Montana Mental Health Nursing Care Center

800 Casino Creek Drive
Lewistown, MT 59457
406-538-7451

Governing Board Meeting
Meeting Date/Time: 11/14/2023 3PM-5PM

Meeting Location: Virtual (MS Teams)

Member Name	Title	Membership Type
Mike Randol	Executive Director, Medicaid and Health Services	Chair, Voting
Dr. Douglas Harrington	CMO and Interim Chief Healthcare Facilities Officer	Voting
Christy Kemp	Interim Administrator, MMHNCC	Voting
Rebecca De Camara	Administrator, Behavioral Health, and Developmental Disabilities Division	Voting
Chad Parker	Deputy Chief Legal Counsel	Voting
Jennifer Savage	Chief Operating Officer, Healthcare Facilities Division	Voting
Kim Aiken	Chief Financial Officer	Non-voting

1. Call to Order
    a. Public Comment Period (*MCA 2-3-201 et seq.)*
    b. Board Comment Period
    c. Agenda changes
2. Old Business
3. New Business
    a. Consent Agenda
        a) Approval of Meeting Minutes from [Last GB Meeting] **ACTION**
4. Reports
    a. Facility Administrator - Chisty Kemp
    b. Director of Nursing - Jessica Homme BSN, RN
    c. Quality Improvement Committee - Danielle Wichman MHA
    d. Human Resources - Christy Kemp
    e. Infection Prevention - Adrienne Castillo RN, IP

Attachments:
A: Administrator's Report
B: Director of Nursing Report
C: Quality Assurance and Performance Improvement Report
D: Human Resources Report
E: Infection Prevention Report

Attachment A
Administrator's Report
(John Parker MS, RN substituting for Ms. Christy Kemp)

MMHNCC Administrator's Board Report
Nov. 14, 2023

On August 4th, Mike Zwicker stepped down as Administrator for MMHNCC. Ms. Christy Kemp was named interim administrator with support from John Parker MS, RN, A+M Consultant. Our ADON, Branigan King stepped down on 8/21/23.

A search for a new administrator was initiated. To date, the position remains vacant.

On Aug. 16th, CMS conducted a Complaint Survey at MMHNCC. The results were 3 citations, all of which were remedied, and no Corrective Action Plan was required. We are still awaiting the Remedy Letter from CMS.

On September 19th and 20th, MMHNCC had a Board of Visitors inspection. It went excellently and was very collegial in nature. They had no specific recommendations for us and appeared very pleased with the functioning of the facility. Final report from BOV is pending.

On 9/21, Montana Dept of Labor and Industry did a Safety Walk through. Findings included Electrical Panel CB$ in boiler room needed a cap. Applied. Air compressor in the Boiler room needed to be fixed to the floor. A non-flammable in the Flam locker (removed). There was one thing in the garage, the Parts rest on the bench grinder was ¼" from the wheel and should be 1/8". It was adjusted, and those were all the findings.

In the past 3 months, we have added some key personnel to our facility team. Gary Westberg has joined us as Mechanic and Maintenance Supervisor, Shalon Wilson has taken a case manager position, Jamee Barman is our new Support Services Director and is doing a wonderful job. Rachel Taylor is our new recreation aide.

We have obtained 2 travel nursing supervisors for the night shift which allows us greater supervisory coverage.

We still have a few important vacancies. First is our Administrator which we are actively seeking a replacement. 2nd is the COO position that has been put on hold. 3rd is the ADON, vacated since 8/21/23 remains vacant.

Building Projects: A safety panic alarm system was installed in the business office. A heated garage has been approved and being designed by the architect, A card swipe system for the main doors and the locked units is also being developed, and replacement for the Wanderguard system is being contracted with construction to start ASAP. An HVAC system repairs to correct a negative air flow from the dirty linen room in the laundry is about to begin as well.

Long range budget requests include:
All three of these projects were approved as long range budget requests. Here are the amounts each was funded for:

MHNCC	bill page	Amount	
Supplemental MMHNCC Roof Replacement	2	$ 1,500,000.00	**in the A&E Budget**
Key Card Entry System	5	$ 125,000.00	**in the A&E Budget**
Heated Storage Unit	16	$ 360,000.00	**in the A&E Budget**
Maintenance funding put to MHNCC budget for storage unit	*22*	*$ 21,312.00*	**in our DPHHS budget**

We remain in RED mode, "ready every day" for our annual CMS survey with a focus on quality audits originating from our January 2023 Complaint survey citations and subsequent corrective action plan.

Respectfully submitted,
Christy Kemp RN
Interim Administrator MMHNCC

Attachment B

Director of Nursing Report

Jessica Homme BSN, RN

11/14/2023

Governing Board Summary Nursing Department

Updates:

- Currently we are still using the compliance store to review and update policies following CMS and CDC requirements and recommendations.
- PIP for oral/bathing documentation most recent compliance rates are 88% for Oral Care and 80% for bathing compliance of documentation for the months of July, August, September. The resident appearances show that cares are being completed, just not documented. Continued education with staff on importance of correct documentation as soon as completed. With an E.H.R tailored to a long-term care facility setting, this would mitigate our frequently noted documentation issues.
- New activities of daily living (ADL) flow sheets to match Minimum Data Set (MDS) changes. Staff education conducted on correct coding for documentation.
- Skills Fair- Oct 31st and Nov 1st
- Survey preparedness/mock surveys conducted- areas that needed improvement were addressed and corrected, along with education for preparing staff for our annual survey.
    - Auditing low hanging fruit areas.
    - Refrigerator temps
    - Expired items in wing fridges
    - Expired medications on carts
- August complaint survey results- 3 citations of NPC no POC required.
    - Freedom from Abuse and Neglect
    - Competent Nursing Staff
    - Residents Free of Significant Medication Errors.
- Cleaning and organization of refrigerators, medication, and treatment carts and supply storage areas.
- January 2023 POC continued quarterly audits and ensuring compliance of interventions implemented from citations received.
- Updating/creating job descriptions throughout the nursing department.
- Approved for an Education RN position.
- Current outbreaks Noro, Covid, and STEC. Reported to appropriate agencies and continuing with source control, PPE, and necessary precautions for each outbreak.
- Nursing skill supplies ordered for training/competency.
- Medication error review:
    - June 0.56%
    - July 0.73%
    - August 0.71%
- Wound care training upcoming for Rounding Nurse and DON
    - Steps to Skin Integrity: A comprehensive wound management and prevention program from the Civil Monetary Penalties (CMP) funding through the Public Health and Safety Division (PHSD).
    - Both will receive certification for this training.

- Staffing/travel ratios:
    - CNA Core = 23 (5 are relief and 5 are part time)
    - CNA Travel = 20 (16 are full time and 2 are part time)
    - 0 ADON
    - 2 RN Supervisors
    - 2 RN Travel Supervisors
    - RN core = 8 (1 part time, 7 full time)
    - Travel LNs = 10 (3 PRN, 7 Contracts)
    - Medication aides 4
    - 0 LPNs
    - 1 Infection Prevention Nurse
    - 1 MDS Coordinator & 1 backup
    - 1 Rounding nurse/wound care
    - 0 Education RN

Issues:

- Water temperature on one wing not up to code- working with FICO to fix.
    - Have offered residents to shower on other wings. Consistent refusals of showers are noted due to cold shower temperatures and not wanting to go to other wings for showering. Have had three new skin issues due to refusal of showering or going to another wing. Have offered bed baths which has been regularly refused as well.
- Requesting an Electronic Medical Records System (PointClickCare) to assist with compliance of documentation. (Safety and compliance issues)
- Secure Care Band system not functioning correctly, currently working with vendor to replace system.
    - Continued wing protocol of resident checks every 30 minutes. Staff by exit doors aware and have increased supervision of the entry/exit doors.
- As for Peer-on-Peer abuse, with our newly focused attention, these numbers reflect the nature of the beast in that we have added focus on aberrant behaviors that come from our more acute residents. Often these are simply verbal confrontations that happen when cranky residents are in proximity to other cranky residents. The cross residents are distracted and separated but it is business as usual, and the data reflects our focus to these issues.
- As for patient grievances, all are resolved at the social work level.

Attachment C

Quality Assurance and Performance Improvement Report

Danielle Wichman, MHA

Quality Summary of Q3 Calendar Year 2023 Trends

Quality Summary of July through September Calendar Year 2023 Trends

- **Falls**
  - The facility had 30 falls from July through September of 2023.
  - This is a reduction from 54 falls the previous quarter.
  - The most falls occurred during the evening shift, or 2:00-10:00PM. A focus has been placed on staffing during evenings and weekends. Quality assurance has implemented additional audits on frequent fallers due to the identified areas of concern with staffing.
  - There were no falls with major injury this quarter.
- **Medication Errors**
  - There were 20 medication errors out of a total 2518 billed prescriptions from July through September of 2023 averaging 0.79% error for three months.
  - The error percentage was under 1% error each month within the quarter.
  - Total medication errors the previous quarter were 47, so the facility is seeing a positive reduction in errors. This may be due to the implementation of additional supervision during traveler orientation for medication administration and prioritizing longer contract length for traveling nurses.
- **Patient Safety Events**
  - There was a resident and staff norovirus outbreak in September. See Infection Prevention report.
- **Restraints & Seclusion**
  - There is one individual within the facility that is currently ordered a posey lap belt restraint, posey pelvic restraint and a “onesie” restraint. This places the facility slightly above national nursing home average of long-stay residents’ who are physically restrained.

- Physical restraint occurrence within the facility has increased from the last year. Chart audits and frequent monitoring of the individual ensure proper compliance with long-term care regulations regarding restraints.
- The facility remained 99% compliant in 30-minute check audits for restraint use during the quarter.

- **Abuse & Neglect and Patient Grievances**
  - There were two substantiated grievances in the quarter from one resident. Resident received appropriate and timely intervention from the dietician regarding the grievances and has expressed satisfaction with the resolution.
  - The facility identified new Support Service Director as Grievance Officer.
  - The facility investigated 10 alleged abuse incidents this quarter.
  - There was one substantiated, peer-to-peer verbal abuse. Both residents involved received appropriate follow-up with no recollection of the incident after the conclusion of the investigation. Staff received appropriate education regarding the specific medical diagnoses that may have led to the incident.

Attachment D

Human Resources Report

(John Parker MS, RN substituting for Ms. Christy Kemp RN)

Dimension	Performance Indicator	Description	Jul-23	Aug-23	Sep-23
Operations Metrics					
Operations	Employee Vacancy Rate	# of vacant positions divided by # of budgeted positions	36.0%	34.0%	36.0%
Operations	Employee Turnover Rate	# of separations divided by # of employees	0.7%	1.1%	0.7%
Operations	Net Employee Hires	# of employees hired minus # of employees separated for the month	(1)	1	0

Attachment E

Infection Prevention Report

Adrienne Castillo RN, IP

1. Outbreaks

Covid

In August our facility had two residents and three residents test positive for covid. Due to difficultly assigning consistent staffing on units and multiple recreational activities with mixed unit outings a broad based testing strategy was utilized.

September there were no covid cases in the facility.

October two staff positive with covid. One unit and three staff were close contact exposures and placed on a contact tracing testing schedule

Noro

September six residents placed on enteric contact precautions for Noro signs and symptoms. One resident had a positive stool sample and one had a negative sample. Multiple staff called out of work with noro symptoms and were asked to return to work 48 hrs after symptoms had resolved without medications. Worked closely with facility provider, county and state health departments. The facility purchased bleach wipes

October three residents placed on enteric contact precautions for noro signs and symptoms. Two of the residents had positive samples including noro and Shiga-like-toxin-producing E.coli (STEC). Again multiple staff call offs with symptoms of noro or fevers.

2. The facility signed a contract with FICO and is pending a HVAC assessment.
3. Vaccines

Influenza

Our medical director asked that we wait to administer influenza vaccines until November. Consents were sent out in September, we will start administering the beginning of November. I have offered staff influenza vaccines starting in October and scheduled a vaccine clinic during the skills fair October 31st and November 1st.

Covid

Pharmacy has an order in for the Moderna (Spikevax) covid vaccine. It should arrive within a few weeks. The facility is waiting on updated VIS that has approval for 12 years of age and older, to gather consents.

Pharm 406

Helped administer Prevnar and Shingrix at the end of September.

4. Infection Control Committee

A new respiratory policy has been drafted, pending approval from ICC on the 23rd. Will also discuss the emergency preparedness influenza plan at that time.