KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Sunflower Connection

http://www.kdads.ks.gov/AdultCareHomes/Newsletters/Newsletter_Index.html

January 2014 Volume 10, Number 4

Ask Al

Question: Does KDADS need to be notified of all facility construction, new and remodeling projects?
Answer: Yes. Prior to a facility beginning new construction or an addition, or remodeling that involves structural elements, the administrator or operator must send a letter of intent to Rita Bailey, Licensing Administrative Officer, and receive approval of the project. Structural changes may include removing a weight-bearing wall. When any wall is removed, the architect needs to send a letter to Al Gutierrez, Environmental Specialist, stating whether the wall is weight bearing or not. Remodeling projects that involve cosmetic changes such a painting and replacing carpet does not require notification and approval from KDADS. However, facilities are encouraged to notify Al about the project so the agency can respond appropriately if any complaints are received about paint or carpet glue odors in the facility. His e-mail is al.gutierrez@kdads.ks.gov.

Question: When do you do the final construction inspection?
Answer: According to K.A.R. 26-39-101, Licensure (d) New construction or conversion of an existing unlicensed building to an adult care home (4) (B) and (e) Additions and renovations (2) (B), the licensee shall submit to the department a 30-day written notice of the date on which the architect estimates that all construction will be completed. The written notice needs to send to Rita Bailey, Licensing Administrative Officer. Her e-mail is rita.bailey@kdads.ks.gov. In addition, the licensee and the architect need to complete and resolve all items from their own internal final inspection (punch-list) before KDADS does the final inspection. The punch-list needs to be sent to Al Gutierrez.

Kansas Department for Aging and Disability Services

Regulatory Update

State
KAR 26-40-303(h)(1)(G)
(i) The nursing facility shall be equipped with a system that records activated calls.
(ii) A signal unanswered for a designated period of time, but not more than every three
minutes, shall repeat and also be sent to another workstation or to staff that were not designated
to receive the original call.

All facilities should make sure that their system meets these requirements; a call light if un- answered should be transferred to another staff person after 3 minutes.

Federal
CMS has issued a new Survey and Certification letter that addresses Cardiopulmonary Resuscitation.

S&C: 14-01-NH - A facility must have CPR certified staff at all times

Facility policy should specifically direct staff to initiate CPR when cardiac arrest occurs for residents who have requested CPR in their advance directives, who have not formulated an advance directive, who do not have a valid DNR order, or who do not show AHA signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC). Additionally, facility policy should not limit staff to only calling 911 when cardiac arrest occurs. Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest in accordance with that resident's advance directives or in the absence of advance directives or a DNR order. CPR-certified staff must be available at all times to provide CPR when needed.

Please see below CMS responses related to S&C 14-01 CPR Certification and Expectations of Staff:

Question 1: As there are two types of CPR certification, does CMS expect the certification to be for the Healthcare providers class or will certification for lay persons class be accepted?

CMS would expect that nursing home staff who are CPR certified would maintain CPR certification for health care providers. CPR for health care providers does include AED instruction, however, CMS recognizes that not all facilities have AEDs. If surveyors find that they need to verify CPR certification of any staff during a survey, they should ascertain that the certification is current and is for health care providers.

Question 2: A provider representative asked what the expectation for CPR is if residents are out on a bus trip (for example) with facility staff who currently are not certified in CPR. Their nurses are the ones who are CPR certified but they do not accompany residents on these trips.
CMS would expect that nursing home staff who are CPR certified would maintain current certification in CPR for health care providers. We would also expect facility staff would provide CPR to residents (as appropriate) when residents are on facility outings.

Facilities must not establish and implement facility-wide no CPR policies

Please go to this link to read the full guidance.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-01.pdf

Enhanced PEAK 2.0 for FY 2014-15

In the two years since release of PEAK 2.0, KDADS has learned a lot about culture change and person-centered care in Kansas nursing homes. As a result, the program is being revamped in keeping with the philosophy that culture change is a journey. Successfully reaching milestones and continuing efforts toward person-directed care will drive recognition and incentives. More details will be forthcoming.

But for now - The Kansas Department of Aging and Disability Services in partnership with the Kansas State University Center on Aging announce the release of PEAK 2.0 for fiscal year 2014-15. Among other things, the program includes some new enhanced features based on experience and feedback with homes currently enrolled in the program.

Applications are now being accepted and will continue to be accepted through April 30, 2014 for those homes that wish to participate. If your home is currently not enrolled in the program, we urge you to get involved.

Those currently enrolled in the program should continue on the PEAK 2.0 track that you are currently on. Your home will need to re-enroll in the program to continue by filling out and following the instructions on the application. Enrollment simply verifies your intent to continue with PEAK 2.0 and updates the KCCI assessment. The KSU Center on Aging (ksucoa@gmail.com or 785-532-2776) staff can address any questions you have about your standing and next steps in the program.

Here is how to apply:
Go to the following website:
http://www.he.k-state.edu/aging/outreach/peak20/

Click on the APPLY NOW link.
Follow ALL the instructions on the application.

Once you have completed all application steps, your home will receive a confirmation email that your application has been accepted.

Your incentive payment and program work will occur between July 1, 2014-June 30, 2015.

Questions: Contact the PEAK 2.0 team at (785) 532-2776 or ksucoa@gmail.com

Reporting Allegations of Abuse, Neglect, Misappropriation and Injuries of Unknown Source to KDADS

The Centers for Medicare & Medicaid Services released Survey & Certification Letter 05-09 in December 2004. This letter, "Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation" has been and continues to be the standard for reporting allegations of ANE to KDADS. The Decision Trees created by the survey commission at KDHE prior to 2004 are no longer effective. The guidance contained in the S & C Letter applies to all certified nursing facilities. The Letter can be accessed on CMS' website at:

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf

Summary of Regulation Changes

The Kansas Department for Aging and Disability services reviewed and revised a number of CNA and CMA regulations earlier this year. The new regulations became effective July 1, 2013. Below is a summary of the significant changes.

1. Medication aides will have one year from the date their medication aide certification expires to take a refresher course. If the course is not taken within one year of the certification expiration date, the entire medication aide course must be retaken.
2. An individual must be 18 years of age to be certified as a medication aide. This requirement does not restrict individuals' ability to enroll in a medication aide course.
3. Health Occupations Credentialing will no longer issue certification cards for nurse aides, home health aides or medication aides. Any required certification information is available on the Kansas Nurse Aide Registry at www.ksnurseaidregistry.org . There is no federal or state requirement that an individual possess a

Continued on page 4.

physical certification card only that they are listed on the state nurse aide registry with a certification which is active and with no prohibitions.

4. Changes in requirements for nurse aide instructors are as follows:

a. Each nurse aide course must have a designated course supervisor that meets the following requirements:

(1) Be licensed to practice as an RN and have no pending or current disciplinary actions against that individual's license;

(2) Have at least two years of full-time licensed nursing experience, which shall include at least 1,750 hours of licensed nursing experience in an adult care home or a long-term care unit of a hospital; and

(3) Meet at least one of the following requirements:

(A) Completed a course in adult education;

(B) Completed a professional continuing education offering on supervision or adult education;

(C) Taught adults; or

(D) Supervised nurse aides.

b.When seeking approval as a course supervisor, the person shall submit a completed course supervisor application to the department at least three weeks before offering an initial training course and shall have obtained approval from the secretary before the beginning date of that training course.

c.Each instructor who does not meet the long-term experience requirements shall meet the following requirements:

1. Be licensed to practice as an RN and have no pending or current disciplinary actions against that individual's license;
2. Have at least two years of full-time licensed nursing experience;
3. Have completed at least seven hours of professional continuing education offerings on person-centered care in an adult care home or a long-term care unit of a hospital not more than one year before becoming an instructor of the nurse aide training course and each year while serving as an instructor; and
4. Meet at least one of the following requirements:

(A) Completed a course in adult education;

(B) Completed a professional continuing education offering on supervision or adult education;

(C) Taught adults; or

(D) Supervised nurse aides.

d. Any supplemental instructor may provide training in a subject area of the supplemental instructor's healthcare profession if that person has skills and knowledge in the subject area, has at least one year of full-time experience in that person's healthcare profession, and is under the direct supervision of the course supervisor or instructor.

e. One person may serve as both course supervisor or instructor, if the person meets the qualifications of the designated positions as specified in subsections (a) and (c).

5. Demonstration of initial competency Task Checklist must be completed at the end of Part I and demonstrated to an RN meeting the criteria outlined in (a) and (c).

Below is the link to the regulations.
http://www.kdads.ks.gov/HOC/Regulations/regs.html

From the MDS Corner

The new rule of 3 as of 10/1/2013:

- The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.
- The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
  - Code 0, Independent – only if resident completed the ADL activity with no help or oversight every time the activity occurred during the 7-day look-back period and the activity occurred at least 3 times.
  - Code 4, Total Dependence – only if resident required full staff performance of the ADL activity every time the activity occurred during the 7-day look-back period and the activity occurred at least 3 times.
  - Code 7 - only if the activity occurred fewer than 3 times during the 7-day look-back period.
  - Code 8 – only if the activity did not occur or family &/or non-facility staff provided the care 100% of the time.

Instructions for the Rule of 3:

When an ADL activity has occurred 3 or more times, apply the steps of Rule of 3 below (keeping the ADL coding level definitions and the above exceptions in mind) to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the 1st instruction encountered that meets the coding scenario (e.g., if #1 applies, stop & code that level).

1. When an activity occurs 3 or more times at any level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurred 3 or more times.
3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any 1 level, apply the following:

   (a) Convert episodes of full staff performance to weight-bearing assistance when applying the Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when every episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur 3 or more times or full staff performance that is provided 3 or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).
   (b) When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times – code extensive assistance (3).
   (c) When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total 3 or more times – code limited assistance (2).

IF NONE OF THE ABOVE ARE MET, CODE SUPERVISION.

SCENARIO EXAMPLES

1. During the look-back period, Mr. X required guided maneuvering 2 times. 4 times, he required the staff assist. During these 4 times, the staff had to physically assist him. The appropriate code is 3, Extensive assistance.

Rationale: He required limited assistance 2 times and extensive assistance 4 times. The ADL activity component occurred 3 or more times at 1 level, extensive – thus, this weight-bearing assistance is the highest level of dependence identified that occurred 3 or more times

2. Mrs. C required verbal cueing for hand placement 4 times and 3 times she required weight-bearing assis-

Continued on page 6.

tance. She completed the activity without assistance 14 times. The 4 times she required verbal cueing are considered supervision. The 3 times the staff had to physically assist her are considered weight-bearing assistance. The appropriate code is 3, Extensive assistance.

Rationale: Because the ADL activity occurred 3 or more times at multiple levels, the scenario meets the second Rule of 3 and you will apply the most dependent level that occurred 3 or more times.

3. Mrs. F was in the nursing home for only 1 day prior to transferring to another facility. 2 times staff provided weight-bearing assistance and 1 time they provided full staff assistance. This component of the ADL activity where assistance was required occurred 3 times in the look-back period, but not 3 times at any one level. Based on the Rule of 3, the final code is Extensive assistance (3).

Rationale: The ADL activity occurred 3 times in the look-back period. 2 times staff provided weight-bearing assistance and 1 time staff provided full staff assistance. The first Rule of 3 doesn't apply because it did not occur 3 times at any 1 level. The second Rule of 3 doesn't apply because it did not occur 3 or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred 3 times at multiple levels but not 3 times at any 1 level. Sub-item "a" under the Rule of 3 says to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time.

4. Mr. N was sent to the hospital the 2nd day he was at the facility. The following assistance was provided: Weight-bearing assistance 1 time, non-weight-bearing assistance 1 time and full staff performance 1 time. He was independent 1 time. The final code is Limited assistance (2).

Rationale: The first Rule of 3 and the second Rule of 3 does not apply. The third Rule of 3 applies because the activity occurred 3 times and at multiple levels but not 3 times at any 1 level. Sub-item "a" instructs providers to convert full staff performance to weight-bearing assistance. So there are 2 weight-bearing episodes and 1 non-weight-bearing episode. The 3rd sub-item "c" under the 3rd Rule of 3 applies because there is a combination of full staff performance/weight-bearing assistance and/or non-weight bearing assistance that total 3 times.

5. Mr. S was independent 18 times during the look-back period. The other 2 times he required non-weight-bearing assistance. The appropriate code is Supervision (1).

Rationale: The ADL activity occurred 20 times; non-weight-bearing 2 times and 18 times he was independent. The 1st, 2nd, and 3rd Rules of 3 do not apply so Supervision is the appropriate code.

The best way to code ADL activities appropriately is to use The Rule of 3 instructions found in Chapter G; page G-5 in your RAI Manual. Another useful tool is the ADL Self-Performance Algorithm found in Chapter G; page G-7.

Coding Instructions for Therapies as of 10/1/2013:

- Individual minutes – Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. Enter 0 if none were provided. Individual services are provided by 1 therapist or assistant to 1 resident at a time.
- Concurrent minutes – Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Enter 0 if none were provided. Concurrent therapy is defined as treatment of 2 residents at the same time, when the residents are NOT performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the therapist/assistant for Med A resident. For Part B, residents may not be treated concurrently.
- Group minutes – Enter the total number of minutes of therapy that were provided in a group in the last 7 days. Enter 0 if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other residents. For Med B, treatment of 2 or more residents at the same time is documented as group treatment.

Continued on page 7.

- Co-treatment minutes – Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Enter 0 if none were provided.
- Days – Enter the number of days, therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes (individual +concurrent+ group).
- Therapy Start Date – Record the date the most recent therapy regime (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption on the resident's EOT OMRA, in cases where the resident discontinued and then resumed therapy.
- Therapy End Date – Record the date the most recent therapy regime (since the most recent entry) ended. This is the last date resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

This information is found in Chapter O starting on page O-16 in the RAI Manual.

Distinct Calendar Days of Therapy as of 10/1/2013:

Enter the number of calendar days that the resident received Speech, OT, or PT for at least 15 minutes in the past 7 days. If a resident receives more than 1 therapy discipline on a given calendar day, this may only count for 1 calendar day for purposes of coding.

Examples:

Mrs. T received 60 minutes of PT on Mon, Wed, and Fri within the 7 day look-back period. Mrs. T also received 45 minutes of OT on Mon, Tues, and Fri during the 7 day look-back period. This would be coded as 4 days (Mon, Tues, Wed, and Fri).
Mr. F received 120 minutes of PT on Mon, Wed, and Fri within the 7 day look-back period. He also received 90 minutes of OT on Mon, Wed, and Fri during the 7 day look-back period. He then received 60 minutes of ST on Mon and Fri. This would be coded as 3 days (Mon, Wed, and Fri).

This is found in Chapter O, pages O-32 and O-33 in the RAI Manual.

From CMS Recent MDS 3.0 and SNF PPS Assessment Issues/Responses

COT OMRA and Distinct Calendar Days

Issue: A few people have written in to question/comment on the new language in the manual associated with the COT OMRA, specifically the language on page 2-50, which states:

"Required when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment."

The issue that has been raised is that a resident might be in one of the upper therapy classifications (Rehab High, Very High, or Ultra High) and might no longer qualify for one of these RUGs due to not having 5 distinct days of therapy services. Additionally, the resident may not qualify for Rehab Medium (due to the distinct calendar day item) or for Rehab Low (due to the absence of Restorative Nursing). As such, the resident would only qualify for a non-therapy RUG. Given the aforementioned rule for when a COT OMRA can be completed, this would mean that a resident could not be reclassified into a rehab RUG until the next scheduled assessment or at a point where the resident qualifies for an SOT OMRA.

The question that has been asked is if this is a correct interpretation of the rules and if this was intended by CMS.

Response: First, it is important to point out that the new language in the manual is not a departure from previous COT policy, but rather CMS's attempt to

Continued on page 8.

bring the clarification memos issued at the outset of FY 2012 into the actual manual text. Specifically, in the clarification memo posted to the CMS website on November 29, 2011, which was a clarification tied to the discussion of the COT OMRA on the National Provider Call that occurred November 3, 2011, it states the following:

"Additionally, as noted in Section 2.9 of the MDS RAI manual, the ARD for a COT OMRA may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's current RUG-IV therapy classification."

That the COT could not be the first assessment to establish a resident's RUG-IV therapy classification is a policy that has existed since the outset of the COT OMRA in FY2012.

That being said, this is a proper understanding of the rules and a COT OMRA cannot be completed for a resident that has fallen out of a rehab RUG. Further, it was always the intention of CMS that the COT OMRA should not be the initial assessment which establishes the resident's RUG-IV therapy classification.

Combining COT OMRA and first assessment with therapy RUG

Issue: A question has been asked if the COT can be combined with the first assessment to establish a resident's therapy RUG, as the manual states that the ARD for the COT cannot "precede" the ARD of the assessment which establishes the resident's current therapy classification.

Response: If a COT is combined with the first assessment which establishes a resident's current therapy RUG, then this would mean the COT would be effective at a time when the resident was not classified into a therapy RUG on a prior assessment. This is precisely what is not permitted to be done with the COT OMRA. Therefore, this type of combination is not permissible.

Scheduled Assessment ARD outside the Benefit

Issue: We have received some questions about what happens if a scheduled assessment ARD is set for a skip day. Per the language on page 6-55, which states that a provider may not set the ARD for a scheduled PPS assessment for a day outside the Part A benefit (i.e., 100 days), providers want to know if this means that the assessment is billed at default for days out of compliance (as is done with early/late assessments) or if this assessment is considered a missed assessment.

Response: Scheduled PPS assessments with an ARD outside the benefit are not valid assessments, and therefore do not represent an early or late assessment. As such, in cases where a scheduled PPS assessment has an ARD outside the benefit, and is not a case where modification may be used appropriately to correct the error, then the corrective plan is as follows:

1. If the window for the scheduled assessment is still "open" the provider may move the ARD to any valid day in the window and complete the scheduled assessment timely.

2. If the error is discovered after the window for the scheduled assessment has "closed" but prior to the end of Medicare Part A coverage, the provider may complete a new scheduled MDS using the date the error was identified as the ARD. In this case, default would apply for the number of days the ARD was out of compliance.

3. If the error is not identified until after Medicare coverage had ended, the scheduled assessment is not valid and should be inactivated. Since in this case Medicare coverage has ended prior to identifying the error, there is no remedy and provider liability applies to any covered days related to this assessment.

When an unscheduled assessment is combined with a scheduled assessment, the provider must follow the rules associated with the scheduled assessment. As such, a combined scheduled/unscheduled assessment with an ARD outside the benefit is not a valid assessment. In such cases where the combination is not

Continued on page 9.

an error that may be corrected through modification, the assessment must be inactivated and a new assessment completed.

Coding for K0710A and K0710B

Issue: We have received some questions on the coding for items K0710A and K0710B, specifically for column 3. The question is on how to code this column in cases where the "past 7 days" includes time in both the hospital and the SNF.

Response: To clarify the manual in such cases, we might consider adding something like the following example to the manual in a future iteration. RAI coordinators should be aware of this understanding of how to code these items. It should be noted that the example below uses K0710B, but the same coding and rationale could be used for coding K0710A.

Mr. K. has been able to take some fluids orally, however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

While in the hospital:
Monday= 400 cc
Tuesday= 520 cc
Wednesday= 500 cc
Thursday= 480 cc

While in the nursing home
Friday= 510 cc
Saturday= 520 cc
Sunday= 490 cc

Coding: K0710B1 would be coded 1, 500 cc/day or less. K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident.

The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore code 2, 501 cc/day or more is correct for K0710B2, While a Resident.

The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days.

Unscheduled Assessment ARD on LOA Day in Scheduled Assessment Window

Issue: A question has arisen regarding how to set the ARD for a scheduled assessment that was to be combined with a COT but an LOA results in the ARD of the COT being outside the resident's benefit period. An example appears below:

A resident is classified on the 5-day assessment for RVA, with an ARD of Day 8. The 14-day assessment ARD is scheduled for Day 15, to be combined with a COT because the resident's therapy increased in the past 7 days and the resident now qualifies for RU. Resident goes on LOA to the ER and is gone at midnight on Day 15. Staff must still complete the COT that is due on what was Day 15, because LOA days have no effect on COT.

The question that arises here is whether or not the 14-day assessment ARD can be scheduled for either the new Day 15 or later in the 14-day ARD window. The reason this question is raised is because the instruction in Section 2.10 states the following:

"If an unscheduled PPS assessment (OMRA,

Continued on page 10.

SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required…A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window…"

Response: Based on discussions among CMS and the RAI panel, the consensus is that it would not be appropriate to say that the ARD for the unscheduled assessment, in this case a COT OMRA, falls within the scheduled assessment window. As the unscheduled assessment ARD falls on a skip day that is non-billable and does not count against the resident's benefit, the unscheduled assessment ARD does not occur within the scheduled assessment window. Therefore, the 14-day assessment ARD may be set for any day within the available ARD window, including days that follow the unscheduled assessment ARD.

Coding for Item A0410

Issue: We have received a number of questions on the appropriate coding for item A0410. The question is what criteria should be used to guide the coding for item A0410 and what criteria should be used to guide the decision to submit an assessment to the QIES ASAP system.

Response: As noted on page A-8 of Chapter 3 of the MDS manual, the coding instructions for item A0410 are as follows:

Code 1, neither federal nor state required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does not have authority to collect MDS information for residents on this unit. If the record is submitted, it will be rejected and all information from that record will be purged.

Code 2, State but not federal required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the state has authority, under state licensure or other requirements, to collect MDS information for these residents.
Code 3, Federal required submission: if the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.

The primary question that must be asked when coding A0410 is whether or not the resident is in a Medicare and/or Medicaid certified unit, regardless of payer.

So if the unit is Medicare and/or Medicaid certified, even if the resident is private pay or paid for through Medicare Part C (i.e., a Medicare Advantage Plan or Medicare HMO), always code 3. If the unit is not Medicare and/or Medicaid certified, but a state requirement exists that requires the assessment to be completed, then it would be coded as 2. If the unit is not Medicare or Medicaid certified and no state requirement exists, then code 1.

In terms of submitting an assessment, page 5-1 of the MDS RAI manual provides the clearest direction, where it states:

"Nursing homes are required to submit Omnibus Budget Reconciliation Act required (OBRA) MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS)."

If the reason the assessment is being completed is not one of these reasons, then the assessment should not be submitted to the QIES ASAP system, regardless of how A0410 is coded.

What is the National Partnership to Improve Dementia Care in Nursing Homes?

On March 29, 2010, CMS launched a national partnership with the mission to improve quality of care provided to individuals with dementia living in nursing homes. This focuses on the delivery of care that is person-centered, comprehensive, and interdisciplinary in the addition to protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual. The partnership promotes rethinking approaches that are utilized in dementia care, reconnecting with people using person-centered care approaches, and restoring good health and quality of life. CMS is partnering with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve dementia care. The partnership promotes a multidimensional approach that includes public reporting, national partnerships, and state-based conditions, research, training for providers and surveyors, and revised surveyor guidance.

The Advancing Excellence in America's Nursing Homes Campaign has offered, via their website at www.nhqualitycampaign.org to make available a variety of resources and clinical tools to assist nursing homes achieve the goals of this partnership. Nursing homes are encouraged to review the resources and tolls and select those that will be most useful.

Voluntary stakeholder coalitions organize partnership activities in each state. Coalition membership varies, but often includes the QIO, survey agency, LeadingAge affiliate, nursing home professional associations, resident advocacy groups, state office or division on aging, nursing homes, hospitals, and individuals.

The National Partnership to Improve Dementia Care in Nursing Homes emphasizes non-pharmacological, person-centered, evidence-based practice approaches for resident, such as stronger family involvement, consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities. Utilizing a consistent process to address the behaviors associated with dementia that focuses on the resident's individual needs, will help reduce the percentage of antipsychotic medications that are prescribed.

Currently Kansas ranks 44th in the nation in reducing the percentage of antipsychotic medications prescribed. This proves that Kansas must work hard to reduce antipsychotics and improve the quality of life for our elders with dementia who live in our facilities.

Award Letters

Facility	City	Type	Date	Exemplary	NO DEF CERT/LET
Conser House	Overland Park	ICF/MR	4/2/13		x
Caritas Center, Inc	Wichita	NF	4/4/13		x
Country Place Senior Living of Clay Center	Clay Center	ALF	4/11/13		x
Garden Villas of Lenexa	Lenexa	ALF	4/23/13		x
Mary Martin's Retirement	Wichita	BCH	4/25/13		x
Manor of the Plains	Dodge City	SNF/NF	4/29/13	x	
Comfort Care Homes Inc #219	Wichita	RCHF	4/30/13		x
Shawnee Heartland	Shawnee	ALF	5/1/13		x
Vintage Park at Lenexa LLC	Lenexa	ALF	5/2/13		x
The Autumn Place Memory Care Unit	Columbus	RCHF	5/7/13		x
Kenneth L. Caldwell Assisted Living Manor	Wichita	ALF	5/8/13		x
Bickford at Mission Springs II	Mission	ALF	5/22/13		x
Comfort Care Homes Inc #6505	Wichita	ALF	5/22/13		x
The Sweet Life at Shawnee	Shawnee	RCHF	5/30/13		x
Country Place Home Plus of Scandia	Scandia	HP	6/12/13		x
Parkwood Village	Pratt	ALF	6/13/13		x
Sterling House of Abilene II	Abilene	ALF	6/18/13		x
Comfort Care Homes Inc #441	Wichita	HP	6/19/13		x
Eaglecrest Retirement Community	Salina	ALF	6/19/13		x
Dignity Care Home	Salina	RCHF	6/20/13		x
Gran Villas Atchison	Atchinson	ALF	7/9/13		x
Country Place Home Plus of Hoisington	Hoisington	HP	7/22/13		x
Moundridge Manor	Moundridge	NF	7/23/13	x	
Sterling House of Great Bend	Great Bend	ALF	7/23/13		x
Bethel Home	Montezuma	SNF/NF	7/24/13	x	
Sterling House of Wellington	Wellington	ALF	7/24/13		x
Comfort Care Homes Inc #147	Wichita	HP	7/25/13		x
Country Place Senior Living of Hoisington	Hoisington	ALF	7/25/13		x
Heritage Estates Assisted Living	Harper	ALF	7/25/13		x
Vintage Park at Neodesha LLC	Neodesha	ALF	7/25/13		x
Sterling House of Emporia	Emporia	ALF	8/1/13		x
Eagle Estates, Inc.	Independence	RCHF	8/15/13		x
Clare Bridge of Topeka	Topeka	ALF	8/22/13		x
Assisted Living at Windsor	Coffeyville	ALF	8/22/13		x

Continued on page 13.

Award Letters - Continued

Facility	City	Type	Date	Exemplary	NO DEF CERT/LET
Pleasant View Home	Inman	SNF/NF	9/19/13		x
Vintage Park at Eureka	Eureka	ALF	9/26/13		x
Comfort Care Homes #509	Wichita	HP	10/3/13		x
Vintage Park at Wamego LLC	Wamego	ALF	10/29/13		x
Marjorie's Home LLC	Wichita	HP	10/30/13		x
Reflection Living LLC	Wichita	HP	10/31/13		x
Vintage Park at Osawatomie LLC	Osawatomie	ALF	11/5/13		x
The Autumn Place	Baxter Springs	RCHF	11/19/13		x
Guest Home Estates IV	Pittsburg	RCHF	11/20/13		x
Sterling House of Fairdale	Salina	ALF	11/21/13		x
The Autumn Place	Columbus	RCHF	11/21/13		x

SNF/NF - Skilled Nursing Facility/Nursing Facility; ALF - Assisted Living Faciltiy; BCH - Boarding Care Home; ICF/ID - Intermediate Care Facility for Intellectually Disabled;
RHCF- Residential Health Care Facility; ADC- Adult Day Care; HP- Home Plus

ROUTING SLIP
Administrator_____ Nurse Manager ____ Therapy ____ DON _____
Assist. DON _____ Social Service Director ____ Break Room _____
Activities Director _____Dietary Manager ____ Human Resources _____
MDS Coordinator _____ Other _____