reported incidents (FRIs) AND uses a system to track and monitor the receipt and disposition of complaint and incident intakes.

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SOM Chapter 5 | Complaint Procedures

5060.1 – Data Entry (Implementation 10-24-22)

The SAs and ROs are required to enter into ACTS:

- All complaints gathered as part of Federal survey and Certification responsibilities, regardless if an onsite survey is conducted.
- For nursing homes, all self-reported incidents that are reported under Federal law and the requirements for participation [i.e., reporting to law enforcement of crimes - §1150B of the Social Security Act and §483.12(b)(5); alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property].

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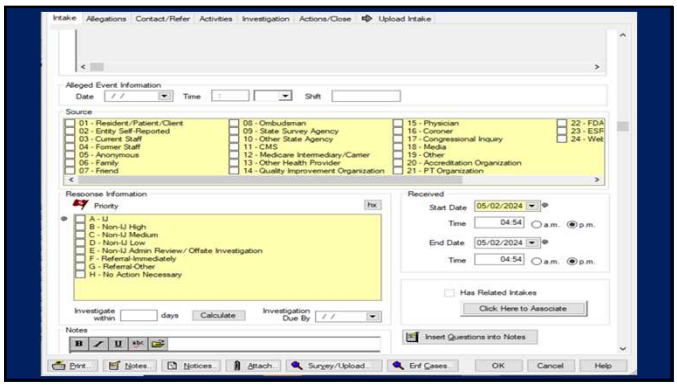

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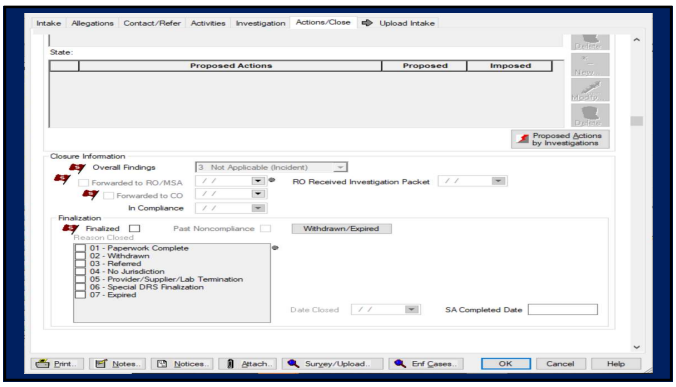

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SOM Chapter 5 | Complaint Procedures

5310.2 – Review and Triage of Allegations (Issued 2-10-23)

The state reviews all allegations of resident neglect and abuse and misappropriation of resident property regardless of the source.

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SOM Chapter 5 | Complaint Procedures

5310.2A – Immediate Jeopardy Priority (Issued 2-10-23)

In cases where the initial report indicates the following, the SA must initiate an onsite survey within 3-business days of receipt of the initial report:

1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident and
2) The facility has NOT implemented adequate protection for all residents or the SA has not received sufficient evidence to conclude that residents are adequately protected.

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SOM Chapter 5 | Complaint Procedures

5310.2A – Immediate Jeopardy Priority (Cont.)

In cases where the initial report indicates the following, the SA must initiate an onsite survey within 7-business days of receipt of the initial report:

1) The alleged noncompliance may have caused, or may likely cause, serious injury, harm, impairment, or death to a resident and
2) The facility has potentially implemented adequate protection to all residents.

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SOM Chapter 5 | Complaint Procedures

(Review/Triage of Allegations, Cont **.)**

Information provided by the facility may assist the SA in determining whether there are potentially adequate protections provided to the resident. Some examples include:

- Monitoring of the alleged victim and other identified residents who are at risk.
- Evaluation of whether the alleged victim feels safe.
- Providing social services to the resident, as needed.
- Immediate assessment of the alleged victim and provision of medical treatment, as necessary.
- Provision of goods and/or services that are necessary to avoid serious injury, harm, impairment, or death to a resident.
- Immediate notification of the alleged victim's physician and the resident representative, when there is injury or a change in condition or status.

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SOM Chapter 5 | Complaint Procedures

(Review/Triage of Allegations, Cont **.)**

- If the alleged perpetrator is staff – removal of access to the alleged victim and other residents.
- If the alleged perpetrator is a resident or visitor – Removal of access by the alleged perpetrator to the alleged victim and other residents.
- Notification of the alleged violation to other agencies or law enforcement authorities, within specified timeframes.
- Whether administrative staff, including the Administrator, were informed and involved, as necessary in the investigation.

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SOM Chapter 5 | Complaint Procedures

(Review/Triage of Allegations, Cont **.)**

Examples that may indicate that a resident(s) may not be protected in the facility:

- The alleged perpetrator continues to have access to the alleged victim.
- Retaliation occurs against a resident who reports an alleged violation.
- A resident who repeatedly fondles other residents is moved to another unit, where he/she continues to exhibit the same behaviors.
- A resident with a history of striking a resident is left unsupervised with a resident who has been targeted in the past.

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SOM Chapter 5 | Complaint Procedures

5075.2 – Non-Immediate Jeopardy – High Priority

(Implementation 10-24-22)

The alleged noncompliance with one or more requirements may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well-being that a rapid response by the SA is indicated.

- The SA must initiate an onsite survey within an average of 15 business days of receipt of the initial report, not to exceed 18 business days.

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SOM Chapter 5 | Complaint Procedures

5075.3 – Non-Immediate Jeopardy – Medium Priority

(Implementation 10-24-22)

The alleged noncompliance caused no actual physical and/or psychosocial harm but there is the potential for more than minimal harm to the resident(s).

FRIs are assigned a "medium" priority if the alleged noncompliance with one or more requirements caused no actual physical and/or psychosocial harm but there is the potential for more than minimal harm to the resident(s) **AND** the facility has not provided an adequate response to the allegation or it is not known whether the facility provided an adequate response.

- The SA must initiate an onsite survey within 45 calendar days of receipt of the initial report.

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SOM Chapter 5 | Complaint Procedures

5075.4 – Non-Immediate Jeopardy – Low Priority

(Implementation 10-24-22)

The alleged noncompliance with one or more requirements may have caused no actual harm with a potential for minimum harm.

In addition, FRI's are assigned a "low" priority if the alleged noncompliance with one or more requirements may have caused no actual physical and/or psychosocial harm but there is the potential for more than minimal harm to the resident(s) **AND** the facility has provided a potentially adequate response to the allegation.

The SA reviews these intakes for tracking of possible trends in order to determine if there are common themes that suggest areas for focused attention when the next on-site survey occurs. If the SA identifies a trend that suggests concerns, the SA either investigates the concerns during the next standard or complaint survey **or** initiates a complaint survey.

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SOM Chapter 5 | Complaint Procedures

5075.5 – Administrative Review/Offsite Investigation

(Implementation 9-19-14)

Intakes are assigned this priority if an onsite investigation is not necessary. However, the SA conducts and documents in the provider file an offsite administrative review to determine if further action is necessary.

Where an administrative review/offsite investigation is conducted by the SA, the SA may confirm the findings at the next onsite survey.

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SOM Chapter 5 | Complaint Procedures

IMPROVING SURVEY OUTCOMES FOR RESIDENT-TO-RESIDENT ALTERCATIONS

When reporting FRI's be sure to provide evidence to support the facility was:

- Providing Care Planned services before the incident occurred.
- Acted immediately to protect any resident(s) involved.
- Assessed for physical and psychosocial well-being, as appropriate.
- Implemented already in place interventions and/or considered revising interventions.
- Determined no staff culpability. (e.g., Staff on unit ignored preceptors to potential incident; Staff assigned not implementing Care Planned interventions?).
- Monitored to ensure no further incidents occurred.
- Demonstrate evidence the facility is tracking incidents for patterns that involve one resident in more than one incident. How is this addressed?

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SOM Chapter 5 | Complaint Procedures

HOW CAN A FACILITY HANDLE CONCERNS RAISED BY RESIDENTS, FAMILIES, AND/OR STAFF?

- Strong Grievance Process – take all reports serious and convey that to the individual. Make them feel heard.
- Develop a working relationship with the Ombudsman. Involve Ombudsman in your grievance procedures.
- Actively involve Social Services to work with families.
- Be visible and available! Administrative staff (including DON and ADON) should be on the units to visit. Not just walk through the hallways.
- ANY OTHER SUGGESTIONS?

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