THE MISSOURI LTC MINUTE

March 29, 2024

Message From the President

Facility Members & Business Partners,

I hope everyone has been able to get outside and enjoy some of the warmer weather we've had recently. I know our residents have enjoyed visiting with friends and family in the sunshine! There is something about a warm, sunny day this time of year that helps us forget about the cold, gray days of winter. Not only do we get the opportunity to warm up this time of year, we also get to see the outdoors come back to life. I'm already seeing some dogwood and redbud trees beginning to bloom and we should not be far from green grass and flowers. Wouldn't it be nice if everything else in life was as predictable as the changing of the seasons?

It would be a pretty significant understatement to say that our world is "unpredictable" right now. However, despite those unknowns, we continue to make solid progress with this year's political agenda. Nikki and our contract lobbyists continue to have positive conversations and productive meetings in Jefferson City. We are more than halfway through the legislative session and still appear to be making great progress on our key goals for the year. As we move through these final weeks of session, please be prepared to assist the MHCA if you're called upon to do so. That might mean making a trip to the Capitol, hosting a legislator at your facility, and/or maybe just making a simple phone call.

Speaking of change, the association is undergoing a rather significant change and I would like to provide an update regarding that change. As I've reported to you in recent months, Nikki will be moving to a new role that will allow her to focus all of her time and energy on government relations. As she transitions to this new role it requires us to identify a new Executive Director to lead the association into the future.

The Executive Committee, with the support of the Board of Directors, conducted a search and we've identified our new Executive Director. With unanimous support from the Board of Directors we have offered the position to Meghan Travis Henderson. Meghan is an attorney with experience in the Missouri legislature and most recently with the Missouri Hospital Association. I am confident she is the right leader with the right experience to lead the Missouri Health Care Association forward. She will be joining the team in July after the legislative session concludes. Nikki will continue to fulfill the role of Executive Director until that time.

As an industry we continue to struggle with current challenges but despite that we know brighter days are ahead. All we need to do is look outside during this Spring season to be reassured, both figuratively and literally, that better days are ahead.

Be proud of the work you do and the amazing service, assistance, and care we provide to our residents each and every day. Our mission is an honorable one and we need to remind ourselves and our teams of that from time to time.

Sincerely,

Eric Doerhoff
MHCA President 2023-2024

MHCA
Missouri Health Care Association

In This Issue. . .

Contact Us

Missouri Health Care Assn.
236 Metro Drive
Jefferson City, MO 65109
(P) 573.893.2060
(F) 573.893.5248
www.mohealthcare.com

Reimbursement Update

FY24 $10 PPD Increase and $0.87 VBP Incentive Increase

The new rates reflecting the $10 PPD increase and $.87 VBP incentive were keyed into the state's system on Wednesday, March 6. All Medicaid days billed on or after that date were paid at the new rate and should have been included in your March 19 payment. All Medicaid days billed before March 6 were paid at the old rate on March 19. The difference in the old rate and new 1/1/24 and 7/1/23 rates for all Medicaid days paid at the old rate will be included in your retro payment. Please note: if your March 19 payment was not paid at the new rate, it was a timing issue and your next payment should reflect the new rate.

The state projects the retro payment for any increases you received to your rate on 7/1/23 and 1/1/24 will be paid with your April 25 payment.

Please remember, if you have a recoupment owed to the state due to rate reductions as a result of a decrease in your 1/1/23, 7/1/23 and/or 1/1/24 CMI/VBP incentive – that recoupment will be taken out of any retro payment due to you. In regard to the recoupments, I have been told there are a small number of facilities whose recoupments were larger than the amount owed to them for the $10 retro pay. MO HealthNet will work with us on a fair recoupment process for any facilities in that situation.

July 1, 2024 CMI Transition From RUGS to PDPM

We are still working with MO HealthNet on the PDPM CMI model that will go into effect on July 1, 2024. We expect to have some direction soon on what model the state decides to implement. As soon as we know, we will share that information with you and begin education. Several members have reached out and questioning whether or not the state will be transitioning to PDPM for CMI on July 1, 2024. The answer is YES, the effective date of the transition to PDPM is still on track for July 1, 2024. We will update you as soon as we have definitive answers on what the model will look like.

Legislative Update

March General Legislative Recap

We are halfway through the 2024 Legislative Session. Legislation continues to move a slow pace. Likewise, we are still waiting for the General Assembly to take action on the renewal of the FRA which must pass this year. There are many pieces of legislation that impact long-term care. Below are updates on just a few issues your MHCA Lobby team is working on this session:

FY25 Budget Update:

Earlier this week, the House Budget Committee passed its version of the FY25 budget. We have great news to report. The budget included funding for a rebase based on 2022 cost reports which would reflect the post-COVID cost increases that the previous rebase did not capture.

The budget still has a long way to go before being passed by the May 10 constitutional deadline. Next week the House will debate and is expected to pass the budget. The budget can be amended during this process; however, we do not expect there to be any changes to our funding from what the House Budget Committee passed. Once the House passes the budget, the budget heads to the Senate. The Senate Appropriations

Committee will craft and pass its version of the budget before heading to the floor of the Senate. Once it passes the Senate, the House and Senate will meet to iron out their differences in their versions. After that both chambers will take one final vote before the budget heads to the Governor.

We will keep you updated as this process continues to move. However, we are very excited the House Budget Committee took this huge step forward.

FRA Renewal:

The bill containing the renewal of the Federal Reimbursement Allowance ("FRA"), otherwise known as the "provider tax", SB748 was heard, voted out of committee and has been sitting on the Senate Calendar since January. Once again, there was no movement in the Senate on SB748 this month. Senate leadership continues to work to find a path forward for this must pass piece of legislation. We expect there will be lengthy floor debate on this issue in the Senate sometime in April.

As a reminder and history on this issue, the FRA will expire on September 30, 2024, if not renewed before. This program accounts for nearly $4 billion in funding for hospitals, nursing homes, pharmacies and ambulance/emergency services through the Medicaid program. The Nursing Facility Reimbursement Allowance (NFRA) accounts for over $60/ppd of our SNF Medicaid rate.

The sunset (or expiration date) must be extended during this legislative session otherwise the program will end on September 30. Expiration of this program would be catastrophic to the overall budget and our SNF Medicaid rate. The program has been in effect for over 30 years. For much of its existence, there was never any discussion when renewing the state's self-imposed sunset on the program since it brings in so much federal money which funds the Medicaid program. However, in recent years, certain legislators have held the renewal of this program "hostage" in order to get their other non-related priorities across the finish line. As you may recall, the last time we renewed the program, the legislature was unable to get the renewal done during the regular legislative session due to the same issues it faces this session. As a result, in 2022 we were forced into a June special session where the renewal of the program finally passed on the last day of the fiscal year.

Our MHCA lobby team, along with other lobbyists who represent other Medicaid providers who will also be impacted, have put together an advocacy campaign to explain the severity of this situation and the extreme need for the passage of the FRA without any amendments. We will let you know in an action alert when the time is right to take action. We ask that you, your staff, residents and their families please be prepared to contact your elected officials. This issue has taken a significant amount of our time in the Capitol this year and will continue to do so until this bill is passed out of the legislature.

Digital Surveillance in LTC Facilities:

HB1709 was heard in the House Children's and Families Committee on March 12. Aside from the sponsor of the bill there was only one individual that testified in support of the bill. While the Committee is generally supportive of the "concept" of this bill, the committee also understood the challenges and privacy concerns we brought up in our testimony. They also acknowledged there is currently a mechanism in place now for residents to install cameras in their rooms and still protect the privacy of other residents, families and caregivers.

HB1709 would require all long-term care facilities to install and operate 24-hour digital surveillance systems in common areas and mandates that recordings be retained for a period determined by the Department of Health and Senior Services. Facilities must provide copies of recordings to residents or their representatives within five business days upon request, particularly for investigations into care concerns or allegations of abuse. The Department of Health and Senior Services would be responsible for creating rules to implement the provisions, ensuring compliance with the broader regulatory framework.

This bill is personal to the sponsor due to a situation he experienced in a facility with his mother. We have talked to the sponsor of the bill who has no intent to back down from his bill, even though cameras are allowed

in residents rooms. We continue to remind legislators, and the chair of the committee Rep. Hannah Kelley, that this was addressed in 2020 and residents are allowed to place cameras in their rooms under current law. The bill has not been brought up for a vote yet.

Modifies the Crime of Abuse of an Elderly or Vulnerable Person:

HB1710 was heard on March 13 in the House Emerging Issues Committee. HB1710 states that if any person knowingly acts or knowingly fails to act in a manner that results in a substantial risk to the life, body, or health of an elderly person, a person with a disability, or a vulnerable person, the offense of abuse of an elderly person, a person with a disability, or a vulnerable person is a class E felony.

The same representative that filed HB1709 dealing with cameras in facilities has filed this legislation. The Committee was supportive of this bill; however, concerned over the unintentional consequences this could have on someone who did not "intentionally" harm someone. We expect more discussion on this issue, but this issue could see movement out of committee.

Requires Long-Term Care Facilities to Obtain Liability Insurance or Reserve Accounts:

HB2519 states that Long-Term Care Facilities must maintain liability insurance in the amount of at least $2 million to insure against losses resulting from negligent or criminal acts in regard to abuse, neglect or wrongful death of a resident. In lieu of maintaining this insurance, a facility can instead maintain a reserve account separate from operating funds, in the amount of $2 million to cover the aforementioned criminal acts. DHSS can revoke a license if the operator of a facility fails to maintain the liability insurance or reserve account.

The same representative that filed HB1709 and HB1710 filed this legislation. The bill has not yet been referred to committee.

Compassionate Care Visits in Health Care Facilities:

HB2869 has been referred to the Government Efficiency and Downsizing Committee and will be heard on April 3. HB2869 would add penalties to health care facilities who fail to allow compassionate care visits. This bill deals with the bill passed post-COVID entitled "Compassionate Care Visitation Act" and "No Patient Left Alone Act". The original bill creating these Acts passed during the 2022 legislative session as a result of the CMS mandate to shut down hospitals and nursing homes to visitation during COVID pandemic. This bill states that any facility violating the act could have its license revoked or suspended. In addition, a facility can be subject to a CMP of $1,000/day for each day of the violation.

The sponsor of this bill had a personal story and was one of the sponsors of the original legislation passed in 2022. Since passing the original "Compassionate Care Visitation Act" and "No Patient Left Alone Act" a couple years agon, there has only been one facility that has been cited for violating this law and it was our understanding it was due to a misinterpretation of the law. We will testify against this bill on the 3rd.

Inspections of Assisted Living and Residential Care Facilities:

HB1825 and SB813 were both heard and voted out of their respective committees. The House bill has one more committee vote before heading to the House Calendar for floor debate. The Senate Bill should make its way to the Senate Calendar soon.

These bills state that if an ALF or RCF receives an accreditation from a recognized accrediting entity, and submits the documentation to DHSS, so long as the facility is in good standing, the facility does not have to undergo its annual inspection. This does not apply to complaint and other surveys. It is our understanding, this accreditation is a very difficult accreditation to get.

Sen. Mary Elizabeth Coleman has filed SB813 and Rep. Travis Smith has filed HB1825 outlining this process.

Referrals to Assisted Living Facilities:

HB1733 requires certain disclosures by referral agencies to prospective residents of assisted living facilities or their representatives. In addition, the bill places certain restrictions on Assisted Living facilities when paying fees to a referral agency for placement of residents. This bill is being pushed by several long-term care placement agencies as a result of deceptive practices by some on-line referral agencies.

The bill was heard in the House Health and Mental Health Policy Committee and has been voted out of committee. The bill was been expanded to include Skilled Nursing Facilities. The language was also added to SB813 voted out of the Senate Health and Welfare Committee.

CON:

There has been no movement on any of the CON bills this session. We anticipate there will be a hearing on the Senate bill later this session. As a reminder, the Senate bill is a full repeal of CON. It is our understanding that the House bill likely will not move. The House bill would reform the CON process.

Each year legislation is filed to repeal the Certificate of Need in Missouri. This is typically filed by Republicans in order to facilitate more of a free market industry in health care. We know that the free-market argument does not translate to the long-term care industry and will continue to have conversations with the legislators who file these bills. Representative Dean Van Schoiack has filed HB1605, a CON Reform bill that was heavily influenced by MHCA and addresses the underlying concerns about the current CON process. However, Senator Moon continues to file the full repeal of the CON process which is contained in SB1087.

Infection Control and Prevention

CMS Implements Enhanced Barrier Precautions Effective April 1, 2024

CMS issued QSO-24-08-NH regarding the implementation of enhanced barrier precautions (EBPs) in nursing homes to prevent the spread of multi-drug resistant organisms (MDROs). While EBPs were introduced by the CDC in 2019, they were not included in guidance for State Survey Agencies (SSAs). **This memo issues formal guidance under F880 Infection Prevention and Control to SSAs and long term care facilities on the use of EBP, aligning with the existing national standards effective April 1.**

Implementation of EBP

EBPs are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) during high-contact resident care activities both inside and outside the residents' room, which can result in transferring MDROs to staff hands and clothing. EBPs should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility.

When to Use EBP

EBPs are indicated for residents with any of the following, regardless of where they reside in the facility:

- Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply.
- Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO.
    - Wounds include chronic wounds, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing, do not require EBP.

- Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for EBP.

Facilities have discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by the CDC.

CMS notes that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents. Residents are not restricted to their rooms or limited from participation in group activities. Because EBPs do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

Education and Resources

Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE with hand hygiene products at the point of care. Educational resources for EBP implementation include:

- The CDC provides several resources for providers when implementing EBP, including educational materials and signage.
- The CDC offers a short video regarding EBP in LTC facilities on its YouTube channel.
- The CDC TRAIN environment provides additional resources.
- A CDC Frequently Asked Questions site is also available.

Upcoming Change to NHSN "Up to Date" Definitions for LTC COVID-19 Vaccine Reporting

The NHSN is changing the definition of "up to date" for COVID-19 vaccine reporting in long term care beginning Quarter 2 of 2024 (the week of April 1, 2024). This change, which reflects the latest guidance from the Advisory Committee on Immunization Practices (ACIP) and the CDC, aims to ensure the most effective vaccine protection for individuals, especially those aged 65 years and older.

Key Points

The ACIP and CDC provided new recommendations of COVID-19 vaccines for individuals aged 65 years and older.

- Those 65 and older are now considered up to date when they have received 2 doses of the updated 2023-2024 COVID-19 vaccine, or 1 dose of the updated vaccine in the past 4 months.
- For individuals under 65 years, there is no change; they are up to date with 1 dose of the updated 2023-2024 COVID-19 vaccine since its approval in September 2023.
- The updated definition applies to both the NHSN Weekly HCP and Resident Vaccination Forms.
- These changes will be implemented at the beginning of Quarter 2 of 2024 (week of April 1, 2024).

Date Reporting in Quarter 2 of 2024

- Residents and health care personnel aged 65 and older should ONLY be counted as up to date after receiving a second dose of the 2023-2024 updated COVID-19 vaccine or if they have received 1 dose in the past 4 months.

- Avoid over-reporting: Residents aged 65 and older who have received only 1 dose of the 2023-2024 COVID-19 vaccine more than 4 months ago should NOT be counted as up to date.
- Continue to count residents and health care personnel under 65 as up to date with 1 dose of the updated 2023-2024 COVID-19 vaccine.

Upcoming Training Webinar
The NHSN Vaccination team has an upcoming webinar to detail these changes to the surveillance definition of being up to date with COVID-19 vaccines. After registering, you will receive a confirmation e-mail containing information about joining the webinar.

Tuesday, April 2 at 2:00 p.m. ET
Register in advance for this webinar
Hosted by NHSN

Questions
For faster response times, please use NHSN-ServiceNow portal to submit questions to the NHSN Help Desk. The new portal can be accessed here and should be used in place of nhsn@cdc.gov, nhsntrain@cdc.gov and nhsndua@cdc.gov.

ServiceNow will help the NHSN team respond to your questions faster. Users will be authenticated using CDC's Secure Access Management Services (SAMS), the same way you access NHSN. If you do not have a SAMS login, or are unable to access ServiceNow, you can still e-mail the NHSN Help Desk at nhsn@cdc.gov.

Current CDC and CMS Expectations Regarding COVID-19 Infection Control

Earlier this month, the CDC announced new simplified respiratory virus recommendations for the public. AHCA/NCAL clarified that these recommendations do not apply to most health care settings, including nursing homes. **However, they may apply to assisted living (ALF) providers based on the level of care provided in the community.** NCAL published additional information to help ALFs determine which guidance to follow.

Nursing homes are currently required at §483.80 of the CMS State Operations Manual to follow the CDC's Interim Infection Prevention and Control Guidance for Healthcare. Nursing homes must also follow the return to work guidance for health care personnel outlined in the Interim Guidance for Managing Healthcare Personnel with COVID-19 Infection or Exposure.

Nursing homes are NOT required to follow separate testing guidance; this requirement was rescinded by CMS through QSO-20-38.

Please email covid19@ahca.org with any questions.

New COVID-19 Vaccine Recommendations for Older Adults

The CDC has released new COVID-19 vaccine recommendations for older adults. The CDC now recommends that adults ages 65 years and older receive an additional updated 2023-2024 COVID-19 vaccine dose. The recommendations were made by the CDC Advisory Committee on Immunization Practices (ACIP) that evaluated existing data on vaccine effectiveness and considered the increased risk of severe disease from COVID-19 in older adults.

The purpose of this additional vaccine dose is to restore protection that may have waned since the fall vaccine dose to prevent serious illness, hospitalizations, or death. Older adults may receive the additional vaccine dose four months after the previous vaccine for Moderna and Pfizer, or two months if immunocompromised. The CDC provides additional clinical considerations that can be utilized when counseling patients regarding this additional vaccine dose.

The AHCA/NCAL #getvaccinated website contains free tools and resources for providers to encourage vaccine uptake and to navigate the reimbursement policies.

Please email COVID19@ahca.org with questions.

New Fact Sheet: Medicare Billing for Respiratory Vaccines in SNFs

After many discussions between AHCA/NCAL and CMS about the confusing payment policies associated with administering preventive vaccines to short- and long-term residents in nursing facilities, CMS has issued a concise and helpful fact sheet that addresses several complex billing scenarios.

The two-page fact sheet explains how Medicare pays for Part B or Part D covered preventive vaccines administered during a patient's stay in a nursing home. Vaccine payment depends on the type of vaccine and whether the patient is using their Skilled Nursing Facility (SNF) Part A benefit, including scenarios where the resident is also receiving Medicare hospice benefits. This document doesn't cover vaccine payment by Medicare managed care, Medicaid, or commercial insurance.

The document specifically discusses billing and payment responsibilities associated with the Part D respiratory syncytial virus (RSV) vaccines, and Part B flu, pneumococcal and COVID-19 vaccines. Links to CMS updates to the price and billing codes for the vaccines each year and more information are provided at the end of the document.

AHCA/NCAL recommends that providers share with billing staff, pharmacies, and residents as applicable as it may help clarify who is responsible for submitting the Part B or Part D claims in specific scenarios.

NHSN Posts Upcoming Office Hours and Additional Reminders

The CDC recently posted a reminder for facilities to log in to the NHSN and make sure that each facility has an active facility administrator. Additionally, the CDC posted a document with instructions for facilities that need to reassign the administrator role in the NHSN.

Please note that only the facility administrator can enroll a facility in one or more components in the NHSN, reassign the role of facility administrator, and manage/negotiate locations that are used across components. It is important for the facility administrator to maintain access to the NHSN and report data. This will assist with submitting data in advance of reporting deadlines, such as the May 15, 2024, deadline to report annual health

care personnel influenza vaccination summary data and the required weekly reporting for the COVID-19 module.

The CDC has scheduled upcoming open office hours for reporting the annual Healthcare Personnel Influenza Vaccination Data (registration is required). REMINDER: Facilities are required to report this data by May 15, 2024, under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) or may face a two percent reduction to their Medicare annual payment update for FY 2025. The final open office hours is:

- Thursday, April 25 at 1 pm CST

Bloodborne Pathogens Standard: Implementing Bloodborne Pathogen/Exposure Control Plan in LTC

The following expands on the protection of staff and residents through the implementation of an OSHA-compliant Bloodborne Pathogen (BBP)/Exposure Control Plan (ECP). It also covers the significance of compliance with special emphasis on the prevention of infection and post-exposure process by identifying and discussion of 4 additional key requirements for establishing and implementing an effective ECP within long term care centers (LTCC).

The OSHA Bloodborne Pathogens Standard:
The Bloodborne Pathogens Standard 1910.1030 provides the requirements to safeguard health care workers from the risks associated with exposure to bloodborne pathogens. Here are the key requirements for an exposure control plan:

Key Requirements for Implementing an ECP:

1. Exposure Determination
2. Written ECP
3. Universal Precautions, Procedural Controls, and PPE
4. Employee Training
5. Hepatitis B Vaccination
6. Post-Exposure Procedures
7. Medical Surveillance
8. Recordkeeping

Hepatitis B Vaccination: 1910.1030(f)(1)&(f)(2)

- Requirements:
  - Mandatory Vaccination Offer:
    - Ensure that all employees at LTCCs are offered the Hepatitis B vaccination series free of charge, within 10 days of initial assignment to a job involving potential exposure to blood or other infectious materials.
  - Training and Information:
    - Provide comprehensive training regarding the benefits, safety, efficacy, and methods of administration of the Hepatitis B vaccine. Employees should receive this training during regular working hours and at no cost to the employee.
- Implementation Recommendations:

READ FULL ARTICLE HERE

What to Improve Your COVID-19 Vaccination Rates? HQIN Can Help!

Vaccines protect us all from illness and disease, but they are especially critical for our most vulnerable populations. Particularly, the COVID-19 vaccine provides increased protection to adults ages 65 years and older.

In their continued effort to support the health and well-being of older adults, the Health Quality Innovation Network (HQIN) provides FREE COVID-19 vaccination clinic support, through a partnership with CPESN-USA, a clinically integrated network of community-based pharmacies. Their team of experts can assist you in securing vaccine doses and coordinating healthcare professionals to immunize and provide vaccine education to residents and staff. In addition to COVID-19 vaccines, support is also available for pneumococcal and influenza vaccines. Simply complete the Nursing Home COVID-19 Vaccine Clinic Support Request Form to start the process today!

Certificate of Need

On March 4, 2024, the Missouri Health Facilities Review Committee (MHFRC) met in Jefferson City, MO. To view the Certificate of Need (CON) decisions for this meeting, please click here. To view the CON decisions for all other past meetings, please click here.

The next scheduled CON meeting is May 6, 2024, in Jefferson City, MO. To view the tentative agenda for the May 6 meeting, please click here. MHCA encourages you to periodically review the agenda, the compendium, and the proposed applications **IN ADVANCE** of the scheduled CON meetings to determine if there is anything that may be of concern to you.

MHFRC meets approximately every eight weeks, in Jefferson City, to consider applications and attend to administrative matters. Once per month, the MHFRC also considers expedited applications by way of a ballot vote conducted by mail, fax, and e-mail. To view the 2024 Letter of Intent and Application Review Calendar, please click here.

AHCA/NCAL & National News

2024 AHCA/NCAL Award Nominations Open on April 1

Nominations for the 2024 AHCA/NCAL Awards Program will open on April 1 and run through May 31, 2024. All nominations will be available via Award Force. Members are encouraged to check back on each of AHCA and NCAL's award pages for more information, including rules and guidelines.

The AHCA Awards Program honors individuals who are dedicated to improving the quality of lives of residents and their surrounding communities. All AHCA member facilities are encouraged to apply, including skilled nursing facilities, short and long term care facilities, Not for Profit (NFP) long term care providers, intellectual and developmental disabilities (ID/DD) residential services providers (including intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and other individuals who work in the long term care field, including direct care, education, researching, and resident advocacy.

Members may nominate eligible candidates in either category:

- **AHCA Leader of the Year Award:** This award recognizes an Administrator/Executive Director, Director of Nursing, or someone in a regional leadership position who demonstrates outstanding innovation, achievement, and capabilities in their provision of high-quality, person-centered care in a service-oriented culture in a long term care facility.
- **AHCA Noble Caregiver Award:** This award recognizes frontline caregivers, support and office staff from any department for their contributions that lead to improved quality of life for the residents and create a better work environment for the facility's staff. This includes, but is not limited to, direct care staff from nursing (also includes CNAs, LNAs, and LPNs), therapists, support/office staff, housekeeping, dietary, activities/recreation, laundry, and maintenance departments.

Please see the AHCA Rules and Guidelines for more information.

Please visit the webpage for the Mary K. Ousley Champion of Quality Award, which recognizes an individual that has made significant national contributions to advancing quality performance in long-term and/or post-acute care, including either skilled nursing or assisted living settings.

The NCAL Awards Program recognizes assisted living employees from around the country who demonstrate exemplary work within the profession. Each year, members may nominate colleagues for either category:

- **NCAL Leader of the Year:** This award recognizes an assisted living Administrator/Executive Director, Director of Nursing, or someone in a regional leadership position who demonstrates outstanding innovation, achievement, and capabilities in their provision of high-quality person-centered care in a service-oriented culture in an assisted living community.

Noble Caregiver in Assisted Living Award: This award recognizes frontline caregivers, support and office staff from any department for their contributions that lead to improved quality of life for the residents and create a better work environment for the assisted living community's staff. This includes, but is not limited to, direct care staff from nursing (CNAs, LNAs, LPNs), support/office staff, housekeeping, dietary, activities/ recreation, laundry, and maintenance departments.

For more information, please refer to the NCAL Rules and Guidelines.

Please visit the webpage for the Jan Thayer Pioneer Award, which recognizes individuals who have moved the senior care profession forward, positively affecting the lives of those served and those who serve. Recipients must demonstrate dedication, leadership, and considerable contributions to the senior care profession.

Honorees in each category will be recognized at Delivering Solutions 24, AHCA/NCAL Annual Convention and Expo October 6-9 in Orlando, Florida.

Provider Magazine Celebrates 50 Years of Excellence and Innovation

Since 1974, *Provider* has established a voice for the long term care sector that has strengthened and grown over the years. With a readership of more than 52,000 owners, operators, clinicians, administrators, and others working in nursing facilities and assisted living communities across the country, it remains the most highly read publication in this care field.

Provider Magazine has tracked and provided information and insights about new trends, regulations and legislation, and technology that have emerged over the years. The publication has also featured pioneers and leaders in the field. At the same time, some topics—such as staffing and the pursuit of quality care—have been ongoing staples. For more information, please click here.

AHCA/NCAL Data and Research

AHCA/NCAL develops and compiles cutting edge, comprehensive research and data concerning the long term and post-acute care sector. Whether conducted by AHCA/NCAL and prestigious research agencies or gathered from government agencies, AHCA/NCAL aims to provide a clear picture about the state of skilled nursing facilities. Please click here to view the COVID-19 Nursing Home Dashboard, SNF Occupancy Data and other Fast Facts.

AHCA/NCAL Reports, Notes and Members-Only Newsletters

Please click here to access AHCA/NCAL Annual Reports and Notes and to sign up for the Capitol Connection, a biweekly email that provides the latest updates and happenings on Capitol Hill and throughout Washington D.C.

Regulatory Updates

AHCA/NCAL Provides More Regulatory Resources for LTC Providers in 2024

In 2024, the AHCA/NCAL Regulatory and Clinical Team are providing LTC providers with recently published resources. These resources were prepared with AHCA/NCAL members in mind and include member feedback in their creation. The Association aims to support providers and ensure they have the tools to stay compliant with various regulatory requirements.

§483.12 Freedom from Abuse, Neglect, and Misappropriation
Abuse Tip Sheets – The abuse tip sheets were added to the previously released abuse, neglect, and misappropriation webinar that was released in 2023. The tip sheets were prepared after reviewing recent citations for each of the F-tags related to abuse. Each tip can be implemented in facilities to work towards regulatory compliance in these areas:

- F602 – F605
- F606
- F607
- F609
- F610

§483.24 Quality of Life
Tips for Meeting the Cardiopulmonary Resuscitation (CPR) Requirements in Skilled Nursing Facilities – The CPR tip sheet was prepared after reviewing recent citations for F678. Each tip reviewed may be implemented in facilities to work towards regulatory compliance and ensure workforce readiness in the event of a cardiac emergency.

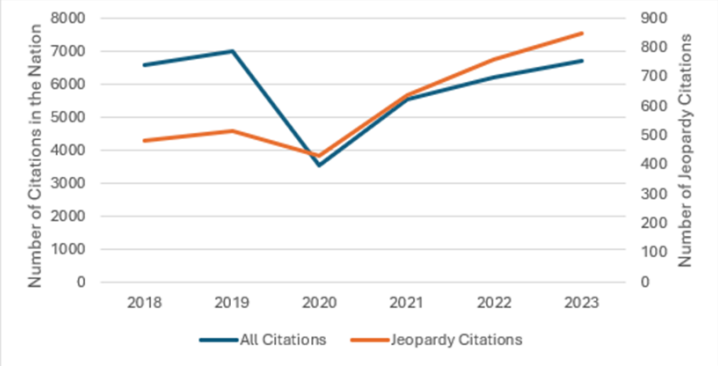
§483.80 Infection Control
The following tip sheets were developed as part of the LTC National Infection Prevention Forum (NIPF) and are available for AHCA/NCAL members. The NIPF reviewed citations related to infection prevention and noticed trends in certain areas. Tip sheets were developed to assist facilities with regulatory compliance in these areas:

- Tips for Meeting the Infection Preventionist Requirements in Skilled Nursing and LTC
- Tips for Meeting the Immunization Requirements in Skilled Nursing and LTC
- Tips for Meeting the Linen Requirements in Skilled Nursing Facilities
- NHSN Tip Sheet: This resource was updated to include tips to ensure timely and accurate reporting of data to the NHSN, avoiding citations under F884 and subsequent civil money penalties.

Please send any questions to regulatory@ahca.org.

Survey Tips for F689 and Past Noncompliance

AHCA/NCAL's Quality and Regulatory Department is offering important survey tips based on the latest trends in surveys throughout the nation. Year after year, F689 (Free of Accident Hazards/Supervision/Devices) continues to be one of the top cited F-tags and frequently cited at a Jeopardy-level scope and severity. In 2024, there has already been almost 400 F689 citations nationally. The graph below displays the number of national citations for F689.



AHCA/NCAL has developed a list of the components of the regulatory requirement for reporting violations and tips on how to ensure compliance based on a review of the common reasons facilities received citations for F689 – Supervision/Hazards/Accidents.

Tips to avoid accidents and keep residents safe:

- Develop a culture of safety and commitment to implementing systems that address resident risk and environmental hazards.
- Ensure you have a process in place to communicate any interventions specific to residents. For example, ensure frontline staff are aware of interventions established for fall prevention so each established intervention is followed.
- If elopement risk assessment shows a resident is at risk for wandering, there should be interventions established to ensure the resident is always appropriately supervised.
- Check wander guard bracelets and door-mounted devices frequently (daily) to ensure the bracelet is in place and working properly, and all exit doors are locking properly.
- Audit all residents who require any devices attached to their bed for mobility purposes to ensure the least restrictive method is used, and the resident is not restrained by the device.
- Complete walking rounds to check for environmental hazards throughout the facility. This responsibility can be shared amongst management staff to ensure multiple individuals are checking for hazards inside and outside the facility.
- Develop facility policies and procedures for allowing residents to sit outside of the facility. These procedures should include supervision by staff, sunscreen application, and protective eyewear/hats, as appropriate.
- Complete competency assessments routinely on mechanical lift transfers.
- Educate, and re-educate facility staff on how to access the residents' individual care plans. Ensure staff are aware that they must check the care plans daily, at the beginning of each shift, to ensure all new/updated interventions are followed.
- Complete a post fall evaluation, as soon as possible after a fall. Develop/update interventions, as appropriate to prevent future falls.

Tips to achieve past noncompliance if an adverse event occurs:
The first step is to ensure the resident is safe and has been assessed as appropriate by nursing staff. Once the resident has been assessed and is in a safe position, providers are encouraged to follow these steps:

- When an adverse event occurs, including an elopement, pull together all appropriate staff to have an Ad Hoc Quality Assurance (QA) meeting.
- At this meeting, discuss what occurred, what you believe to be the root cause (may be an initial conclusion until you can complete a thorough investigation).
- Make sure all staff sign in at the meeting.
- Start a folder or binder for all documentation to support what you have completed.
- Complete any reports to the SSA, as appropriate.
- Begin to fill in your internal Plan of Correction.
- Do an initial audit for elopement. This will normally be a count of all residents in the building to ensure everyone is present in the facility.
- Establish what the ongoing monitor will be, based on the Root Cause Analysis (RCA).
- Identify who will complete the ongoing monitor.
- Complete staff training with all appropriate staff and contract staff.
- Update any care plans, as appropriate, and ensure interventions are appropriate and communicated to all staff.
- Review interventions routinely to ensure they are still appropriate.
- Maintain your folder or binder in a safe place so it is accessible when surveyors enter the facility.

For more tips on preventing accidents, keeping your residents safe, and achieving past noncompliance, review this webinar on ahcancaled. Please send any questions to regulatory@ahca.org.

Facility-Initiated Transfers and Discharges

As a reminder, facility- initiated transfers and discharges (including emergency situations) are required to be sent to the regional ombudsman office. Please see the attached letter for more details. An updated email address for each ombudsman office is listed on the attached map.

AHCA Releases Payroll-Based Journal Best Practices Webinar

AHCA recently released a webinar on best practices for submitting data to the Payroll-Based Journal (PBJ). Speakers during this webinar include members of the AHCA Workforce committee, Peggy Connorton, Covenant Living Communities and Services and Lois McCaskey, Genesis, to provide best practices for submitting mandatory staffing data to PBJ. The speakers cover how PBJ Casper Reports can be utilized prior to the submission deadline to review and validate submitted data. Additionally, strategies are provided to help providers prepare for PBJ audits.

You can log into ahcancalED to review the webinar and prepare for a successful submission of Q1 2024 (January 1 – March 31, 2024) data on May 15, 2024.

Conducting Effective and Compliant Fire Drills

Fire drills are a key component of any fire safety program. While the Life Safety Code requirements for fire drills are not complicated, fire drill compliance consistently lands on the list of top cited deficiencies during life safety surveys (K-712). The following are the key requirements and best practices around fire drills.

Fire drills in healthcare are required to be conducted quarterly on each shift. This is commonly accomplished by facilitating a fire drill each month on a different shift. However, there is nothing that precludes an organization from running multiple fire drills in a single month provided that each shift receives a drill during the quarter.

Fire drills should be conducted at varying times and under varying conditions. While the LSC is not specific regarding what constitutes "varying times", it is wise to consider varying drills by at least one hour for drills conducted on the same shift. Similarly, drills should be facilitated in different parts of the building and with different scenarios. Simulating the same fire scenario in the same location limits the involvement of staff from other areas of the building. It can be beneficial to develop a fire drill schedule at the on-set of each year that outlines fire drill dates, times, locations, and scenarios. This will provide a helpful roadmap to the fire drill facilitator and ensure compliance is maintained regarding variance in time, location, and conditions.

While not specifically required by the LSC, there is an implied expectation that fire drills will be documented. Documentation is your mechanism to prove fire drill compliance during survey. An effective fire drill report will include all the details around the drill including date, time, location, facilitator, and actions taken by staff, specifically any areas for improvement. The reports can be an effective tool for assessing staff competency and identifying trends. It is also wise to maintain a sign-in sheet for each drill to document the staff that were involved.

Fire drills require activation of the fire alarm system including the normal audible and visual notification devices. However, for nighttime fire drills that occur between the hours of 9:00 pm-6:00 am, a coded announcement (commonly an overhead page) is permitted in lieu of activating the fire alarm system audible devices. Visual devices are still required to be activated. If and when CMS adopts a newer edition of the LSC, both audible and visual devices will be permitted to be omitted during overnight fire drills. Overnight fire drills always require staff response and implementation of the fire procedures.

Compliance aside, fire drills can be an extremely effective educational opportunity. Realtime implementation of the fire procedures in a staff member's normal work area can be more memorable and impactful than a training lecture, video, or on-line course. Completing the drill may check the compliance box, but investing the time to facilitate a well-organized drill that includes a comprehensive staff critique will pay dividends during a true fire emergency occurrence.

As always, knowledge of the applicable codes and standards is your best tool for ensuring compliance. You can purchase a copy of the Life Safety Code (NFPA 101) online at www.nfpa.org. The AHCA/NCAL website is also a good source for on-going life safety education, tools, and resources.

Navigating OSHA Record keeping and the Injury Tracking Application: Complying with the New Requirements

The Occupational Health and Safety Administration (OSHA) Standard 1904.41 requires certain employers to comply with electronic submission of workplace injuries and illnesses. OSHA's oversight of recordkeeping of workplace incidents has recently become increasingly more focused.

One significant development in OSHA's approach to recordkeeping is the implementation of the Injury Tracking Application (ITA). Launched as part of the Improve Tracking of Workplace Injuries and Illnesses rule, the ITA introduces an electronic platform for certain employers to submit their injury and illness data—i.e., their OSHA 300 logs, form 301, and 300A summary.

History

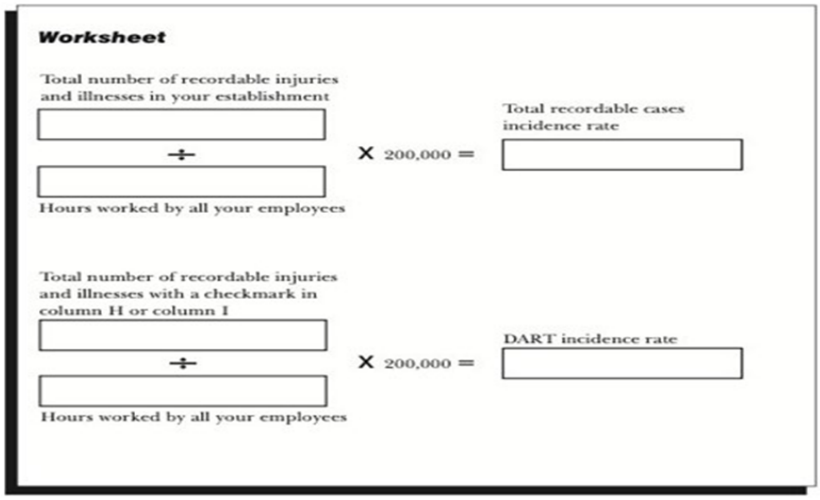
The ITA process for electronic submission of injury and illness data to OSHA was implemented in phases. The **initial** requirement for certain employers to electronically submit their injury and illness summary information became effective on January 1, 2017. The **final** rule became effective January 1, 2024, and expanded the original rule to include the date, physical location, and severity of the injury or illness; details about the worker who was injured and how the injury or illness occurred.

Under the final rule, OSHA requires certain employers to electronically submit their injury and illness data through the ITA. **Although some employers are exempt, most long term care providers should have submitted the required data by March 2, 2024.**

Injury/Illness Rates (DART and Incidence)

OSHA recordkeeping, including the OSHA 300 logs, allows OSHA, an employer, or the public to identify incident rates (Total Recordable Rates) and DART (Days Away, Restricted, or Transferred) rates. The DART rate is a key metric used in occupational safety and health to assess the frequency of workplace injuries and illnesses. It is a commonly used indicator to measure the impact of work-related incidents on a company's workforce. The DART rate is calculated per 100 full-time employees and is often used to compare the safety performance of different companies or industry sectors.

The formula for calculating the *Total Recordable Rate* and *DART* Rate is as follows:



* 200,000 factor is used to standardize the rate per 100 full-time employees working 40 hours per week for 50 weeks.

Components of the DART Formula

- Recordable Events:
  - The total number of events that resulted in an employee having either Days Away from work or Restricted/Transferred due to a work-related injury or illness.
- Total Hours Worked by Employees:
  - The cumulative number of hours worked by all employees during the reporting period.

Why DART Rate Matters

DART rates can be used by OSHA and other outside entities to assess your safety and health program, including in the following ways:

OSHA

OSHA uses the DART rate to determine which employers should be inspected under its emphasis programs. For example, OSHA's Site Specific Targeting (SST) emphasis program uses lists of eligible companies in the following four categories:

- High-Rate Establishments:
  - The SST plan selects individual establishments for inspection based on CY 2021 Form 300A data. Because average DART rates vary widely among industries, OSHA will set one DART rate for manufacturing (NAICS 31-33) and a different DART rate for non-manufacturing (all other NAICS, except construction) as objective selection criteria. This method will allow OSHA to equally target manufacturing and non-manufacturing establishments.

- Upward Trending Establishments:
  - OSHA will identify establishments with rates at or above twice the private sector national average in CY 2019, that have continued to trend upward through CY 2021.
- Low-Rate Establishments:
  - To verify the reliability of the Form 300A data reported to OSHA, the agency will generate a random sample of establishments with low DART rates, using the CY 2021 data.
- Non-Responders:
  - OSHA will generate a random sample of establishments that failed to provide the required Form 300A data to OSHA CY 2021. Inclusion of these nonresponding employers is intended to discourage employers from not complying with their obligation to report injury and illness information to avoid inspection.

Because OSHA includes both high-rate and low-rate responders, it is in the company's best interest to accurately keep injury and illness records.

Other Businesses

More and more often, prospective clients, buyers, partners, and subcontractors are asking for or looking at DART rate data to assess the company's safety program. In short, your DART rate can affect your reputation for safety in the community.

Insurers

Your DART rates may be requested by an insurance carrier and affect the premiums on your workers compensation or other insurance policies.

OSHA is increasingly focused on recording workplace injuries and has now required that the data be uploaded to OSHA's ITA. Since this information is now readily accessible to OSHA and the public, it could have far-reaching effects and should be maintained accurately with attention to detail. OSHA has provided a list of FAQs pertaining to its ITA.

OSHA ITA Submittal Resources

- Recordkeeping - Establishments in the following industries with 20 to 249 employees must submit injury and illness summary (Form 300A) data to OSHA electronically | Occupational Safety and Health Administration
- ITA Coverage Application
- Injury Tracking Application website

Quick Reference ITA Coverage Table*

Requirements:	Peak # of employees during the year		
	11 - 19	20 - 99	100 or more
Maintain OSHA records	Yes	Yes	Yes
Submit 300A data to ITA	No	Yes	Yes
Submit 300 and 301 data to ITA	No	No	Yes

***This table applies to NAICS codes:**

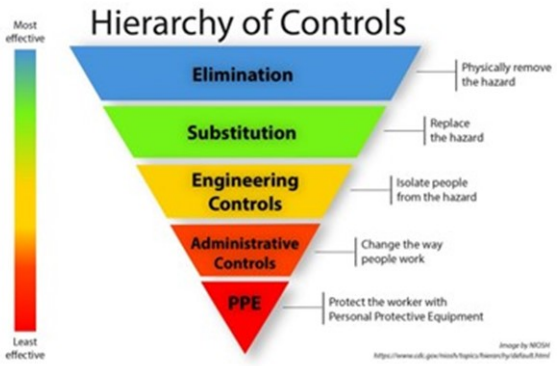
- **6231 -** Nursing Care Facilities;
- **6232 -** Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities;
- **6233 -** Continuing Care Retirement Communities and Assisted Living Facilities for the Elderly;
- **6239 -** Other Residential Care Facilities

Ergonomics 201: Controls, State Regulations, and Resources

As previously stated, Federal OSHA does not have a specific standard dedicated to preventing sprains and strains – often referred to as "ergonomics" by OSHA. Instead, OSHA regulates ergonomic concerns through the General Duty Clause, which requires employers to provide a workplace free from recognized hazards that are likely to cause death or serious physical harm to employees. Importantly, individual states have also issued regulations to address safe patient handling and ergonomics. The following highlights certain controls or interventions that OSHA is likely to expect at a LTC facility, identify resources that may be helpful when implementing or updating a safe patient handling program, and list relevant state regulations.

Common Controls

When talking about employee health and safety, "controls" are the precautions or interventions taken by the employer to reduce the likelihood of an injury or illness. OSHA regards employee safety in terms of a hierarchy of controls, which moves from the most desirable (elimination) to least desirable but still effective (PPE).



When assessing hazards that might contribute to musculoskeletal injuries and identifying the controls that could minimize those injuries, it can be helpful to consider the entire hierarchy, including the following potential controls.

Elimination, Substitution, and Engineering

The lines between these three levels are blurred, but regardless of what you call it, LTC communities use several strategies to eliminate, substitute, or engineer around patient handling hazards. Initially, LTC communities were built to accommodate wheelchairs and similar resident transportation, reducing the frequency of resident transfers. Moreover, communities typically use a range of assistive devices to reduce or eliminate the amount of lifting done by staff. These devices include mechanical lifts, transfer boards, gait belts, and grab bars.

Administrative

One of the most significant advantages LTC communities tend to have related to ergonomics is the early implementation of individualized care plans to identify residents who present a hazard to themselves or employees when being lifted or transferred. These care plans are an important hazard assessment tool, but they can also be considered an administrative control used to reduce the occurrence of musculoskeletal injuries.

Work Practice

How an employee lifts or transfers a resident is a work practice control developed by training on proper lifting techniques, body mechanics, and assistive devices. After an employee is trained, they should be monitored for using proper methods and re-trained or disciplined if they continue to use proper methods.

PPE

Back braces are typically available to staff to reduce the likelihood of back injuries. If back braces are made available, employees should be informed on how to request a brace and trained on how to use it properly.

Relative State Plan Regulations and Emphasis Programs
While Federal OSHA does not have a specific regulatory standard for safe patient handling, it is important for LTC facilities under OSHA approved State Plans to review their state programs for any specific requirements. LTC facilities should also be aware of active emphasis programs. AHCA/NCAL's OSHA Roadmap resource also contains details on state plans that can be referenced.

Resources
- OSHA Ergonomics page
- OSHA Publications
  - Safe Patient Handling – Preventing Musculoskeletal Disorders in Nursing Homes
  - Guidelines for Nursing Homes – Ergonomics for Prevention of MSDs
- OSHA retool for hospitals (including material relevant to LTC communities) – Work-related Musculoskeletal Disorders
- NIOSH Safe Patient Handling and Mobility

Addressing the Challenge: Workplace Violence in LTC Setting

Long term care (LTC) facilities have always served as a place of comfort and safety for the elderly and individuals with disabilities, providing essential support and care in their daily lives. Unfortunately, in recent years, the issue of workplace violence in health care has gained increased national attention, and LTC facilities are not immune.

History
OSHA does not have, and has never issued, a formal workplace violence standard. Instead, since the late 1980s and early 1990s, OSHA has used the General Duty Clause to cite employers that do not follow basic workplace violence precautions. The clause states that "all employers have a duty to provide a place of employment 'free from recognized hazards that are causing or are likely to cause death or serious injury'".

Traditionally, even in LTC settings, workplace violence has always been thought of in terms of active-shooter scenarios or domestic violence extending into work, but increasingly, OSHA is focusing on a much more common occurrence – *resident-on-employee violence*. OSHA is currently in the process of creating a formal regulation to address resident behaviors in health care (the RFI is available here). However, because the timing of this new standard is not yet known, OSHA is trying to reduce instances of resident-on-employee violence by applying its General Duty Clause, which was previously covered here. Like in ergonomics, OSHA's enforcement of the General Duty Clause for workplace violence is based on OSHA's guidelines and expectations. As such, it is important to understand OSHA's current expectations for prevention of workplace violence and anticipated action going forward.

Current Expectations
OSHA defines workplace violence broadly to include "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It can affect and involve workers, clients, customers, and visitors. It ranges from threats and verbal abuse to physical assaults and even homicide." To reduce incidence of workplace violence, OSHA's first recommendation is to develop a "zero-tolerance policy" covering staff, patients, visitors, and others, but that recommendation is difficult, if not impossible, to implement in most LTC settings. A more achievable expectation is to create a "Workplace Violence Prevention Program" to include a hazard analysis, control measures, training, and continued program re-evaluation.

Hazard analysis can be completed on multiple levels, including as an entire facility, by unit, or by individual resident or patient. Facility-wide hazards might be, for instance, low lighting in certain areas or limitations for communication between staff. Resident-specific factors might include a history of violence, behaviors, or volatility. Fortunately, many LTC facilities already complete resident-specific care plans that often identify a

history of behaviors and implement interventions to address those behaviors. For all hazard assessments, OSHA recommends involving both facility management and staff.

Controls will be highly dependent on the facility and resident population and, therefore, cannot be identified by a comprehensive list.

Some examples from the hierarchy of controls might include:

- Substitution: While it may not always be possible, OSHA suggests that a facility's best control might be "transferring a client or patient to a more appropriate facility" that is better suited to care for the resident and protection of others.

- Engineering: One control often mentioned in OSHA enforcement documentation is improving communication with other employees to call for help. In many instances, this might be a phone system, while in other high-risk settings, a panic button might be recommended. Additionally, OSHA often notes that improved monitoring and visibility can help reduce injuries due to violence, including surveillance cameras and positioning nursing stations in areas with high visibility. Like other controls, these engineering controls are highly facility specific and may not be necessary with certain resident populations.

- Work-Practice and Administrative: The primary work practice controls are resident-specific interventions, likely using care plans or trauma informed care. Additionally, staffing levels and turnover are frequently recognized risk factors. OSHA's expectation is for a facility/community to have adequate and trained staff, possibly including security guards, to respond to a workplace violence event to minimize the potential for injury. Often, OSHA's expectations for staffing can simply be having another employee within the area for easy communication to respond to a workplace violence event.

- Training: The most significant control for workplace violence is likely employee training. Training might include recognizing patient-specific risk factors, de-escalation techniques, and understanding when to call for help. In LTC facilities with a population of mentally declining or incompetent individuals, including those with dementia, training on strategies to understand the patient's mindset and challenges, like Hand-in-Hand training, might also be included in the Workplace Violence Prevention Program.

In addition to hazard analysis and controls, OSHA recommends implementing a system for employees to report incidents and for those incidents to be investigated to determine the root cause. From those reports and investigations, further interventions or controls might be added to your Workplace Violence Prevention Program.

More information on OSHA's current expectation on workplace violence and worker safety in hospitals can be found on OSHA's website and in the following publications:

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- Workplace Violence Prevention and Related Goals: The Big Picture (includes state specific regulations)

Anticipated Action

As stated above, OSHA is working through the "notice and comment" process to promulgate a workplace violence regulation specific to health care employers. That said, OSHA has not released an estimated date of issuance. **In the meantime, the best preparation is likely to begin implementing a formal Workplace Violence Prevention Program, using the controls and interventions most appropriate for your facility.** Those should create a solid foundation for any future OSHA regulation.

Workplace violence in long term care settings demands attention and proactive measures. By prioritizing prevention, intervention, and support, facilities/communities can immediately create awareness, which fosters a

safer environment for residents and staff. This may include anything from implementing comprehensive violence prevention programs to simply training employees and encouraging a culture of safety. Operators should begin a process where long term care facilities minimize the threat of workplace violence, ensuring that residents receive quality care and staff can fulfill their roles with confidence and security.

NLRB Joint Employer Rule Vacated

On October 26, 2023, the National Labor Relations Board (NLRB) issued the final joint employer rule that broadens the NLRB's definition of "employer" and could potentially increase liability and exposure for long term care facilities if they utilize staffing agency or contract workers. On November 9, 2023, the U.S. Chamber and a coalition of business groups filed a lawsuit challenging the NLRB's joint employer rule as "statutorily unauthorized and arbitrary and capricious." On March 8, the U.S. District Court for the Eastern District of Texas vacated the NLRB's joint employer rule that was going to be implemented on March 11. More details on the case can be found on the U.S. Chamber's website.

Administrator License Renewals

IMPORTANT: Missouri licensed administrators (NHA or RCAL) expiring June 30, 2024, are due for license renewal. If you plan to renew, please visit the BNHA website at https://health.mo.gov/bnha for important information regarding continuing education and license renewal.

Once your renewal has been successfully processed, you will be issued a current license via email. Please note if you fail to renew by June 30, 2024, you cannot practice as a licensed administrator after that date.

Long-Term Care Ombudsman Program Bed and Service Availability Portal

The Covid-19 Long-Term Care Bed Availability portal has been replaced with the Long-Term Care Ombudsman Program Bed and Service Availability portal. Long-Term Care Homes (all levels of care) have the option to fill out an electronic survey weekly to report how many beds they have available, and which residents they can serve (i.e. memory care, behavioral health, bariatric, etc.). This tool can be used by facilities, families, hospital discharge planners and the general public to determine bed availability and services throughout the state.

Please access this training video for instructions on how to complete the survey. The survey can be accessed from this link: survey. If you have any questions about the survey, please contact the Long-Term Care Ombudsman Program via email LTCOmbudsman@health.mo.gov or call 800-309-3282. More information will be coming soon about how to use the data created from the survey.

Health Education Unit Updates

The DHSS Health Education Unit is conducting Weekly Instructor Info Webinars/Q&A Meetups. These sessions will be held the same day and time each week - **every Tuesday at 2:00 pm.** Click this link to join these weekly meetings. If you have questions, call the Health Education Unit at 573-526-5686.

The HEU and Headmaster met with their Test Advisory Panel in March to address some changes in the skills test and knowledge test. These changes became effective on July 1, 2023, so please check the Missouri Headmaster Website for the most recent version of the Candidate Handbook.

CNA Testing Information from TMU/Headmaster

Below are the links for the CNA Test Candidate Handbook and the Mock Skills. If you have students in your facility who are ready to test with TMU/Headmaster, please make sure they have access to both documents. It is very difficult for a student to pass without reviewing these documents. These are updated often.

- https://health.mo.gov/safety/cnaregistry/pdf/missouri-candidate-handbook.pdf
- https://www.hdmaster.com/testing/cnatesting/missouri/forms/MO%20MOCK%20SKILLS%207.2023.pdf

CNA Testing Events

All regional dates are viewable on the online calendar at https://mo.tmutest.com/calendar. IMPORTANT – these are not the only test sites available. If you need a different testing location, please call Headmaster D&S (1-800-393-8664) and ask for the Missouri Team. **PLEASE NOTE:** There have been changes to scheduling tests through TMU and to the paperwork for RN Observers. Please reach out to Headmaster with questions. missouri@hdmaster.com.

Knowledge and Skill testing is available on March 12, April 11 and 25 at MHCA. Please contact shellie@mohealthcare.com to reserve a time slot.

Updated List of Excluded Individuals and Entities (LEIE) Database File

The Office of Inspector General (OIG) has released its updated List of Excluded Individuals and Entities (LEIE) database file, which reflects all OIG exclusions and reinstatement actions up to, and including, those taken in March 2024. This new file replaces the updated LEIE database file available for download last month. Individuals and entities that have been reinstated to the federal health care programs are not included in this file.

The updated files are posted on OIG's website here. Healthcare providers have an "affirmative duty" to check to ensure that excluded individuals are not working in their facilities or face significant fines. As a best practice, long term care providers should check the LEIE on a regular basis.

Quality, Programs and Resources

Join AHCA/NCAL's Dementia Care Connect Community

Build community and connect with your colleagues by joining the Dementia Care community via AHCA/NCAL Connect. The Dementia Care Connect Community is for subject matter experts (SMEs) in long term care. SMEs may include people who have advanced education in dementia care or those who have extensive experience in dementia care. This community strives to share helpful resources and tools, identify best practices and lessons learned, and share innovative ideas in dementia care. To request to join, please follow the instructions below.

1. Log in to AHCA/NCAL Connect.
   - If you are new, create an account. Follow all prompts on the Create New Account page. *NOTE: You must enter job role (in company information) to complete account creation. If you have just created your account, the request to join button is delayed and should display within approximately one hour of creating your account. After one hour, you may need to refresh your screen for the button to update and reappear.*
   - If you already have an account, sign in with your username and password.
   - If you have forgotten your password, please click here.

2. Join the Dementia Care Connect Community
   - The first time you sign in, you must agree to the terms and conditions to proceed.
   - Once you are successfully signed in to AHCA/NCAL Connect, click the green Communities link to expand the dropdown menu, then click My Communities.
   - Click the blue REQUEST to JOIN button next to the link for Dementia Care Connect Community. In the text box labeled "Please provide a short message for joining this community", please include the following information:
     - Name
     - Email
     - Organization/Company Name
     - Organization/Company State
     - Job Role
   - Additionally, please select an option for community discussion notifications. You may select Daily Digest or Real Time to receive email notifications when there is a message posted in the Connect Community. If you opt-out, you will not receive any email notifications.
   - You will receive an email indicating your request is being reviewed, and a second email when your request is approved.

Once approved, Join the Discussion!
Once your request is approved, you can access the Connect Community by signing in to AHCA/NCAL Connect and selecting the green Communities link and following the link for the Dementia Care Connect Community. Please review the AHCA/NCAL Connect Quick Start Guide for more information about how to navigate the Dementia Care Connect Community.

Important – Please add the following email addresses to your safe senders list:
- DC@ahca.org
- mail@connectcommunity.org
- donotreply@connectcommunity.org

Please email questions to DC@ahca.org.

AHCA/NCAL's Quality Summit 2024 – Registration is Now Open

Mark your calendars for three dynamic days at the AHCA/NCAL Quality Summit focused on effective leadership, strategic planning, customer engagement, data management, and workforce challenges. The AHCA/NCAL Quality Summit will be held **Monday, May 20 – Wednesday, May 22, 2024, in San Antonio, Texas**. Please click here for more information on the Summit and to register!

At this conference, you can customize your experience to meet your needs with educational programming based on the *Baldrige Criteria for Performance Excellence*. With session topics aligned with the seven Baldrige Criteria, you can select specific areas of focus that will elevate your skills and contribute to your facility's success!

National Skilled Nursing Care Week – Resources and Exclusive Products Now Available

AHCA has announced that resources for this year's National Skilled Nursing Care Week (NSNCW), including the Planning Guide, marketing tools, and special products, are now available at NSNCW.org. These materials are designed to assist you in planning, promoting, and celebrating NSNCW. Discover everything you need to make this week memorable for your residents, staff, and volunteers and to spread joy throughout the community.

HQIN Strategies to Use During Your Nursing Home Stand-Up Meetings

HQIN is presenting an educational series tailored for nursing home stand-up meetings, aimed at decreasing preventable emergency room (ED) visits and hospital readmissions. HQIN is sending out talking points that can be included in daily stand-up meetings to increase staff knowledge on relevant topics like effective communication, adverse drug events and infection prevention. The program is designed to empower nursing home staff with practical knowledge to foster a safer environment.

Here are some of the topics they've covered:

1. Discharge Analysis – Below is an overview of information and resources.

- Any time an emergency department (ED) visit, unplanned discharge or adverse event occurs, we can identify areas where improvement is possible.
  - Do you have a process in place to review ED visits and unplanned discharges?
  - Does an interdisciplinary team conduct these reviews?
  - Are they done after each transfer or adverse event?

  Discuss current strategies for improvement. If not already established, consider assembling an interdisciplinary team consisting of leadership, the medical director and direct care staff to review these events.

- A resident may discharge unexpectantly for several different reasons. It might seem like there was nothing that would have prevented an ED visit or hospitalization but often processes could have identified a problem before it resulted in discharge. Facilities must have processes in place for early identification of changes in condition and to communicate those changes to ensure timely interventions.

Assess your facilities communication processes. Do you have a huddle meeting with frontline staff to share and discuss important information? If not, consider using the HQIN Huddle Toolkit to implement huddles at start of shift and end of shift, quality improvement huddles, new resident huddles or "Everyone Stands Up Together" huddles where the daily standup meeting is conducted on the unit(s) with frontline staff. Also, INTERACT® (Interventions to Reduce Acute Care Transfers) offers communication tools at no cost including Stop and Watch Early Warning Tool, SBAR (Situation, Background, Appearance and Review and Notify) and the Medication Reconciliation Worksheet.

- Other adverse events should trigger the same evaluation as unplanned discharges. Reviewing adverse events helps to find opportunities for improvement that can prevent future ED visits or hospitalizations.
  - When issues are identified or communicated, how are these issues reviewed?
  - Are they reviewed at risk management meetings?

  Discuss how possible opportunities are communicated to the risk management team. Use the EMR to help identify factors like changes in condition, falls, medication errors, etc. to include in risk management meetings.

- Residents and families play an important role in preventing ED visits and hospitalizations. Care planning and advanced care planning should be discussed with patients and families regularly. Review CMS' Go to the Hospital or Stay Here Decision Guide for patients and families. Make use of the resource to assist patients and families to plan for future care.

  INTERACT® (Interventions to Reduce Acute Care Transfers) also offers care planning tools at no cost including the Advance Care Planning Communication Guide and Identifying Residents who may be Appropriate for Hospice or Palliative/Comfort Care Order. Choose your favorite resources as a team and make sure they are available to assist with care planning.

- Sometimes the root cause of an adverse event is not immediately clear. Root cause analysis can help uncover the cause, and a fishbone diagram can assist with finding it. Fill out the problem (adverse event) at the head of the fish. As you brainstorm possible causes, group them into categories. Use these categories to identify areas where improvement would be beneficial.

  When you have identified a problem and root cause, you will want to implement quality improvement interventions. Consider the problems and root causes you have noted this week. Use the QAPI Sustainability Decision Guide to assist with choosing effective interventions.

  INTERACT® Version 4.5 Tools For SNFs/Nursing Homes also offers quality improvement resources including an Acute Care Transfer Log, Calculating Hospitalization Rates, Hospitalization Rate Tracking Tool, Quality Improvement Tool for Review of Acute Care Transfers and Quality Improvement Summary Worksheet.

2. Medication Reconciliation – Below is an overview of information and resources.

- If a resident's medication orders reflect the wrong medication, the wrong dose, the wrong time, or the wrong route, adverse drug events are likely. Review which staff reconciles medication on admission. Discuss with the team the policy for admission medication reconciliation.
  - How many times are admission orders reviewed?
  - Is the contacted pharmacy made aware when orders are for a new admission?
  - How are diagnoses, indications and allergies identified?
  - Are medications reviewed with the previous facility during report?

  Review the Interact Medication Reconciliation Worksheet. How does this compare to the facility's medication reconciliation processes?

- After admission, every nurse that gives medication is responsible for giving medication correctly. Along with the Five Rights of medication administration (right patient, right drug, right dose, right route, right time), nurses will need to be aware of the indications for medications, any needed lab work or monitoring and possible adverse reactions. Discuss the systems in place at your facility to ensure medications are given properly. Review the Five Rights with staff.

- Doctors, nurse practitioners and pharmacists should be involved in medication reconciliation. Ask your team these questions:
  - When is this review triggered in your facility?
  - If there has been a behavior change, is medication reviewed for possible side effects?
  - Who can you reach out to internally and at the contracted pharmacy if you are unsure if orders or administration are appropriate or with any other questions?

- Medication reconciliation should not stop at admission. Changes in condition or changes in locations should trigger a medication review. Are physicians or pharmacists notified when a resident's condition changes? Are they notified when a resident becomes more or less compliant with medication or diet? These changes could result in the need for closer monitoring or changes to medications. Residents with over eight scheduled medications are at higher risk for drug-to-drug interactions. Do you have a process to handle those higher risks?

- Medication needs to be administered according to company policy. Using a computer system to assist with medication administration helps prevent medication errors. Discuss the drawbacks staff see in using the computer system. Do you experience fatigue due to repeated drug interaction alerts? How can those drawbacks be eliminated? Review some lessons learned about implementing and using technology in a clinical setting.

3. Falls – Below is an overview of information and resources.

- Talk about environmental hazards that may contribute to a resident falling.
- How many can your staff name (wet floors, poor lighting, incorrect bed height, improperly fitting wheelchair, poor shoes, or resident needs such as the need to use bathroom, items not in reach, call bell not in reach)?

  Print the Environmental Safety resource and review with your team, then post it for other staff members to have for reference. Create a Falls bulletin board to display educational resources to reduce falls for your team.

- How many times have you seen a resident try to stand, transfer or walk unassisted? It takes a team, working together, to reduce falls.
  - If you see a resident that looks unsafe, let someone know. Purposeful rounding can be conducted by anyone (housekeeping, dietary, maintenance, nursing, social services, activities and volunteers) who is "walking" in the facility.
  - Print the Falls Prevention resource and share with team members, then post it for others to reference.

- What are the 4 P's to reduce fall risk? Pain. Potty. Positioning. Possessions. Implementing purposeful rounding for all staff can significantly reduce fall risk.
  - Print and post the following resource on The 4 P's of Reducing the Risk of Falls and discuss them in depth with your staff. Also, download these 4 P's Cards that can be cut out and shared with staff.
- It is time to talk about engagement and sleep hygiene. Improving mobility, psychosocial well-being and sleep hygiene has been shown to reduce fall risk.
  - Print and post Simple Strategies to Prevent Falls: Engagement and Sleep Hygiene for your team. Discuss ways your team can improve sleep for your residents.

- Who is tracking falls in your facility and are they including it as part of QAPI? Is there a system of sharing information on falls and letting all members of the team know the facility's fall data?
  - Designate a "falls champion" today and continue to find great information on fall reduction to share with your team. Charts and graphs can be great to share! Download the Health Quality Innovation Network (HQIN) Nursing Home Falls Tracking Tool and implement it into your team processes.

Health Quality Innovators (HQI) serves as the CMS-designated Quality Improvement Organization (QIO) for Missouri. Facilities throughout the state partner with the Health Quality Innovation Network (HQIN) on various projects to improve operational processes and clinical outcomes.

HQIN is funded by CMS to deliver no-cost education, resources, and technical assistance to nursing homes through the Quality Innovation Network - Quality Improvement Organization (QIN-QIO) Program, a role formerly held by Primaris. HQIN's team of nursing home experts will help you create an action plan to establish a strong infection control and surveillance plan so you can comply with new CMS requirements and ensure the safety of your residents and staff. To learn more about HQI and HQIN, visit www.hqin.org or contact Judy Carte, jcarte@hqi.solutions.

QIPMO

QIPMO has a dedicated website with important information and helpful links on COVID-19 and how to prevent the spread in nursing homes. Your QIPMO nurses and LTC Leadership Coaches are always available to help and guide you with any questions or concerns you may have. Their contact information is available here. Provided below is some resources and services from QIPMO that can benefit your facility in maintaining and enhancing your infection prevention and control processes:

- Infection Control Manual
- Infection Preventionist Zip Kit
- Infection Control Assessment and Response (ICAR) Team evaluation - ICAR assessments are free of charge and provide non-punitive feedback on your existing practices. You will receive immediate feedback during an ICAR assessment (virtual or onsite), followed by a detailed report. Your ICAR feedback report can be used as an internal working document to support your existing Quality Assessment and Assurance (QAA) program. For more information or to schedule an ICAR for your facility, email musonicarproject@missouri.edu.

The Center of Excellence for Behavioral Health in Nursing Facilities

The COE-NF released new trainings for the month of February that offers Accreditation Council for Continuing Medical Education (ACCME) credits. The COE-NF also continues to provide tailored technical assistance, such as an individualized plan to assist your facility with specific behavioral health needs to include training as needed.

The COE-NF also has on-demand training videos, which includes bite-sized learnings and longer video modules with pre/posttests on topics such as Schizophrenia, Bipolar Disorder, Mental Health, Substance Use, Trauma Informed Care, and Alcohol Use Disorder. They also offer a wide array of resources on a multitude of mental health topics via the resource hub.

Other Links:

- The Center of Excellence Fact Sheet
- Sign up for the monthly newsletter

Enhanced Leadership Development Academy for LTC Leaders

Do you…..

- need a leadership course that addresses the unique challenges SNF leaders face?
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If you answer YES to any of these questions, this course may be for YOU! Open to RNs, NHAs and LPNs! For more information visit this web site, download the postcard or contact Todd Winterbower at winterbowert@missouri.edu. Please take the survey now to see if you qualify for FREE registration.

Assisted Living Update

CDC Updates Respiratory Virus Recommendations for ALFs

The CDC announced updated and simplified respiratory virus recommendations for the public. **These recommendations do NOT apply to health care settings, including nursing homes. However, in certain circumstances, they may apply to assisted living (AL) providers.** AL is a unique setting where the type of care provided varies greatly. For this reason, NCAL sought additional guidance and clarification from the CDC.

Frequently, the care provided in ALFs fits into what the CDC defines as “non-skilled personal care”, similar to what can be provided by family members in the home setting. This type of care would include helping with activities of daily living, such as bathing and dressing. However, some ALFs provide care that could be described as “healthcare” or nursing care. This could include medication administration, symptom monitoring, or wound care.

The CDC clarifies that ALFs, who know their residents and community best, need to assess their own risk factors and level of risk tolerance in deciding about whether they follow the health care infection prevention and control (IPC) guidance or adopt the new updated community guidance. **However, the CDC also clarifies that health care personnel who are providing health care or nursing care to assisted living residents must follow the healthcare IPC guidance.**

Regardless of the care provided, AL residents have many of the same risk factors for respiratory virus transmission and severe infection seen among residents in nursing homes, which ALFs should take into consideration when making the decision to either follow the community guidance or health care guidance for respiratory viruses.

Join the Nurses in Assisted Living Connect Community

NCAL is pleased to announce a Connect Community specific to nurses working in assisted living. The Nurses in Assisted Living (NAL) Connect Community is a forum to share lessons learned, resources, and get questions answered related to nursing in assisted living. It provides a mechanism to rapidly disseminate updates and resources about nursing in assisted living. The goal of this forum is to foster collaboration and sharing experiences between nurses (RNs, LPNs, and LVNs) in the assisted living space. To request to join, please follow the instructions below.

1. Log in to AHCA/NCAL Connect.

- If you are new, create an account. Follow all prompts on the Create New Account page.
- If you already have an account, sign in with your username and password.
- If you have forgotten your password, please click here.

2. Join the Nurses in Assisted Living (NAL) Connect Community
   - The first time you sign in, you must agree to the terms and conditions to proceed.
   - Once you are successfully signed in to AHCA/NCAL Connect, click the green Communities link to expand the dropdown menu, then click My Communities.
   - Click the blue REQUEST to JOIN button next to the link for Nurses in Assisted Living Connect Community. *NOTE: You must enter job role (in company information) to complete account creation. If you have just created your account, the request to join button is delayed and should display within approximately one hour of creating your account. After one hour, you may need to refresh your screen for the button to update and reappear.*
   - In the text box labeled "Please provide a short message for joining this community", please include the following information:
     - Name
     - Email
     - Organization/Company Name
     - Organization/Company State
     - Job Role
     - Years Served as a Nurse in Assisted Living
   - Additionally, please select an option for community discussion notifications. You are encouraged to select Real Time messages. If you opt-out, you will not receive any email notifications.
   - You will receive an email indicating your request is being reviewed, and a second email when your request is approved.

Once approved, Join the Discussion!
Once your request is approved, you can access the NAL Connect Community by signing in to AHCA/NCAL Connect and selecting the green Communities link and following the link for the NAL Connect Community. Please review the AHCA/NCAL Connect Quick Start Guide for more information about how to navigate the NAL Connect Community.

Important – Please add the following email addresses to your safe senders list:
- NAL@ahca.org
- mail@connectcommunity.org
- donotreply@connectcommunity.org

Please email questions to NAL@ahca.org.

Assisted Living Webinar Series - The New Generation and the Challenges They Face

Assisted Living is going through a period of change. Is your facility ready? This webinar series, led by Speaker Barbara Speedling, will discuss topics including caring for the new generation in assisted living, overcoming social isolation and loneliness, preventing resident-to-resident aggression, and leadership in a transformative culture. AHCA/NCAL members can purchase individual webinars for $25 each, or bundle and save by purchasing all four webinars now at the discounted rate of $90.

Wednesday, April 17 at 1 pm CST – Caring for a New Generation in Assisted Living
Wednesday, June 12 at 1 pm CST – All by Myself: Overcoming Social Isolation and Loneliness in Assisted Living
Wednesday, August 14 at 1 pm CST – Love Your Neighbor: Preventing Resident-to-Resident Aggression
Wednesday, October 16 at 1 pm CST – Metamorphosis: Leadership in a Transformative Culture

Membership Updates & Services

2023/2024 Expected Lobbying Expense Percentages

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) included changes in the tax code that affects you and the Missouri Health Care Association. The law requires all associations to estimate for the coming year the amount that will be spent on lobbying based on a very broad definition of the term. Associations are then to determine the percentage of dues attributable to lobbying. Please click here for the full memo providing the applicable percentages for both MHCA and AHCA dues.

April 2024 - Employee Recognition Program

In the month of April, MHCA will recognize **Occupational Therapists and Office Personnel.** To request certificates for your personnel, please click here or login to your member account to fill out the online form. Or if you have the ability to print color certificates, click here to fill in names and print directly at your facility. This is a members only service, so please sign in to view/print the certificates.

Career Opportunities In Long-Term Care

Administrator - Moore-Few Care Center has an immediate opening for an Administrator at their location in Nevada, MO. For full details, please click here.

To place an ad with us, go to the Career Center on our website and login using your Website Login information (not your Account Login information) or email Teresa Baysinger, Accounts Manager.

Centenarian Club Members

NO IMAGE AVAILABLE

Ann Hartman will celebrate her 102nd birthday April 2, 2024! She is a resident at Sylvia G. Thompson Resident Center. She is widowed with two children and one grand child. Her hobbies include volunteer work and being an ombudsman. She attributes her longevity to not smoking or drinking and eating her vegetables. Her advice to others is to be kind and helpful, and follow the lord. Ann says she has lived a very fulfilling life.

Vivian Putnam-Johnson will celebrate her 102bd birthday April 18, 2024! She is a resident at Winchester Nursing Center in Bernie, MO. She is widowed with four children, ten grandchildren, eighteen great grandchildren and several great-great grandchildren! Vivian enjoys playing cards and word searches. She attributes her longevity to never drinking, never smoking, never doing drugs, working hard, and being very blessed. Her advise to others is to always be honest; if you're honest with yourself, you'll be honest with everyone else. She thanks God for her blessings.

2024 MHCA SPONSORS!

Thank you to the following 2024 MHCA Sponsors! *Your continued support of MHCA helps ensure we are bringing the very best in education and annual events to the Membership.*

If you are interested in becoming an MHCA sponsor, please click here to view the 2024 Sponsorship and Marketing Guide.

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Education Sessions, Meetings & Events

Workshops & Seminars: In-Seat and Hybrid

RAI Process from Start to Finish Workshop
April 9-10 | Courtyard by Marriott | Jefferson City

SNF ICD-10 CM Workshop
April 17 - 18 | Capitol Plaza Hotel | Jefferson City

CMT/Insulin Certification Class
April 22 - July 8 | Jefferson City / Hybrid

Long-Term Care Administrator 101 Hybrid Workshop
May 15 | Jefferson City / Hybrid

Virtual Workshops & Webinars

Online Activity Director Workshop & Online Social Service Designee Workshop. *Both courses are held on a monthly basis. Next courses are April 2 - April 30, 2024*

Deconstructing IJ & High Risk Tags Webinar Series - "Immediate Jeopardy Risk: Quality of Care
April 9 | Live Webinar
To register for the full 2024 series, please click here.

Clinical Supervisor Virtual Workshop
April 16 | Live Streaming | Morning or Afternoon option

Documentation in Depth Webinar Series - "Documentation for Elopement Risk & Incidents"
April 16 | Live Webinar
To register for the full 2024 series, please click here.

ICD-10 CM Coding Refresher for SNFs Webinar
May 23 | Live Webinar

Online C.N.A. Student Training and more can be found at: https://www.staffdevelopmentsolutions.com/eb-courses/

MHCA is proud to partner with Curses to provide our membership with discounted online CEU! Use Promocode MHCA2024 for 20% off!

NAB Preceptor Training - This online training program for Preceptors is divided into four unique modules of education. Preceptors will be able to earn NAB-approved continuing education (CE) for completion of each of the modules and successfully passing the post-test. Each module is worth 1.25 NAB-Approved CEs.

AHCA/NCAL Webinars - Online Training

- Facility Assessments 101: The Driver of Resources, Training, and Competencies - Online Training
- Mindfulness-Based Stress Reduction Training - Online Training
- Prepare for Compliance Now - Online Training
- Building Trust: A Strategy to Improve Patient Safety, Staff Wellbeing & Vaccine Uptake in Long Term Care Free Four-Lesson Virtual Program
- PHI Coaching Supervision - Online Training
- Infection Preventionist Specialized Training - IPCO Version 2 - Online, Self-Study Program
- Using UV-C Disinfection to Advance Environmental Safety in Healthcare - On-Demand Webinar
- Creating Inclusive Communities for LGBTQI and HIV+ Older Adults - Online Training
- Functional Outcomes Improvement - Online Training