

# Sunflower Connection



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## Adequate Repositioning

**Question:** Is standing a resident up from a wheelchair for a few seconds and then sitting them back down in the same position considered adequate repositioning since pressure was relieved for only a few seconds and the resident was put back in the same position? If this is considered adequate repositioning, how often should staff do this?



**Answer:** Just for some clarity first, is the patient on an adequate support surface in the wheelchair?

A few seconds of off-loading is insufficient for reperfusion based on references used in last webinar. Kloth and McCulloch state that for the seated individual it is recommended to off-load the ischial tuberosities for 1 min every 15 min and micro-shifts of 10 to 15sec are not sufficient. In reality the practice at the bedside (based on my literature review for my part of recent webinar) is a 1 min off-load every 30 to 60 min while seated, given the patient is on an appropriate support surface in the wheelchair.

*From the National Pressure Ulcer Advisory Panel Directors Michelle Deppisch and Joyce Black*

*Residents assessed to be at risk for developing pressure ulcers must have an individualized turning and repositioning program. The standard of practice is every 2 hours, some residents may need a change in position more frequently and some may not need it as often.*

*There must be evidence in the clinical record to support the reason why a facility is extending the time between changes in positions. From the KDADS Staff*

## Long Term Care Advance Payment

**A message to providers and stakeholders regarding long-term care advance payment**

You are no doubt aware that the Kansas Department of Health and the Environment (KDHE) has been experiencing delays in processing applications for Medicaid benefits. Until these delays are resolved, KDHE has agreed to issue advance payments to qualified long-term care providers that submit advance payment requests for specific applicants who are awaiting an eligibility determination.

To submit an advanced payment request, the long term care (LTC) facility will use the current status-inquiry process to provide KDHE with a list of their applicants who have a pending determination for Medicaid eligibility.

- The facility will flag each of the applicants for whom they are requesting an advance.
- Only application dates older than 60 days will be considered.
- Priority will be given to smaller facilities versus large, corporate-owned facilities.

Within 15 days KDHE will complete a high-level triage of the applicants to determine their probability of becoming eligible.

KDHE will then calculate the amount of the advance payment. This payment will be paid at 50 percent of the calculated monthly payment, which is based on the beneficiary's number of days/months in the LTC facility and the LTC daily rate.

KDHE will send a Payment Agreement letter to each LTC provider for signature. This letter will identify the advance payment amount, the option of paper or EFT payment, the terms for repayment and information about the provider ( KMAP provider number, TIN number, MCO provider numbers and daily rates).

When the signed LTC Payment Agreement letter is returned to KDHE, the LTC advance payment will be processed.

Once eligibility is approved and payment starts on behalf of a beneficiary, the advance payments will be collected by the MCOs on claims submitted by the LTC provider for that beneficiary. KDHE will apply all payments associated with the specific beneficiary to the reimbursement of the advance first.

If the applicant is denied eligibility, the agency will request a refund of the advance payment. The refund must be returned within 30 days of the date of the request. If the advance payment is not returned to the agency within 30 days, KDHE will direct the MCOs to collect the advance payment from any current disbursement due to the provider.



## New Regional Manager for the Northeast Region

**Kim Barnes is the Regional Manager for the Northeast Region.**



**Kim comes to us with a wide variety of experience in Nursing and Management.**



**Kim has been working at KDADS for the past 3 years as a Health Facility Surveyor**

*"I am excited, honored, and humbled by the opportunity to assume the role of Regional Manager for the NE region of KDADS. I believe in KDADS mission to foster an environment that promotes security, dignity and independence for all Kansans. And, I look forward to making NE Kansas my new home." - Kim Barnes*

### Here is her contact information:

Kim.Barnes@kdads.ks.gov  
612 S. Kansas Ave.  
Topeka, KS 66603  
Office: (785) 296-1256  
Fax: (785) 296-0256



## KDADS Complaint Program/Hotline staff changes

**MaryJane Kennedy,**  
Complaint Coordinator  
retired on March 24, 2016.



**Caryl Gill, RN, BSN**  
will be taking MaryJane's place.

Your E-mail communications should now be sent to the three staff below.

- 1) [caryl.gill@kdads.ks.gov](mailto:caryl.gill@kdads.ks.gov)
- 2) [ernie.beery@kdads.ks.gov](mailto:ernie.beery@kdads.ks.gov)
- 3) [marla.myers@kdads.ks.gov](mailto:marla.myers@kdads.ks.gov)

Please share this information with any of your staff who needs to know.

# ASK JOHN (EASLEY)



**JOHN EASLEY**  
is A PHYSICAL  
ENVIRONMENT  
SPECIALIST for KDADS

### Question:

When does a facility need to inform the state when changes are being made?

**Answer:** KAR 26-39-101, Licensure. (e) Additions and renovations. (1) The licensee shall submit on copy of final plans by a licensed architect to be in compliance with the regulations:

The definition of renovations is very general. This is seen as any structural changes, or any changes beyond cosmetic changes, such as paint or floor coverings. Any relocation of walls, plumbing, electrical, etc.

Additionally, KAR 26-39-101, Licensure. (f) Change in use of a required room or area. If an administrator of operator changes resident bedrooms, individual living units, and apartments used for an alternative purpose back to resident bedrooms, individual living units, and apartments, the administrator or operator shall obtain the secretary's approval before the change is made.

If a required room is relocated, modified, or changed the administrator or operator needs to notify the state agency.





# MDS 3.0



<p><b>Q:</b> Resident admitted skilled on Thursday 2/25, therapy evaluated her on Friday 2/26, no therapy on Saturday and Sunday. On Monday she decided to move to another facility so therapy did not see her. On Tuesday she was still here and said she was moving today. What assessments should I do?</p>	<p><b>A:</b> Do Entry record, 5 day assessment and Discharge assessment. An EOT is not needed because she is not in a therapy RUG.</p>
<p><b>Q:</b> If a resident has a problem on admission, what date do you use for the problem (the admission date or date of the 14 day)?</p>	<p><b>A:</b> The problem date is the date the problem was identified. This date does not change. If the problem was identified on admission, then the problem date is the date of admission.</p>
<p><b>Q:</b> A 60 day assessment was done 9/10/15. On 10/10/15 it was noted a COT was missed that was due on 9/17/15. A combined 90/COT was done on 10/10/15. Does the default payment end 10/3/15 or 10/13/15 the end of the 60 day payment window?</p>	<p><b>A:</b> The default payment would cover the number of days the late COT was out of compliance or until the next intervening assessment used for payment, whichever is first (pages 6-54 &amp; 6-55). In this case the AAA days will end when the 90/COT takes over payment on 10/4/15.</p>
<p><b>Q:</b> For Section I, if a resident has a diagnosis of COPD but the doctor says it is stable – no meds or treatment given during the look-back period – would it be considered an active diagnosis.</p>	<p><b>A:</b> For a diagnosis to be coded active you need that diagnosis from the physician in the last 60 days but you also need, in the 7 day look-back period, documented symptoms, abnormal lab or x-ray results, treatment or meds for the condition or increased nursing monitoring. If you don't have some of these you cannot code it. (Pages I-7 &amp; I-8)</p>
<p><b>Q:</b> COT date is 3/24. The resident is going out for eye surgery that day and may not return until 3/25. If they are out overnight, is it a Medicare skip day/LOA? Do I still have to do the COT?</p>	<p><b>A:</b> While the Medicare skip day moves the PPS day count forward, it does not impact the unscheduled assessment. Therefore, if the COT is due 3/24 and the resident is on a skip day, the COT is still required. If the resident were discharging on 3/24 then the COT would not be required.</p>
<p><b>Q:</b> Resident admitted 1/17 and discharged home 1/21. Therapy evaluated on 1/18 and treated on 1/19 and 1/20. No therapy was done on day of discharge 1/21. Does this qualify for a Short Stay since no therapy was done on 1/21?</p>	<p><b>A:</b> If therapy was not provided because all therapy services had been discontinued, then short stay would not apply. If the resident was still on therapy caseload and therapy expected treatment to continue but treatment was not given on the day of discharge for an unexpected reason, such as unexpected discharge, then a short stay is appropriate and you put dashes in the rehab end dates.</p>
<p><b>Q:</b> How far back can a modification be done on an assessment?</p>	<p><b>A:</b> Assessments can be modified for up to 3 years.</p>
<p><b>Q:</b> EMS was wheeling a resident on a stretcher when the stretcher wheel caught the curb, tilted, and landed on its side. The resident was still strapped in, but their thumb and forehead hit the ground resulting in a fractured thumb. Is this considered a fall or was it caused by an “overwhelming external force”?</p>	<p><b>A:</b> So the stretcher with the resident on it fell and parts of the resident hit the ground causing an injury. Basically, the resident was dropped. It is similar to a situation in which a resident is dropped while being transferred via a mechanical lift. There was no over whelming external force as defined in the manual – that would mean that the person was pushed by another person, hit by a car, something like that.</p>
<p><b>Q:</b> If a resident goes on Part A services and then goes off but is staying, do we have to do a COT if it's on a check point day to reset the payment?</p>	<p><b>A:</b> If the COT checkpoint is on the last covered day and the RUG would change, the COT is required. (Page 2-52)</p>
<p><b>Q:</b> Resident is on Hospice services and Sig Change has been done. She fell and went to the hospital, she further declines d/t her current condition. Do I need to do another Sig Change?</p>	<p><b>A:</b> See page 2-25 in the manual: “If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.”</p>

## Intro to the CARE Staff

Effective January 19, 2016, **Ellen H. Bartz, RN, MS** assumed the position of CARE Program Manager. She replaced Sue Schuster. Ellen's background includes working in the prison system for 14 years, and working as a State Surveyor in the Survey, Certification and Credentialing Department. She oversees the development, implementation and monitoring of activities for the CARE Level I and Level II programs.

### Her team includes



**Terry Fogle**, who replaced Galen Rhodes in September 2015 after starting with KDADS in June. Terry gathers medical records and distributes determination letters for the level II screens. You can contact him at 785.291.3360.



**Sharon Dabzadeh** who has worked for the state for 32 years. She is responsible for Terminal Illness notifications, Resident Reviews and tracking of less than 30-day provisional request. She can be contacted at 785.296.6295.



**Mary Woltje, RN** who transferred from the Survey, Certification and Credentialing Commission on March 14 where she worked in the complaint department. She works part time and will provide assistance for the full time staff members.

*Jessie McFarland retired on January 29, 2016 and currently has not been replaced.*



**Ellen Bartz and Mary Woltje** who are covering her position. Jessie input Level I's into KAMIS, and reviewed the Terminal Illness and request for less than 30-day provisional stays, before giving to Sharon to log-into the system. Please call 785.296.0387 with and questions.



# Step Up Your RUG Classifications

By Michelle Synakowski, LNHA, C-NE, RAC-MT,  
a policy analyst and consultant with LeadingAge New York.

## Routinely Monitor temps



A feeding tube by itself is a qualifier for Special Care Low; a tube feeding with a fever is Special Care High.

Pneumonia by itself qualifies for Clinically Complex; pneumonia with a fever is Special Care High.

Capturing a fever can make a difference of \$50 to \$60 a day.

## Assess for shortness of breath while lying flat

COPD does not result in a significant RUG score usually qualifies them for a Reduced Physical Function category (about \$200 a day). If the resident has COPD and also has shortness of breath while lying flat they will qualify for a Special Care High (ranges from about \$350 to \$480 a day).

It is important to do a true assessment. Documenting the results of the assessment in the progress notes is critical. You need that documentation to support the coding of the MDS.



## Differentiate between septicemia and UTI

UTI is not a RUG qualifier. Add Septicemia and the resident will qualify for a Special Care High versus Reduced Physical Function category.



## Be more flexible scheduling PPS assessments

Some staff are very rigid in setting ARDs. If they move that ARD to an other date within the ARD window, they might capture other things that are higher RUG qualifiers. Some want the ARD to fall on a COT in order to make their lives easier. Maybe they should think, "If I choose this date I get the best RUG score."





## 2016 - Zero Deficiency Surveys

The following facilities received “zero” deficiencies on their 2016 survey.

**SNF / NF:** Skilled Nursing Facility **ADC:** Adult Day Care **HP:** Home Plus  
**ALF:** Assisted Living Facility **RHCF:** Residential Health Care Facility

Facility	City	Type	Survey Date
The Meadows	Burlington	ALF	1/5/16
Reflection Living Maize Ct 1	Wichita	HP	1/7/16
Country Living Inc	Anthony	ALF	1/12/16
Guest Home Estates III	Chanute	RHCF	1/13/16
Reflection Living Maize Ct 2	Wichita	HP	1/14/16
Meadowlark Adult Care Home 2	Wichita	HP	1/20/16
Cypress Springs - Kansas City	Overland Park	RHCF	1/26/16
Neuvant House of Lawrence	Lawrence	ALF	1/28/16
Brookdale McPherson	McPherson	ALF	2/2/16
Independent Living	Smith Center	BCH	2/4/16
Brookside Retirement Assisted Living	Overbrook	ALF	2/9/16
Kelly House of Meridien South	Meriden	HP	2/11/16
Guest Home Estates VII	Garnett	RHCF	2/15/16
Residencies at Pleasanton	Pleasanton	RHCF	2/15/16
Guest Home Estates IV	Pittsburg	RHCF	2/17/16
Midland Care Lawrence Adult Day Health	Lawrence	ADC	2/17/16
Bethel Home	Montezuma	SNF/NF	2/23/16
Care Haven Homes - Fontana	Overland Park	HP	2/24/16
Vintage Park at Hiawatha LLC	Hiawatha	ALF	2/25/16
The Forum at Overland Park (RHCF)	Overland Park	RHCF	3/2/16
The Homestead of Leavenworth	Leavenworth	ALF	3/2/16
Vintage Park at Baldwin City LLC	Baldwin City	ALF	3/2/16
Vintage Park at Tonganoxie LLC	Tonganoxie	ALF	3/7/16
Peggy Kelly House I	Topeka	RHCF	3/10/16
Peggy Kelly House II	Topeka	RHCF	3/17/16

**Let's Celebrate!**

**ZERO**

