

# SHORTS

## ON LONG TERM CARE

Poyner Spruill LLP's International Award-winning Newsletter for the North Carolina LTC Community

*For Skilled Nursing Facilities*

### The Citation of Immediate Jeopardy Deficiencies Against Nursing Facilities: Unforeseen Consequences

*By Ken Burgess*

There are no words more feared by a skilled nursing facility Administrator during an annual recertification survey or complaint survey than these from a surveyor: “we’re citing you for an Immediate Jeopardy.” Those words set in motion a series of events, both during and after the actual survey itself, which can make the strongest Administrator—man or woman, experienced or novice—weak in the knees.

First, there’s the rush to figure out exactly what is being cited at a point when the facility has no written survey report (CMS 2567) so the facility can draft and submit the required Allegation of Compliance (AOC), which must be presented to and accepted by the survey team, and its managers back at the Division of Health Service Regulation (DHSR), before the Immediate Jeopardy (IJ) can be lifted. There’s the risk, which we are seeing increasingly, that DHSR won’t accept the facility’s draft AOC and the survey team will leave the facility with the IJs pending, the facility on a 23-day fast-track decertification from the Medicare and Medicaid programs, and a host of other punitive sanctions which kick in within a very short time frame.

Even if a facility manages to submit an acceptable AOC and have its IJ lifted before the survey team leaves the facility, there is the inevitable soon-to-come letter from the Centers for Medicare and Medicaid Services with a range of penalties, almost certain to include a civil money penalty (often a daily one that grows quickly to big numbers) and a looming deadline by which, if all deficiencies are not corrected, not just the IJs, the facility is denied payment for new admissions.

Couple that with the inevitable reputational damage of IJ citations to the facility as well as the impact on its Star Rating, subsequent survey citations, managed care contracts and even some insurance policies and, well, you get my point. It’s not good.

There is, however, another potential negative impact from an IJ citation that many Administrators learn about only later, and the hard way. Whenever a facility is cited with an IJ deficiency, the N.C. Board of



Examiners for Nursing Home Administrators (the Board of Examiners) receives a copy of the CMS 2567 survey report. In response to the citation of any IJ deficiency for any regulation or FTag, the Board of Examiners sends the facility Administrator a letter asking for a written explanation of the citation and, more importantly, how the facility and Administrator responded to the IJ citation. Typically, this letter, if properly written and comprehensive, resolves the matter and that’s the end of the issue. However, the Board of Examiners can, and on occasion does, require a licensee to meet in person with the Board’s Standards of Practice Committee.

Lately, we have seen an increase in the number of IJ citations cited at what is commonly known as FTag 490, governing Administration of the facility. This FTag, and its related federal regulation, requires that the facility be “administered” in a way that ensures the ability of all residents to achieve and maintain their highest practicable mental, physical and psychosocial well-being. When this FTag is cited, then the Board of Examiners is especially interested in hearing how its licensee, the facility Administrator, responded to correct the situation cited and maintain compliance.

Administrators should remember that just as DHSR is the facility’s government licensing entity, the Board of Examiners is the Administrator’s government licensing agency and it is charged by statute and regulation with enforcing the standards set forth in law for SNF administrators. As such, the Board has an obligation to inquire into allegations that a licensed Administrator has, or may have, failed to meet those standards, including such allegations when they are set forth in a CMS 2567 survey report. The Board of Examiners has authority to dismiss such allegations upon review of the Administrator’s written

*continued on back page*

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## DOL Signals That It Will Not Support Obama Era Salary Basis Test

By Susanna Gibbons

Employers across the country received some good news recently when the U.S. Department of Labor (DOL) filed its Reply Brief in the Texas lawsuit that halted implementation of the \$913 per-week salary requirement for exempt status under the Fair Labor Standards Act (FLSA). As everyone recalls, in March 2014, President Obama directed the DOL to update and modernize the regulations setting forth the requirements for administrative, executive, and professional employees to be exempt from the FLSA's minimum wage and overtime requirements. In response, the DOL issued a new Final Rule on May 23, 2016, which made three significant changes to the salary basis test:

- It increased the minimum annual salary level from \$23,660 to \$47,476 – a rate based on the 40th percentile of average salary for full-time workers in the lowest census region. The rate previously had been set at the 20th percentile.
- It created automatic increases every three years with salary-level increases based on the average salary levels for full-time workers as reported by the Bureau of Labor Statistics.
- It permitted commissions and other nondiscretionary incentive pay to satisfy up to 10% of the minimum salary level.

The new salary requirements were set to go into effect on December 1, 2016. Twenty-one states and a group representing businesses sued, claiming that the new rule was unconstitutional, arbitrary, and capricious, and beyond the DOL's authority. Commentators were nearly



unanimous in predicting that the cases would not be successful. Stunningly, on November 22, 2016, a Texas District Court Judge (an Obama appointee) granted a nationwide preliminary injunction blocking implementation of the Final Rule. *Nevada et al. v. U.S. Department of Labor et al.*, No. 4:16-CV-0073. The court held that the DOL did not have the authority to set a salary level as a requirement for exempt status, but could only define exempt status requirements by the duties being performed by the employee. The DOL appealed that injunctive ruling during the waning days of the Obama administration, but the final briefs on the matter had not been filed when President Trump was inaugurated. In late April, Alexander Acosta, who had been the Dean of Florida International University College of Law in Miami, was confirmed by the Senate and sworn into office as the new Secretary of Labor.

In the brief filed last week, the DOL stated that it does not intend to implement the \$913 perweek salary basis test. Instead, it indicated that it will pursue further rulemaking to determine what the appropriate salary level should be for exempt status. The DOL stated that it intends to publish a request for information seeking public input on several questions that will aid in the development of a proposed substitute rule. Thus, it appears that the mandatory salary level for exempt status will go up in the future, but will not double. Prudent employers should monitor this issue to ensure they have plenty of time to plan for the increase that is no doubt coming.

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## Five Takeaways From The OCR Reminder On HIPAA Obligations In Ransomware Incidents

*By Saad Gul and Michael E. Slipsky*

Apparently prompted by the recent high-profile wave of ransomware attacks, the Department of Health and Human Services' Office of Civil Rights (OCR) has reminded hospitals, healthcare systems, and other covered entities and business associates of their cybersecurity obligations. The reminder follows a previous warning that unless the affected covered entity or business associate can establish that there is a low probability that personal health information (PHI) has been compromised, a breach is presumed to have occurred.

OCR's reminder reiterated that the HIPAA Breach Notification Rule defines a breach as the impermissible acquisition of, access to, use of, or disclosure of PHI. Under these criteria, most ransomware incidents would be considered breaches absent an affirmative showing, under a high evidentiary standard, that specific safe harbors apply.

Second, if the ransomware incident implicates the Breach Notification Rule, OCR emphasized that patients, regulators, and in certain instances, the media must be notified within the regulatory guidelines. The guidelines provide for notice "without unreasonable delay." Sixty days is considered the outer limit. Timely reporting helps mitigate damage at the individual level (by preventing identity theft) and at the aggregate level (by enabling detection and suppression of threats).

Third, OCR underscored the necessity of having an incident response policy and different types of contingency plans in place. These policies and plans provide the affected entity with a mechanism to continue services even while the security incident is in progress.

Fourth, these policies and plans should be regularly vetted and tested, under the sponsorship of management. In addition to addressing disaster recovery and emergency contingencies, they should encompass maintenance (such as containment testing and regular updates, including data backups). They should also factor in post-incident reviews and investigations.

Finally, OCR stressed the desirability of information sharing, pooling threat and vulnerability information to enable greater robustness of the



healthcare sector as a whole. The federal government has encouraged the process via measures such as the Cybersecurity Information Security Act (CISA) and Executive Order 13691.

The healthcare sector has been particularly vulnerable to ransomware. Both operational needs and the stored PHI are extremely sensitive, while technology infrastructure may be dated, resources are limited, and IT departments and budgets are stretched thin. Nevertheless, HIPAA's stringent penalty regime and OCR's stated intention to expand enforcement mean that HIPAA-compliant plans and processes are more important than ever. In short, pay a little for compliance now, rather than a lot - in ransom payments, remediation costs and OCR-imposed penalties - later.

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For Skilled Nursing Facilities & Assisted Living Communities

## North Carolina Medicaid Provider Enrollment: To Disclose Or Not To Disclose, That Is The Question

By Iain Stauffer and Ken Burgess

The use of criminal background checks is becoming more prevalent as a form of credentialing for both individual and institutional healthcare providers seeking licensure, certification, or the benefits of other government licensing and payment agencies. Specifically, criminal background checks are now routinely used by professional licensing board and payment entities to determine which providers have the privilege of practicing their craft and being paid for their services. One area where we are seeing criminal background checks have a significant impact is Medicaid provider enrollment, and the process impacts every type of provider seeking certification by the state's Medicaid program.

In North Carolina, Medicaid providers must complete a lengthy list of disclosure and sanction questions during the application process; these inquiries dealing with convictions, disciplinary actions, and civil monetary penalties, for example. Applicants often do not pay careful attention to these questions, including the scope and time parameters contained in them. Similarly, applicants tend to move quickly through the questions and assume that nothing in their past would require disclosure. This conduct can lead to inadvertent errors, which can have significant ramifications for the processing time and ultimate eligibility as a Medicaid provider. It is essential that applicants take their time and closely examine the questions and the above metrics.

For instance, while the North Carolina Medicaid enrollment application asks about healthcare-specific fraud and abuse convictions, findings and sanctions, it also asks about any convictions other than minor traffic violations. This question is very broad in both scope and time. First, the scope involves any conviction, including a felony or a misdemeanor, for any reason, other than a minor traffic violation. Second, it is important to note that there is no time period in the question. The time parameter is nonexistent so even a 30-, 40-, or 50-year-old conviction would be subject to the disclosure requirements.

It is important to carefully and properly answer the sanction questions because of the subsequent criminal background check. Typically, a provider enrollment application is prepared and submitted by the applicant or the applicant's attorney. After submission of the application and as part of the review process, a criminal background check is performed on the owners, managing employees and agents. If there is a "hit" on the criminal background check, the agency gets the report and the applicant does not know what it shows. If the conviction that caused the hit was not disclosed on the application and supporting documentation provided, the application is subject to a denial based on the failure to disclose. Then, the applicant either needs to engage

in a time-consuming process to either attempt to have the application withdrawn to avoid a denial, or in the worst case, receive a denial, which then triggers additional disclosure requirements on a subsequent application. If the provider applicant is successful in withdrawing the application, or the application is denied, the applicant will have to start the enrollment process from the beginning and re-apply, with the appropriate disclosure and supporting documentation. If the application was denied, the applicant will also need to provide an explanation of why the conviction was not originally disclosed on the prior application. Either of these scenarios causes delays in the processing time of the application and subsequent approval. Any delay in approval could have serious repercussions for the provider because of the length of time necessary for the application to be processed. Remember, a provider cannot submit claims for reimbursement or be paid by Medicaid for claims until the provider has successfully enrolled.

The fact that a provider enrollment application contains an affirmative response to a disclosure or sanction question does not necessarily mean that the application will be denied. For purposes of Medicaid provider enrollment in North Carolina, the Division of Medical Assistance has discretion to approve an application if it is in the best interest of the integrity of the Medicaid program based upon consideration of the seriousness, age, and other circumstances involving the conviction.

When a provider applicant answers "yes" to one of the disclosure or sanction questions, it is essential to attach documentation explaining the reason for the response. North Carolina Medicaid requires that an applicant submit copies of the documents reflecting the disclosable activity which also show the final disposition or resolution. In addition, this is the applicant's opportunity not only to identify what the conviction or licensing issue was, but also to explain it, provide the circumstances, and provide any facts to mitigate the issue and support enrollment as a provider. A provider applicant will want to demonstrate that its enrollment is in the best interest of the Medicaid program and address the seriousness, age, and circumstances surrounding the event.

Generally, an enrollment problem with the criminal background check is caused by the failure to disclose a conviction, rather than the conviction itself. The failure to disclose often ends up being a more significant issue than the underlying offense. When answering disclosure and background check questions, it is critically important to be careful, thoughtful and comprehensive. If you are unsure how to answer a criminal background check question, seek competent advice from counsel before proceeding. Forewarned is forearmed.

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# ASSISTED LIVING COMMUNITIES



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## Employee Benefits: Time To Prepare For The End Of The Year

By Kelsey Mayo

### Part One

The end of the year is rapidly approaching! To avoid costly penalties that can arise from inadvertent errors in the year-end rush, plan sponsors should begin talking with their service providers now about what must be done by year-end.

#### Retirement Plan Disclosures

As a quick reference, the following is a list of certain year-end disclosure requirements for retirement plans:

- 401(k) safe harbor notice – to be distributed to participants 30-90 days prior to the beginning of each plan year; by December 1, 2017, for calendar year plans. The same deadline applies to traditional safe harbor plans and qualified automatic contribution arrangement (QACA) safe harbor plans.
- Automatic contribution arrangement (ACA) notice – to be distributed to participants 30-90 days prior to the beginning of each plan year; by December 1, 2017, for calendar year plans. The same deadline applies to plans with plain ACAs and eligible automatic contribution arrangements (EACAs).
- Qualified default investment arrangement (QDIA) notice – to be distributed to participants 30-90 days prior to the beginning of each plan year; by December 1, 2017, for calendar year plans.
- Annual participant fee disclosure documents – ERISA plans must provide an annual fee disclosure at least once in each 14-month period. If you distributed the fee notice with your other notices toward the end of last year, plan to do so again this year.
- Summary annual report (SAR) – ERISA-covered defined contribution plans must provide the SAR to participants within 9 months of the end of the plan year or 2 months after the Form 5500 filing deadline. For calendar year plans, this means the SAR is due September 30 if the Form 5500 was not extended, or December 15 if the Form 5500 was extended.

Keep in mind that vendor-prepared and distributed notices are often computer-generated and may not accurately reflect special features of your plan. Ineffective or incorrect notices may result in confusion among your participants as well as errors and penalties. Be sure to review all notices carefully and address any concerns or questions with your benefits counsel.

### Part Two

#### Retirement Plan Amendments

The end of each plan year also brings required plan amendments. Below are a few amendments that may need to be made to your plan:

- Changes implemented operationally this year – generally, the plan must be amended by the last day of the plan year to reflect any changes that were implemented operationally during the plan year. Common amendments are the addition of in-service distributions or crediting of additional service for mergers completed during the year. Certain plans may also need to be amended to reflect required disability claims procedures, which we'll discuss in the next issue of this newsletter series. Keep in mind that retroactive amendments may not, however, retroactively reduce or "cut back" benefits.
- Design changes effective on the first day of next year – changes to plan design may need to be adopted before the beginning of the plan year. As referenced above, not all amendments can be made retroactively at the end of a plan year. Changes to matching formulas, for example, should be made before they are effective (particularly if they reduce the match). Similarly, changes to safe harbor designs must be made in advance of the change.
- For collectively bargained hybrid plans (such as cash balance plans), amendments to reflect the final hybrid plan rules - this deadline was delayed until the first day of the first plan year beginning on or after January 1, 2019. However, if the last collective bargaining agreement was ratified on or before November 13, 2015, and expires before January 1, 2019, the amendment must be adopted before the first day of the plan year that begins on or after the later of the date on which the last applicable collectively bargained agreement expires, or January 1, 2017. Close attention must be paid to the applicable deadline for these collectively bargained plans.

Failure to adopt amendments in a timely manner can result in costly qualification issues, operational errors, and IRS penalties. All plan amendments should be carefully reviewed to ensure they match the plan sponsor's intent and the requirements of the law. Be sure to review all amendments carefully and address any concerns or questions with your benefits counsel.

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# New OSHA Regulations Does Your Drug Testing Policy Comply?

By Thomas Davis, Jr.



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At the end of last year, OSHA began enforcing new regulatory rules expanding the requirements for employers' reporting and submitting workplace injury and illness records. These new reporting requirements also contain new anti-retaliation regulations. These new provisions include the ability of OSHA compliance officers to issue citations based upon alleged retaliation, even in the absence of any employee complaint. A citation can be issued solely based upon the written requirements of the employer's safety plan.

Unfortunately, the new anti-retaliation provisions may operate to make many current drug testing policies noncompliant and subject to sanctions. The new rules prohibit an employer "from using drug testing, or the threat of drug testing, as a form of retaliation against employees who report injuries or illnesses." Specifically, the new regulations prohibit universal drug testing of employees after every work-related incident.

OSHA's new rule does not create a blanket prohibition on the drug testing of employees. It does, however, provide limitations on such testing. OSHA requires that "drug testing policies should limit post-incident testing to situations in which employee drug use is likely to have contributed to the incident, and for which the drug test can accurately identify impairment caused by drug use." An employer seeking to utilize post-incident drug testing of employees must be able to show:

- Probable cause the work-related incident was caused by drug-related impairment (e.g., slurred speech, erratic actions, the smell of alcohol);
- The test will actually test for and identify the substance suspected in the impairment;
- The employer's motivation in giving the test was not retaliation; and
- The test was not given as punishment or to embarrass the employee tested.

Employers are urged to review their current safety policies to determine whether provisions relating to the drug testing of employees after a work-related incident are in conformity with the current OSHA requirements. If they are not, the offending provisions should be revised immediately.

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## Unforeseen Consequences

*continued from page 1*

response, meaning the Board takes no action against the Administrator. However, the Board also has legal authority to issue a letter of caution or letter of warning to the Administrator, both of which become part of the Administrator's public file with the Board of Examiners, or to place an Administrator's license in probationary status, require additional continuing education (usually reserved for cases involving potential ethics issues) and, in the most severe cases, revoke a license.

We decided to run this article now, and to remind Administrators of this sometimes forgotten impact of receiving IJ citations, because in our law practice we are seeing more IJs cited by DHSR and, more importantly, more citations at FTag 490, which then prompt the Board of Examiners to request an explanation from the Administrator. So, if you happen to find yourself in that unpleasant situation, remember these tips:

1. If you receive an IJ citation, you will receive a letter from the Board of Examiners asking for an explanation and response.
2. When you receive such a letter, don't panic, but also don't bury it on your desk and engage in avoidance. It won't go away. The Board typically allows ample time to respond to such letters, usually at least two weeks or more. That schedule is driven by the meeting schedule of the Board's Standards of Practice Committee and the time committee members need to receive and review both the CMS 2567 and your response letter. But, trying to throw together a response at the last minute is not wise.
3. If you plan to seek assistance from counsel in responding to a Board letter, which many Administrators do, then as soon as you receive your Board letter, get the letter and the CMS 2567 that prompted it, and your facility's Plan of Correction, to your attorney as soon as possible to allow time to review the survey report, talk with you and prepare the response.
4. In most cases - but not all - the Plan of Correction you filed for your facility, along with some additional explanation, will become the core of your response to the Board of Examiners, but each case is different and you'll want to present your best case to the Board.
5. If you receive an IJ citation at FTag 490 for Administration, remember that this brings heightened attention from the Board of Examiners and thus warrants a strong response on your behalf.
6. Situations where the facility has been cited for both FTag 490 (Administration) and FTag 520 (Quality Assurance) present additional considerations since these two citations together, if accurate, can suggest issues with leadership and facility systems. Both of these citations should be addressed in your response letter to the Board.
7. Finally, if you are asked to appear before the Board's Standards of Practice Committee, don't go alone. Bring competent counsel, because such a request means there are some serious concerns by the Standards of Practice Committee and you need to come fully prepared to respond to them and reassure the Committee of your professional competence.