



Legionella Infection: What is it and How can we prevent the spread? *By Kelli Ruff, Surveyor, Health Facilities*

The Center for Medicare & Medicaid Services (CMS) sent out S&C 17-30 revised June 09, 2017 to all hospitals, critical access hospitals and nursing homes regarding a new requirement to reduce the Legionella risk in healthcare facility water systems to prevent cases and outbreaks of Legionnaires' disease.

Legionella is a type of bacterium found naturally in freshwater environments, like lakes and streams. It can become a health concern when it grows and spreads in human-made water systems like:

- Hot and cold-water storage tanks;
- Water heaters;
- Pipes, valves and fittings;
- Expansion tanks;
- Water filters;
- Aerators;
- Faucet flow restrictors;
- Centrally-installed misters, atomizers, air washer and humidifiers;
- Non-steam aerosol-generating humidifiers;
- Eye wash stations;
- Ice machines;
- Showers and faucets;
- Cooling Towers (air-conditioning units for large buildings);
- Hot tubs that aren't drained after each use;
- Decorative Fountains and water features;
- Medical devices (such as CPAP machines, hydrotherapy equipment, Bronchoscopes, heater-cooler units).

How It Spreads

After *Legionella* grows and multiplies in a building water system, that contaminated water then must spread in droplets small enough for people to breath in. Less commonly, people can get Legionnaires' disease by aspiration of drinking water. This happens when water "goes down the wrong pipe," into the trachea (windpipe) and lungs instead of the digestive tract. In general, people do not spread Legionnaires' disease and Pontiac fever to other people. However, this may be possible in rare cases.

People at Increased Risk

Most health people exposed to *Legionella* do not get sick. People at increase risk of getting sick are:

- People 50 years or older;
- Current or former smokers;
- People with a chronic lung disease (like chronic obstructive pulmonary disease or emphysema);
- People with weak immune systems or who take drugs that weaken the immune system (like after a transplant operation or chemotherapy);
- People with cancer;

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- People with underlying illnesses such as diabetes, kidney failure, or liver failure.

People who get sick after being exposed to *Legionella* can develop two different illnesses: Legionnaires' disease and Pontiac fever.

Legionnaires' Disease

Legionnaires' disease symptoms are similar to other types of pneumonia and often looks the same on a chest x-ray.

- Cough
- Shortness of breath
- Fever
- Muscle aches
- Headaches



Legionnaires' disease can also be associated with other symptoms such as diarrhea, nausea, and confusion. Symptoms usually begin two to ten days after being exposed to the bacteria, but it can take longer so people should watch for symptoms for about two weeks after exposure.

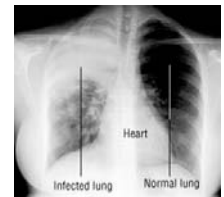
People with Legionnaires' disease have pneumonia (lung infection), which can be confirmed by chest x-ray. Clinicians typically use two preferred types of tests to see if a patient's pneumonia is caused by *Legionella*:

- Urine test;
- Laboratory test that involves taking a sample of sputum (phlegm) or washing from the lung.

Diagnosis

Possible complications of Legionnaires' disease include:

- Lung failure;
- Death.



About one out of every ten people who get sick with Legionnaires' disease will die due to complications from their illness. For those who get Legionnaires' disease during a stay in a healthcare facility, about one in four will die.

Treatment and Complications

Legionnaires' disease requires treatment with antibiotics (medicines that kill bacteria in the body), and most cases of this illness can be treated successfully. Healthy people usually get better after being sick with Legionnaires' disease, but they often need care in the hospital.

Pontiac Fever

Pontiac Fever symptoms are primarily fever and muscle aches; it is a milder infection than Legionnaires' disease. Symptoms begin between a few hours to three days after being exposed to the bacteria and usually last less than a week. Pontiac fever is different from Legionnaires' disease because someone with Pontiac fever does not have pneumonia.

Treatment and Complications

Pontiac fever goes away without specific treatment.

Prevention

New regulations for skilled nursing facilities require the facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of *Legionella* and other opportunistic pathogens in building water systems.

Surveyors will review policies, procedures, and reports documenting water management implementation results to verify that facilities:

- Conduct a facility risk assessment to identify where *Legionella* and other opportunistic waterborne pathogens could grown and spread within the facility water system.

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- Implement a water management program that consider the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.
- Specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.

There are no vaccines that can prevent legionellosis.

Disease Patterns

Illness caused by *Legionella* continues to be detected, now more than ever. About 6,000 cases of Legionnaires' disease were reported in the United States in 2015. However, because Legionnaires' disease is likely underdiagnosed, this number may underestimate the true incidence. More illness is usually found in the summer and early fall, but it can happen any time of year. Legionellosis outbreaks occur when two or more people are exposed to *Legionella* and get sick in the same place at about the same time.

Incubation Period Considerations

The incubation period is most commonly two to ten days with an average of five to six days, but has been reported to be up to 19 days in rare cases. For **routine** surveillance purposes, exposure histories are collected for the two to ten days prior to onset. However, in outbreak settings where it is important to consider a wide range of possible sources, use of a 14-day incubation period is often desirable.

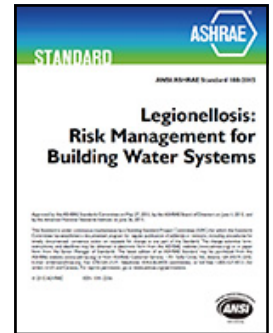
Method of Surveillance

All **confirmed** cases (travel-associated and non travel-associated) should be reported to your local or state health department within seven days. A case report form from CDC should also be completed and sent to your local and state health department.

Assistance/Guidance

Guidelines for reducing the risk of *Legionella* growth and spread are available for those who maintain and manage building water systems, including systems for potable (water for drinking and showering), non-potable, and recreational water from ASHRAE®.

- [ASHRAE Standard 188: Legionellosis: Risk management for building water systems \(ANSI approved\)](https://www.cdc.gov/Other/disclaimer.html) <https://www.cdc.gov/Other/disclaimer.html>
- [ASHRAE Guideline 12-2000: Minimizing the risk of legionellosis associated with building water systems](https://www.cdc.gov/Other/disclaimer.html) <https://www.cdc.gov/Other/disclaimer.html>



CDC developed a toolkit to help building owners and managers better understand ASHRAE Standard 188 and how to develop a water management program to reduce the risk of *Legionella* growing and spreading in their building(s). The first step is determining if your building or certain devices in your building need a water management program.

Most Commonly Cited Deficiencies in Nursing Homes

Following is a breakdown of the most common deficiencies cited in nursing homes from December 4, 2017 to May 29, 2018.

F657 — Care Plan Timing and Revision
F658 — Services Provided Meet Professional Standards
F689 — Free of Accident Hazards/Supervision/Devices
F880 — Infection Prevention & Control
F641 — Accuracy of Assessments

F812 — Food Procurement, Store/Prepare/Serve-Sanitary
F550 — Resident Rights/Exercise of Rights
F684 — Quality of Care
F686 — Treatment/Services to Prevent/Heal Pressure Ulcer
F761 — Label/Store Drugs and Biologicals

Summer 2018

IMPORTANT NOTICE—PLEASE READ CAREFULLY

Changing Bed Capacity in Medicare/Medicaid Certified Skilled Nursing Facilities (SNF) and Hospital Distinct Part SNF's

By Bruce Pritchet, Director, Health Facilities

The process of changing the bed capacity in healthcare facilities in North Dakota has, over the years, been viewed by the providers as something that can and will be accomplished according to their timeframes and specific needs. On many occasions, notifications of bed changes are sent to the Division of Health Facilities after the effective date of the change has passed. In fact, the bed capacity change process is enforced by the Centers for Medicare and Medicaid Services (CMS) for certified facilities and by the State Survey Agency for the licensed facilities in the state.

In an effort to provide better directions and adhere more closely to the certification regulations and licensing rules, we are again providing guidelines that apply to bed capacity changes in skilled nursing facilities and distinct SNF's in hospitals. The licensing rules for skilled nursing facilities require a 30 day notice in writing for any change in bed capacity. Since all skilled nursing facilities in North Dakota are fully certified in the Medicare/Medicaid program, we are also obligated to follow the more stringent 45 day notice requirement for CMS certified skilled nursing facilities (SNFs/NFs). The CMS state operations manual at 3202B contains the following instructions for change bed capacity in a certified facility.

An institution or institutional complex (nursing facility) seeking a change in the number of Medicare and/or Medicaid certified beds must:

1. Submit a written request to the State Survey Agency (SSA) for the change **45 calendar days before:**
 - The first day of its cost reporting year to effect a change on the first day of its cost reporting year; or
 - The first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.
2. Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the SSA to determine that the proposed change is in conformance with the rules for full participation or distinct part certification, whichever applies.

An institution or institutional complex may only change the bed size of its SNF/NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year in order to affect one of the following combinations:

- An increase in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost report year; **or**
- An increase in its bed size on the first day of the beginning of its cost reporting year and a decrease in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year; **or**
- A decrease in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost report year.

At no time can the Regional office or the SSA approve two decreases in the bed size of an institution within the same cost-reporting year. The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it undergoes a change of ownership (CHOW) or because it has been approved to change its cost report year.

A request for a change in the number of certified beds cannot be approved on a retroactive basis. All changes are made on a prospective basis only accordance with the effective date indicated above. The institution requesting a change in bed size must submit a written request to the SSA in conformance with the guidelines listed above. An institution or institutional complex cannot self designate the effective date of a change in bed size.

The CMS requirements, as well as the licensing requirements, are in effect at this time. Beginning January 1, 2008, it was the expectation of the State Survey Agency that facilities adhere to these timelines when requesting a change in bed capacity. If you have questions related to this notification, please contact our office at 701.328.2352.

CHAPTER 23-16

Licensing Medical Hospitals

By Bruce Pritchet, Director, Health Facilities

23-16-01.1. Moratorium on expansion of long-term care bed capacity.

1. Notwithstanding sections 23-16-06 and 23-16-10, except when a facility reverts basic care beds to nursing facility beds or relicenses nursing facility beds delicensed after July 31, 2011, nursing facility beds may not be added to the state's licensed bed capacity during the period between August 1, 2017 and July 31, 2019. A nursing facility may not delicense nursing facility bed capacity, relicense nursing facility bed capacity, convert licensed nursing bed capacity to basic care bed capacity, revert licensed basic care bed capacity back to nursing facility bed capacity, or otherwise reconfigure licensed nursing facility bed capacity more than one time in a twelve-month period.
2. Transfer of licensed nursing facility bed capacity from a nursing facility to another entity is permitted. The nursing facility may transfer the bed capacity either as nursing facility bed capacity or basic care bed capacity. Transferred bed capacity must become licensed by an entity within forty-eight months of transfer. Bed capacity transferred as basic care bed capacity may not be reverted to nursing facility bed capacity at any time. A receiving entity may transfer the received bed capacity to another entity with the forty-eight month period originally established at the time the nursing facility first transferred the licensed nursing facility bed capacity. The subsequent receiving entity must license the received bed capacity with the forty-eight month period originally established at the time of the first transfer.
3. A nursing facility may convert licensed nursing facility bed capacity to basic care. If the converted beds remain in the same facility and are not transferred, the beds may revert to nursing facility status after one year of licensure as basic care beds.
4. Nursing facility beds that are converted to basic care may be transferred as basic care beds. However, upon the transfer, the basic care beds may not be relicensed as nursing facility beds.
5. If an Indian tribe acquires nursing facility beds, the tribal facility must meet state licensing requirements for those beds within forty-eight months of acquisition. A tribal facility may seek to participate in the medical assistance programs. Medical assistance payments may only be made to a Medicaid certified tribal facility that agrees to participate and adhere to all federal and state requirements of the medical assistance program, including participation, screening, rate setting, and licensing requirements.
6. A nursing facility, upon prior written notice to the state department of health, may delicense a maximum of twenty-five percent of its licensed nursing facility bed capacity and have the delicensed nursing facility held for a period of twenty-four months. The total delicensed nursing facility bed capacity that may be held for a nursing facility at no time may be greater than fifty percent of the number of currently licensed beds in the nursing facility. Delicensed nursing facility bed capacity in excess of fifty percent of the nursing facility's licensed capacity may not be held and is not eligible for the provisions of subsection 7. Delicensed bed capacity not sold or relicensed at the conclusion of the twenty-four month holding period ceases to exist.
7. During the twenty-four month holding period established at the time of delicensure, delicensed nursing facility bed capacity that is being held for the nursing facility may be:
 - a. Relicensed by the nursing facility. Relicensing of nursing facility bed capacity may not occur for twelve months from the time of delicensure.
 - b. Transferred to another entity as nursing facility bed capacity or basic care bed capacity. The receiving entity must license the transferred bed capacity as the type of bed capacity transferred within the forty-eight month period originally established at the time of delicensure. Bed capacity transferred as basic care bed capacity may not be reverted to nursing facility bed capacity at any time. A receiving entity may transfer the received bed capacity to another entity within the forty-eight month period originally established at the time of delicensure. The subsequent receiving entity must license the received bed capacity within the forty-eight month period originally established at the time of delicensure.
 - c. Licensed as basic care beds by the same facility. If the licensed basic care beds remain in the same facility and are not transferred, the beds may be reverted to licensed nursing facility bed capacity after twelve months.

Certified Nurse Aide Competency Evaluation Program Clarification Memo

By *Bruce Pritschet, Director, Health Facilities*



To: North Dakota State Approved Certified Nurse Aide (CNA) Test Vendors;
North Dakota State Approved CNA Training Programs; and
North Dakota State Approved CNA Competency Evaluation Programs

From: Bruce Pritschet, Director, Division of Health Facilities

Date: August 13, 2013

Subject: **Certified Nurse Aide Competency Evaluation Program Clarification**

This memo replaces a memo that was sent out from the department dated May 20, 2013. The purpose of this memo is to further clarify the nurse aide competency evaluation program (NACEP) or testing process to obtain North Dakota department's registry status as a certified nurse aide (CNA), and is based on our research and communications with the Centers for Medicare and Medicaid Services.

The process described in the May 20, 2013 memo was meant to provide a more detailed explanation of what should have been occurring in the state in regard to completion of the NACEP or testing process consistent with state and federal requirements, and to respond to concerns which had been identified. Over the years the testing process had evolved in such a manner that, in some instances, potential CNAs were attempting to have more than three opportunities to successfully complete the NACEP or to complete the NACEP by taking portions of the NACEP from different test vendors which is not consistent with the requirements. Examples of concerns specifically identified included:

- Some individuals would take the NACEP (written or oral and skills demonstration portion) and if they failed a portion of the NACEP they would take the failed portion of the NACEP from a different test vendor. Taking a portion of the NACEP from two different test vendors is not allowable as the individual would be completing a portion of two competency evaluation programs rather than successfully completing one competency evaluation program. The end result would be that neither program being able to report that the individual had successfully completed both portions of their competency evaluation program.
- Some individuals would fail a portion of the NACEP then retake it once or twice and then switch test vendors and retake an additional two times from the second test vendor before passing successfully. Since the testing can be taken only three times without retraining, this is not allowable.
- While reviewing nurse aide registry records we determined some individuals would take and pass only one portion of the NACEP and then not attempt a re-take on the failed portion of the NACEP until a year or more later. After waiting that long between re-takes, successful completion of the NACEP is significantly flawed and does not adequately determine the competency of the individual to become a CNA. Also, this is inconsistent with the six month timeframe allowed an individual with a lapsed registration to renew.

When these issues were identified, much research was completed related to the federal and state regulations. The department could only find regulations which addressed completion of the NACEP in its entirety. On May 20, 2013, the memo went out from the department to all facilities and testing vendors to clarify the NACEP process that would prevent the above circumstances from occurring.

Since May we have been made aware the changes may have caused hardship, both financially and in hiring potential CNA staff, and also that bordering states were not applying the NACEP or testing process in the same manner. The department then reached out to the Centers for Medicare and Medicaid Services (CMS) to seek their guidance on the correct interpretation of the federal requirements regarding retesting and received their response the end of July 2013. CMS indicated that after extensive research, the federal laws and regulations are silent regarding the NACEP retesting process and advised the department that this gives states some flexibility. Based on this information, the following revised direction is being provided from the department to address the situations listed above and the facilities' need for competent CNA staffing at a reasonable cost, while providing some flexibility with the NACEP retesting process.

The federal regulations indicate an individual may be hired and enrolled in an approved nurse aide training and competency evaluation program (NACEP) and be eligible to have direct contact with residents for up to four months in a skilled nursing home as long as: 1) the individual does not perform tasks for which competence has not been determined unless under the direct supervision of a licensed nurse; and 2) the individual who is trained and determined proficient to provide specific services by the instructor but has not completed the NACEP, may provide the specific services to residents under the general supervision of a licensed nurse.

- By the end of four months, to continue to have direct contact with and provide cares to residents, the individual would be

(Continued on page 7)

required to have successfully completed the NATCEP and have active status on the department's registry as a CNA.

- If an individual completed the nurse aide training program early within the four month period, however, failed to successfully complete all or a portion of the NACEP, the individual would have the ability to retake the portion(s) of the NACEP [either the written or oral and/or the skills demonstration portion(s)] the individual failed again for two more times before the end of the four month period, while continuing to provide care that required direct contact to a resident while under the supervision of a licensed nurse as discussed above.
- If the individual had not passed all or a portion of the NACEP by the end of the four month period since their hire date or their enrollment date (whichever is earlier), they would be required to stop providing direct resident care in the facility. If the individual had not already completed three attempts to successfully complete the NACEP by the end of the 4 month period, the individual would then have an additional two months to complete any of the remaining three testing opportunities allowed prior to being required to retrain.
- At the end of six months from the date of hire or date of enrollment into a NATCEP or completion of the three opportunities to test without the individual successfully completing both portions of the NACEP, the individual would be required to be retrained. After retraining the individual would be required to re-take the complete NACEP.
- The individual can have only three opportunities for successful completion of the NACEP without re-enrolling in an approved nurse aide training program and completing the training program prior to taking both the written or oral and skills demonstration portion of the NACEP again. After the individual has successfully completed an approved nurse aide training program, the individual has up to three opportunities to successfully complete the NACEP to obtain registry status.

A couple examples of the three opportunities to test prior to retraining being required are as follows:

Example 1:

- An individual is hired by a skilled nursing facility and entered into a NATCEP on April 1, 2013.
- The individual completed the training portion by May 1, 2013 and is scheduled to take the entire competency evaluation program (written or oral and skills demonstration portions) on May 7, 2013.
- The individual successfully completes the written or oral portion, however failed to successfully complete the skills demonstration portion.
- The individual can continue to provide cares under the supervision of a licensed nurse while planning to reschedule and retake the skills demonstration portion of the test on June 1, 2013.
- The individual again fails to successfully complete the skills demonstration portion of the competency evaluation and is rescheduled to retake this portion of the competency evaluation on August 20, 2013.
- All nurse aide competency evaluations have been administered by the same test vendor.
- The individual fails to successfully complete the skills demonstration portion of the competency evaluation on this third attempt. The individual would no longer be able to provide direct services to residents at this facility or any facility after September 1, 2013, and the individual would need to successfully complete a nurse aide training program again prior to being allowed additional attempts at completing the nurse aide competency evaluation program. Another test vendor can be used at this point if desired.

Example 2:

- An individual is hired by a skilled nursing facility and entered into a NATCEP on April 1, 2013.
- The individual completed the training portion by June 1, 2013 and is scheduled to take the entire competency evaluation program (written or oral and skills demonstration portions) on June 7, 2013.
- The individual fails both the written or oral and skills demonstration portions of the nurse aide competency evaluation program.
- The individual is rescheduled to take both portions of the nurse aide competency evaluation again on July 10, 2013.
- The individual successfully completes the skills demonstration portion of the nurse aid competency evaluation program, however does not successfully complete the written or oral portion.
- The individual is rescheduled to take the written portion of the competency evaluation on September 9, 2013.
- The individual can no longer provide direct services to a resident under the supervision of a licensed nurse after September 1, 2013.
- The individual successfully completes the skills demonstration portion of the competency evaluation during the September 9, 2013 retest and obtains registry status on September 15, 2013.
- The individual is eligible to provide direct services to residents under the supervision of a licensed nurse once active registry status has been obtained on September 15, 2013.
- All competency evaluations in this example have been administered by the same test vendor.

We hope you find this information beneficial and that it clarifies the expectations related to the completion of the nurse aide competency evaluation program to obtain registry status as a CNA. If you have questions related to this memo you may contact Bruce Pritschet by phone, 701-328-2352, or email, bpritsch@nd.gov.

Guidelines for Design and Construction of Residential Health, Care, and Support Facilities — Hot Water Use

By Lucille Rostad, Manager, Health Facilities

TABLE 2.5-1

Hot Water Use - Residential Health, Care, and Support Facilities

¹Quantities indicated for design demand of hot water are

	Resident Care Areas	Food Service Facilities	Laundry Facilities
Liters per hour per bed ¹	11.9	7.2	7.6
Gallons per hour per bed ¹	3	2	2
Temperature (°C)	21-<43 ²	60 ³	60 ⁴
Temperature (°F)	70-<120 ²	140 (min.) ³	140 (min.) ⁴

for general reference minimums and shall not substitute for accepted engineering design procedures using actual number and types of fixtures to be installed. Design will also be affected by temperatures of cold water used for mixing, length of run and insulation relative to heat loss, etc. As an example, total quantity of hot water needed will be less when temperature available at the outlet is very nearly that of the source tank and the cold water used for tempering is relatively warm.

²The range represents the minimum and maximum allowable temperatures. Where sinks are used primarily for hand-washing and are served by a single pipe supplying tempered water, the tempered water shall not exceed 80°F (21°C).

³Provisions shall be made to provide 180°F (82°C) rinse water at warewasher (may be separate booster) unless a chemical rinse is provided.

⁴Provisions shall be made to provide 160°F (71°C) hot water at the laundry equipment when needed. (this may be by steam jet or separate booster heater). However, it is emphasized that this does not imply that all water used would be at this temperature. Water temperatures required for acceptable laundry results will vary according to type of cycle, time of operation, and formula of soap and bleach as well as type and degree of soil. Lower temperatures may be adequate for most procedures in many facilities, but higher temperatures should be available when needed for special conditions. Minimum laundry temperatures are for central laundries only.

Dental Screens for New Nursing Home Residents: A Promising Practice for North Dakota

By Toni Hruby

Federal law (42 CFR § 483.20) requires all nursing home facilities to conduct an oral health assessment upon admission of a new resident and periodically. Although required, 28% of North Dakota long term care facilities surveyed in 2015 stated that no assessment was conducted. According to the North Dakota Department of Health's 2016 Basic Screening Survey, roughly 34% of all nursing home residents in the state needed early or urgent dental care. In collaboration with the North Dakota Older Adult Oral Health Workgroup and the Department of Health Oral Health Program, staff at the Center for Rural Health (CRH) reviewed state and federal laws, CMS regulations, and national promising practices guides addressing oral health assessments and screenings in long term care settings. The CRH then developed a template for screening the oral health status of all new nursing home residents upon admission. The template was reviewed by a focus group and state stakeholders. A full presentation of the tool along with an implementation strategy may be found in the [Standardized Dental Screening for New Nursing Home Residents: A Promising Practice Guide](#). The guide suggests all new nursing home residents will have a dental screen completed by a dental hygienist and a direct care provider at the nursing home within 14 days of admission. The completed screen will then be utilized to develop a resident's daily plan of care for oral hygiene. If you would like more information about North Dakota oral health access or reimbursement, visit the Center for Rural Health's oral health topic page at: <https://ruralhealth.und.edu/what-we-do/oral-health>.



If you have questions about the Promising Practice Guide, you may contact Shawnda Schroeder at Shawnda.schroeder@med.und.edu. If you have questions about the Older Adult Oral Health Work Group or the Department of Health Oral Health Program, contact Toni Hruby at tlhruby@nd.gov.

RAI Updates

By Kelly Beechie, RAI Coordinator, Health Facilities

My name is Kelly Beechie and started as the new State RAI Coordinator on Feb. 1, 2018. I have been a Health Facilities surveyor for approximately 11 years. I survey Long Term Care Facilities, Acute Care Hospitals, Critical Access Hospitals, and Ambulatory Surgery Centers.

I will be attending federal RAI Training/Education the end of June. I am looking forward to this training and expanding my knowledge. I plan to provide RAI Provider Training in July or August.

Thank you to the LTC MDS Coordinators who have called or emailed questions. I appreciate your patience and understanding as I transition into this position. I look forward to working with you all in the future.

Some helpful websites:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterial.html>

MDS 3.0 RAI Manual, October 1, 2017

MDS training videos

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>

Appendix PP of the State Operations Manual

www.aanac.org/

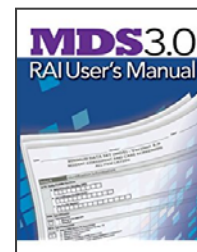
American Association of Nurse Assessment Coordinators (AANAC); This association provides information on the MDS. You can email knowledgeable members of the association if you have questions on completing the MDS, etc. (Please note: You cannot access many of the association's sites unless you are a member).

<https://www.ahrq.gov/>

United States Department of Health & Human Services Agency for Healthcare Policy and Research (AHCPR)
This site has Clinical Practice Guidelines, Publications and Products.

<https://surveyortraining.cms.hhs.gov/pubs/ProviderTraining.aspx>

This site provides a variety of training/education courses including some specific to the MDS.



North Dakota Nurse Aide Registry

By Bruce Pritschet, Director, Health Facilities

Reminder: The North Dakota (ND) nurse aide registry does not contain any Certified Medication Aides (CMAs). This is not a title recognized by the ND nurse aide registry. The CMA abbreviation is **not used** because it can imply the person is certified to distribute medications when in reality the person is certified as a nurse aide and only registered to distribute medications.

Before you can become a medication assistant I (MAI) on the ND registry, you must first be either an "active" NA or an "active" Certified Nurse Aide (CNA). Before you can become a medication assistant II (MAII) on the ND registry, you must first be an "active" CNA.

If you are a CNA on the ND nurse aide registry and you successfully pass an approved medication assistant I or II training program you are not designated as a CMA. You are a CNA who has added a medication assistant category to your current status in the registry.

IMPORTANT ANNOUNCEMENT

On September 30, 2018 (or sooner if our card printer fails or supplies run out), the plastic cards currently sent to initial applicants will no longer be used by the Registry. You may print out your own card from the following web site at any time: <https://www.ndhealth.gov/hf/registry/print-certification-card.aspx>.



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