KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Sunflower Connection

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

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What Adult Care Homes Need To Know About Ebola

KDADS, in partnership with KDHE, wants to inform the Adult Care Homes about Ebola. This is to ensure the safety of our residents, their family members, employees, and visitors to the facility. It is highly advisable to assure your teams and staff are aware of the current outbreak occurring in West Africa, and risk factors, signs, and symptoms of Ebola so proper action can occur in the event of a suspected Ebola case.

Situation Update:

The 2014 Ebola epidemic is the largest in history, affecting multiple countries in West Africa, specifically Liberia, Sierra Leone and Guinea. There were a small number of cases reported in Nigeria and a single case reported in Senegal; however, these cases are considered to be contained, with no further spread in these countries.

One imported case from Liberia and associated locally acquired cases in healthcare workers have been. CDC and partners are taking precautions to prevent the further spread of Ebola within the United States. CDC is working with other U.S. government agencies, the World Health Organization (WHO), and other domestic and international partners and has activated its Emergency Operations Center to help coordinate technical assistance and control activities with partners. CDC has also deployed teams of public health experts to West Africa and will continue to send experts to the affected countries.

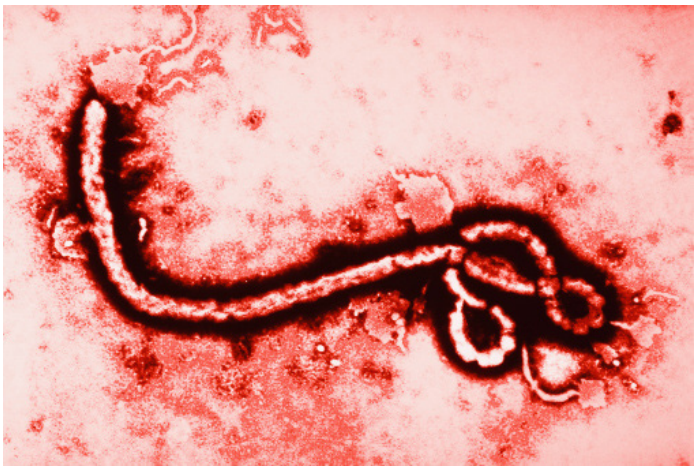
Continued on page 2.

Ebola can be transmitted from person to person by

- Direct contact with the blood or secretions of an infected person
- Exposure to objects (such as needles) that have been contaminated with infected secretions

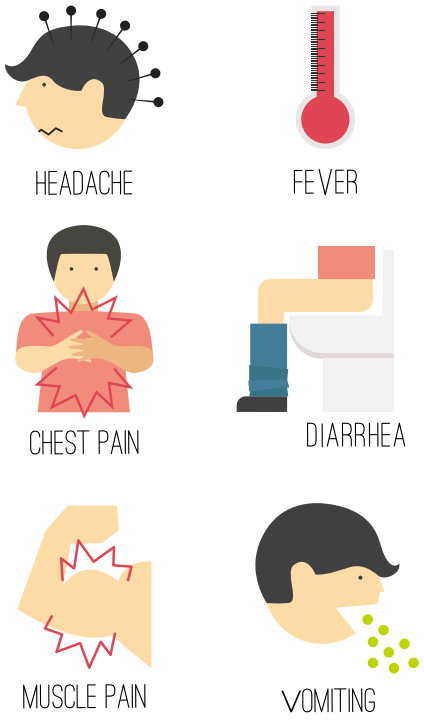
Ebola is **not** transmitted from person to person through the air, or water, food although some evidence suggests that bush meat (e.g. bats, other animals that we do not usually eat in this country).

Adult Care Homes need to be aware if employees, residents' family members, or visitors have traveled to or resided in one of the affected countries within the previous 21 days. If this happened a Risk Assessment must be conducted by KDHE, local health department, or a consultant with KDHE or local health department. Each adult care home will need to determine what policy/procedure will work for them to gather this information.



Close up of Ebola virus

Signs and Symptoms



Some people may also experience:

- Rash
- Red eyes
- Hiccups
- Cough
- Sore throat
- Chest pain
- Difficulty breathing
- Difficulty swallowing
- Bleeding inside and outside the body

*Symptoms of Ebola typically begin 2-21 days after exposure to an infected individual.

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Report all suspected Ebola cases within four (4) hours to the KDHE Epidemiology Hotline: 877-427-7317

What Is Expected

Long term care facilities should focus prevention efforts on early recognition of suspected cases or contacts with cases. This can be done by assessing travel history for new residents and staff. Please notify KDHE of any suspected cases by calling the Epidemiology Hotline at 1-877-427-7317.

Educate your staff on the current Ebola outbreak, including which countries have active outbreaks. Additionally inform staff remind staff of your Infection Control Policy and Procedures and i Include your residents in some of this education.

For more details, go to:

CDC: http://www.cdc.gov/vhf/ebola/index.html

KDHE: http://www.kdheks.gov

Shawnee Public Health Department: http://www.shawneehealth.org/index.aspx?NID=64

Facility Statistical Reports

This is just a friendly reminder that it's time once again to complete the Facility Statistical Reports (Part I and II). On January 2, 2015 the Facility Statistical Reports will be available on the Facility Home Page. Both reports are to be completed and submitted by January 30, 2015.

Personal resident alarms: More protection or more risk?

Not all alarms are equally important. Critical alarms, such as those on ventilators and smoke detectors are essential. Likewise, alarms on intravenous pumps and exit doors are often necessary. But, what about bed and chair alarms, also known as "personal alarms"?

Prior to the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the use of physical and chemical restraints in long-term care facilities was widespread. Following OBRA '87's focus on quality of care and enhanced enforcement actions, the use of restraints diminished while the use of bed and chair alarms grew exponentially. The primary purpose of bed and chair alarms is to alert staff to a potential fall when a resident attempts to get out of bed or up from a chair. Bed and chair alarms are typically pressure sensitive devices placed in beds, chair pads and wheelchair seats that respond to changes in pressure with a warning signal. Other alarms are wearable or can be attached to a resident's clothing, programmed to activate when the person attempts to move a certain way or beyond a certain distance.

However, the widespread use of personal alarms may not be justified, and, in some cases, may be more of a liability burden than a resident benefit. Surveyors frequently ask whether alarms are used and incorporated into the care plans of residents who either fell or are at risk for falls. There is no shortage of cases where the failure of an alarm to function properly resulted in a deficiency and a civil money penalty (CMP) imposed by the Centers for Medicare and Medicaid Services (CMS). In the 2008 case JFK Hartwyck at Oak Tree v. CMS, Administrative Law Judges held that "alarms that were not working properly would not have constituted adequate assistance devices as required." More pointedly, said judges in the 2005 case Birmingham Nursing & Rehabilitation Center—East v. CMS: "Once [the facility] opted to utilize an alarm to protect the resident, it assumed the responsibility of making sure that the alarm worked properly." Apart from concerns about survey deficiencies, facilities need to examine if alarms are more of a problem than a solution.

Approximately 1,800 nursing home residents die each year as a result of falls, according to Falls in Nursing Homes, published by the Centers for Disease Control and Prevention (CDC). The CDC notes that the "typical nursing home" with 100 beds reports between 100 and 200 falls each year, and of those falls, 10–20 percent are associated with serious injuries.

Research published in the Journal of Nursing Care Quality suggests that little evidence exists to demonstrate that alarms prevent falls. On the contrary, evidence is growing that personal alarms create confusion, anxiety and adversely affect the quality of life of residents. Worse, alarms can be counterproductive by fostering a false sense of security for staff and creating a reactive rather than proactive paradigm.

"While alarms seem like a possible intervention to reduce the incidence of falls, they have not been effective in most cases. They have, in fact, actually contributed to unsafe environments and resulting incidents," says Beryl Goldman, PhD, RN, NHA, director of Kendal Outreach and the outreach leader for the Food and Drug Administration's Hospital Bed Safety Workgroup. "Staff often depend on the sound of the alarm to notify them that a person is getting out of a bed or chair but, by the time they get to the resident, the person has already gotten up and landed on the floor," Goldman notes. "Alarms often exacerbate situations, scaring a resident into moving even faster and then falling."

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ALARM ELIMINATION PROGRAMS

In order to eliminate bed and chair alarms, facilities must have effective fall risk and prevention programs. A fall risk assessment begins at admission and includes a history of falls as well as risks related to medications, functional limitations, gait and balance abnormalities, mental status, orthostatic hypotension, underlying pathology, neurological conditions and environmental factors. The nature, frequency and causes of falls should be examined and documented as well as potential post-fall complications.

Any program aimed at eliminating bed and chair alarms must be thoroughly developed with input by clinicians from the medical director to certified nurse aides. A multidisciplinary approach is essential. Experts in the area of falls suggest a two-tiered approach, explains Laurence Rubenstein, MD, MPH, professor and chairman in the Donald W. Reynolds Department of Geriatric Medicine, University of Oklahoma College of Medicine. "Every nursing home needs a standardized fall prevention program with environmental safety adaptations as well as a systematic approach to assessing risk factors in individual residents," Rubenstein says. "The benefits of bed alarms have not been proved."

However, the benefits of eliminating alarms may be compelling. A Massachusetts facility was able to systematically eliminate resident alarms while experiencing a 32 percent reduction in its quarterly average for falls, according to data from the Massachusetts Quality Improvement Organization (QIO). In Connecticut, "nursing homes that have become alarm-free have reported a reduction in both falls and falls with injuries," says Ann Spenard, vice-president of operations at Qualidigm, which has been the Connecticut Medicare QIO for thirty years.

Sue Ann Guildermann, director of education at Empira, Eden Prairie, Minn., has been helping facilities to become alarm-free. She oversaw a project at 16 facilities that eliminated their alarms within a three-month period and says the facilities experienced a reduction in falls. Guildermann stresses the importance of performing a root-cause analysis to determine what factors contributed to a fall. The root cause of a fall is not because a resident moved, she says; "the root cause is that the resident has a need, a need that set the alarm off." She suggests that caregivers ask, "What was the resident's need [and] what was the resident doing just prior to the alarm going off?"

The American Medical Directors Association (AMDA)—The Society for Post-Acute and Long-Term Care Medicine offers a Falls and Fall Risk Clinical Practice Guideline (CPG). Barbara Resnick, PhD, CRNP, FAAN, professor at the University of Maryland School of Nursing, has conducted several studies utilizing that CPG, which she co-authored. Her results showed that falls decreased significantly and consistently following the implementation of the guidelines.

Based on her research, Resnick stresses the importance of exercise and maximizing residents' physical and mental conditions in order to help prevent falls and says she "strongly support[s] a move towards eliminating bed and chair alarms in the long-term care setting."

PROBLEMS ASSOCIATED WITH BED AND CHAIR ALARMS

Personal alarms can create a host of unwanted complications, because they:

- Can create a false sense of security
- Can promote a reactive rather than proactive approach to falls
- May be inactivated by residents
- May fail through weak batteries or mechanical damage
- Can make an environment seem institutional instead of home-like
- Can create fear, confusion or agitation, especially in residents with dementia
- May reduce activities of daily living and functional status of residents
- May interfere with resident dignity
- May interfere with sleep, which contributes to agitation and decreased balance

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- "Alarm fatigue" leads to staff desensitization and caregiver frustration
- May increase survey deficiencies related to alarms
- May actually lead to increase in falls and serious injuries

It is imperative not only to determine the obvious cause but to perform a root-cause analysis for falls. For example, if a resident fell while attempting to walk to the bathroom at night, look beyond the fall itself. Determine if diuretics, increased fluid intake prior to sleeping or a urinary tract infection played a role. Consider whether lighting levels or clutter on the floor may have contributed, or whether gripper slippers or a walker should have been used.

Not all falls are avoidable and some residents will continue to fall—with or without bed and chair alarms and in spite of a facility's best efforts. For those residents, an anticipatory approach is recommended. Interventions such as keeping the bed in the lowest position, placing mats on the floor adjacent to the bed and providing hip protectors may reduce injuries.

Preventing falls in the long-term care setting requires a substantial and sustained interdisciplinary team effort. Towards that goal, the time has come to rethink the appropriateness of bed and chair alarms and to utilize more effective, evidence-based methods of reducing falls and fall-related injuries while enhancing resident dignity and quality of life.

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The Incredible Edible (Pasteurized) Egg

In this article, KDADS reviews the core message of a recent CMS guidance document which clarifies when it is acceptable for long-term care facilities to serve their residents soft-cooked, undercooked or sunny-side up eggs.

Question: What safeguards are facilities expected to have in place when honoring a resident's request for an "over easy", "soft-cooked", "sunny-side up" or "soft fried" egg?

Answer: The Centers for Medicare & Medicaid Services (CMS) issued an advance copy of revised F371 mid-2014.1 The new guidance plainly says:

- Only ***pasteurized*** shell eggs or liquid ***pasteurized*** eggs may be prepared soft-cooked, undercooked or sunny-side up by a nursing facility;
- Unpasteurized shell eggs when cooked to order for resident consumption must be cooked until both the yolk and white are completely firm, and served immediately; and
- It is not acceptable to have a resident (or his/her representative) who requests to be served undercooked eggs sign a release agreement form.

This guidance recognizes FDA Food Code and CDC food safety guidance as national standards to procure, store, prepare, distribute, and serve food in long-term care facilities in a safe and *sanitary manner. Currently, both FDA and CDC strongly advise against* serving unpasteurized, undercooked eggs to highly susceptible populations, including people who reside in long-term care facilities.

Nursing facilities can safely honor resident choice, while meeting these national standards, through the use of pasteurized eggs. Organizational policies on egg storage, handling and preparation should be in-place and reviewed with food employees during new employee orientation and in-service training as appropriate.

To access the advance copy of revised F371, go to: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

CMS also issued an advance copy of Appendix PP-guidance to surveyors on July 3, 2014 related to S&C policy memo 14-34.2

Shell egg pasteurization requires the egg to have been subjected to a 5-log kill process for Salmonella Enteritidis.

References

1. REF: S&C 14-34-NH. Advance Copy of Revised F371; Interpretive Guidance and Procedures for Sanitary Conditions, Preparation of Eggs in Nursing Homes, issued May 20, 2014
2. REF: S&C 14-37-NH. Advance Guidance – Revisions to State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long-Term Care (LTC) Facilities and Chapter 4, issued July 3, 2014

A1900 Admission Date (Date this episode of care in this facility began)

An episode of care begins on the original admission to the facility and ends when one of the following occurs: discharge with return not anticipated, discharge with return anticipated but does not return for more than 30 days or death. And episode can include multiple stays. A stay begins with an entry/reentry and ends with a discharge event (may be with return anticipated).

Example:
Episode of care in this facility begins 1/1
Resident discharges to the hospital on 3/1 (end of stay) and returns 3/4
Resident discharges to hospital on 7/3 (end of stay) and returns on 7/9
Resident discharges home with return not anticipated on 10/1 (end of stay and end of episode of care in this facility)

Episode of care in this facility was 1/1 to 10/1

PASRR CARE Program Updates

New staff:

The CARE program would like to officially introduce our new team member working in our CARE Specialist position. **Sharon Dabzadeh** has joined our CARE team as of November 10th. Sharon will be in contact with many of you in the course of completing her job duties. She will be working with 30 day provisional issues, Terminal Illness Letters and contacting nursing homes with regard to Resident Reviews for residents with a temporary Level II Determination Letter. Sharon has a long history with KDADS and formerly worked processing payments to nursing homes among other duties. A phone number for Sharon is 785-296-6295.

PASRR and Medicaid Payments:

The CARE staff has fielded numerous calls re: payment issues related to PASRR not being in place. To assist nursing homes to understand how your payment may be impacted by PASRR/CARE we review the following:

1-Any building licensed as a NURSING HOME in the state of KS and certified to accept Medicaid as a payment source MUST complete PASRR (in some version) for each admission.

Remember: **PASRR is NOT dependent on the payment source of any resident**: doing the process is dictated **by the way your BUILDING is licensed and certified**.

The CARE program should not be receiving calls telling us a resident is "*on Medicare so we didn't have to do the CARE assessment*," or "*the resident is private pay so we didn't need a CARE assessment*." Any building operating in this fashion puts itself at risk in (3) areas:

1. The building is not in compliance with Federal PASRR law and can receive citations at survey time as such; and
2. Many nursing home residents deplete their funds and need Medicaid to supplement their payment for nursing home care at some time during their stay in the building. Medicaid is NOT available as a payment source for the care of any resident until PASRR is complete; and
3. The building is running the risk of accepting a resident into their care that may have ID/DD/MI needs. Once the person has admitted, not only is the building out of compliance with federal regulation and cannot receive Medicaid payment for the care of the resident, but you will also be unaware of the special needs required to care for a person requiring a Level II PASRR screen and specialized services in support of these needs while in your care. As such you may be cited for not meeting the needs of the resident as well.

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Please make sure each resident in your building has a completed PASRR process in their file. This will be either a Level I CARE assessment certificate, a Level II Determination Letter, a Terminal Illness Letter or a 30 day provisional on file at KDADS with your building calling for a Level I timely if the person is unable to discharge within the 30 day window.

A word about the 30 day provisional:

Nursing homes have been allowed to admit residents for up to 30 days without a CARE Level I ONLY for the purpose of 30 days or less **of respite or rehabilitation**. Every resident entering your building from a hospital SHOULD NOT BE coming 30-day provisional. Please visit with any hospital doing it and give our office a call if the hospital will not comply with CARE Level I requirements.

The next issue we deal with is nursing homes with skilled and rehabilitation units who admit people for a short term stay **without completing and forwarding a "30 day provisional" request to be documented at KDADS**.

The discharging hospital must forward, at the time of admission, discharging orders stating the admission is for a period of 30 days or less, the physician (or "physician extender" – i.e. PA, ARNP, APRN) must sign it (can be signed electronically), and the stay must be for the purpose of rehabilitation from the condition for which the person was hospitalized. Persons may also admit under the 30 day provisional for "respite care as well."

The 30 day provisional admission is considered a categorical determination under PASRR law and allows the nursing home to access Medicaid payment should it be needed to supplement payment for the care of a resident. **Without this in place**, if a person who was admitted under "skilled" status should be discharged from skilled -or has no other payment source at day 20 after Medicare no longer covers the cost of care at 100% - the nursing home will be unable to receive Medicaid payment until a Level I CARE assessment is completed. The ADRC's have been instructed to wait until day 20 to agree to complete a Level I assessment for a 30 day provisional admission to avoid unnecessary assessments on persons who may discharge prior to day 30.

Requests for payment under a "30 day provisional" prior to a CARE assessment being completed can only be honored when the building staff complete Sections A and B of the Care Level I assessment and forwards it to KDADS CARE staff along with the discharge information specifying a stay of 30 days or less with physician signature. Once that is "on file" at KDADS -if a person qualifies for Medicaid payment through DCF- KDADS will return information upon request from DCF allowing Medicaid payment for those initial 30 days.

Please remember: **KDADS does NOT authorize Medicaid eligibility**. DCF completes Medicaid eligibility. KDADS CARE Level I does assess for a level of care score that then becomes the basis for determining **FUNCTIONAL eligibility ONLY for the Medicaid program**. If a person should have the functional criteria to be eligible for Medicaid but DCF determines the person not to be eligible FISCALLY, Medicaid payment will not be available for nursing home care for that individual.

For this reason **KDADS discourages the practice** of attempting to call either KDADS or your ADRC and request a "level of care" score for a person admitting to your nursing home. Functional eligibility does NOT mean the person will be eligible for Medicaid payment. The person will work with DCF to determine whether Medicaid will be available as a payment for their care.

Ask Al

Question: What are the regulations for a nursing facility requesting a section or a wing to convert into a special care unit and who do we call at the Kansas Department for Aging and Disability Services for advice?

Answer: The facility must follow state regulations KAR 28-39-160. Other resident services. (a) Special care section… (9) The facility shall provide a substation for use by the direct care staff in the special care section. The design of the substation shall be in accordance with the needs of the special care section and shall allow for visibility of the corridors from that location. (10) Staff in the section shall be able to observe and hear resident and emergency call signals from the corridor and nurse substation. (11) The facility shall provide living, dining, activity, and recreational areas in the special care section at the rate of 27 square feet per resident, except when residents are able to access living, dining, activity, and recreational areas in another section of the facility.

It is also recommended for the facility to call Al Gutierrez, environmental specialist, who will discuss the state regulatory requirements for remodeling a special care unit. To contact Al, he can be reached at 785-296-1247 or Al.Gutierrez@kdads.ks.gov

Question: What is the nursing facility regulation for the nurses' workroom or area to view the corridors outside the resident rooms?

Answer: According to KAR 26-40-302 and KAR 26-40-303 (e) Resident unit care support rooms and areas. (1) Nurses' workroom or area. (B) The nurses' workroom or area shall be located so that the corridors outside resident rooms are visible from the nurses' workroom or area. The nursing facility may have cameras and monitors to meet this requirement.

Question: What is the regulation for heated surfaces in nursing facilities?

Answer: According to KAR 26-40-304 (b) Details (8) Heated surfaces. (A) Each heated surface in excess of 100° F with which a resident may have contact shall be insulated and covered to protect the resident. (B) If heated surfaces, including cook tops, ovens, and steam tables, are used in resident areas, emergency shutoffs shall be provided.

Taking Proactive Care of Skin

Taking proactive care of the body's largest organ is an extra challenge for older adults, whether it be on Worldwide Pressure Ulcer Prevention Day (Nov. 20) or any other day of the year. Everything from chair padding to eating habits, and cleansing products to bedding fabrics can play a role in skin breakdown.

Skilled nursing facilities need to take a holistic and multidisciplinary approach to residents' skin health, coordinating the efforts of shift nurses, nutrition teams, direct-care workers and primary care clinicians, says Martie Moore, RN, chief nursing officer at Medline, Mundelein, Ill., and a member of the National Pressure Ulcer Advisory Panel (NPUAP).

"It needs to be many hands, one team," Moore tells Long-Term Living. "The skin is the first line of protection from infection and injury, but it's also an organ you want to preserve and love, instead of viewing it as utilitarian. You want to exercise it like you exercise your heart or your brain."

FEEDING THE SKIN

Moisturizing is important, but nourishing healthy skin also is about a diet, fluid intake, proper vitamin balance, sunlight and activity. "Proteins are the building blocks of the skin, yet the majority of the elderly population is malnourished," Moore says.

External hydration is key, too, she adds. "Moisturizing is critical. You have to care for the skin from the inside and from the outside."

Don't forget the extremities, especially the feet, Moore adds, noting that special attention should be given to properly fitting footwear, good moisturization regimens and keeping a close eye on pressure points. "People forget about their feet. Some of the saddest ulcerations I've seen have been on the feet."

Pressure ulcers are ugly on both a visual and an emotional level. Residents experience agonizing pain, caregivers chastize themselves and families express outrage. But Moore says it's misleading to believe that pressure ulcers are an unfortunate fact of life in a nursing home.

"To some extent, I think there's still a bias that pressure ulcers occur with the elderly and that's just what happens. We still have a kind of acceptance that skin just breaks down," she says. "But when I work with families to educate them, they realize that we can work to prevent skin issues, just like we'd work to prevent heart issues."

Skilled nursing caregivers know that immobile residents must be turned on a regular basis to prevent their resting on the same pressure points for too long. But even ambulatory residents need to be reminded to "shift those cheeks" and change positions more often, Moore says.

"The body is programmed to move around and off-lift its pressure points," she says. "When people can't move around well anymore, you have to become that role."

For the first time, the NPUAP has joined forces with the European Pressure Ulcer Advisory Panel and the Pan Pacific Pressure Injury to develop new guidelines for pressure ulcer care and prevention. The new guidelines, which contain 575 evidence-based recommendations, are available via NPUAP's website. A 72-page quick reference guide also is available as a free download.

Extra obstacles

Aging skin is thinner and more fragile than younger skin, but older adults have some extra challenges, too. Any of these can affect skin health:

- Chronic diseases like diabetes and circulatory illnesses
- Medication interactions
- Poor diet and inadequate liquid intake
- Over-exposure or under-exposure to sunlight

Color is skin deep

The prevalence of pressure ulcers can vary based on race and ethnicity, notes a 2014 article in the Journal of Gerontological Nursing. In a study of pressure ulcers at Stages 2 to 4 among older nursing home residents, black residents experienced pressure ulcer rates 1.7 times higher than white residents. Rates for Hispanic residents fell in between. The research upheld findings from a 2004 cohort study, which also noted higher rates for black residents versus white residents.

Award Letters

Facility	City	Type	Date	Exempt	NO DEF LETTER
Clare Bridge of Wichita	Wichita	RHCF	1/9/14		x
Vintage Park at Paola LLC	Paola	ALF	1/14/14		x
Vintage Park at Osage City LLC	Osage City	ALF	1/14/14		x
Twin Oaks Assisted Living	Lansing	ALF	1/22/14		x
Meadowlark Adult Care Home 4	Wichita	HP	1/23/14		x
Cypress Springs - Kansas City	Overland Park	RHCF	1/27/14		x
Reflection Living Maize Ct 1	Wichita	HP	1/28/14		x
Reflection Living Maize Ct 2	Wichita	HP	1/30/14		x
Country Living	Anthony	ALF	2/3/14		x
Midland Care Lawrence Adult Day Health	Lawrence	ADC	2/3/14		x
Sterling House of McPherson	McPherson	ALF	2/3/14		x
The Homestead of Halstead	Halstead	ALF	2/3/14		x
Vintage Park at Baldwin City LLC	Baldwin	ALF	2/10/14		x
The Pines of Hiawatha South	Hiawatha	HP	2/11/14		x
Arkansas City Presbyterian Manor	Arkansas City	SNF/NF	2/18/14		x
Arkansas City Presbyterian Manor	Arkansas City	SNF/NF	2/18/14	x	
Sterling House of Junction City	Junction City	ALF	2/19/14		x
Marquis Place	Concordia	ALF	2/10/14		x
Keen Boarding Care Home	Clay Center	BCH	2/24/14		x
Rescare Home Plus	Winfield	HP	2/27/14		x
Country Living of Larned	Larned	ALF	3/4/14		x
Peggy Kelly House II	Topeka	RHCF	3/5/14		x
Glen Carr House #2	Derby	RHCF	3/5/14		x
Asbury Village	Coffeyville	RHCF	3/11/14		x
Haven House	Haven	HP	3/18/14		x
Parkview Care Center	Osborn	SNF/NF	3/27/14		x
Vintage Park at Hiawatha	Hiawatha	ALF	4/1/14		x
Comfort Care Homes of KC #7010	Overland Park	HP	4/2/14		x
Vintage Park at Waterfront LLC	Wichita	ALF	4/9/14		x
Prairie Homestead Assisted Living	Wichita	ALF	4/10/14		x
Marion Assisted Living LLC	Marion	ALF	5/1/14		x
Comfortcare Homes Millie's Place	Pittsburg	HP	5/8/14		x
Caritas Center, Inc.	Wichita	SNF/NF	5/14/14		x
Ft Scott Presbyterian Village	Ft Scott	ALF	5/20/14		x
Vintage Place of Russell	Russell	ALF	5/20/14		x
Cedarview Assisted Living	Hays	ALF	5/21/14		x
River Bend Assisted Living	Great Bend	ALF	6/5/14		x

Continued on page 11.

Award Letters - Continued

Facility	City	Type	Date	Exempt	NO DEF LETTER
Seniorcare Homes Hanover House	Overland Park	HP	6/4/14		x
Seniorcare Homes Waveny Park House	Overland Park	HP	6/4/14		x
The Homestead of Topeka	Topeka	ALF	6/9/14		x
Vintage Park at Tonganoxie	Tonganoxie	ALF	6/12/14		x
Cornerstone Assisted Living Inc	Wichita	ALF	6/18/14		x
Redbud Plaza Assisted Living	Onaga	ALF	6/23/14		x
Regent Park AL & Memory Care	Wichita	ALF	6/23/14		x
Rose Estates Assisted Living Community	Overland Park	ALF	6/30/14		x
The Homestead of Lenexa	Lenexa	HP	7/2/14		x
Heartland Haven	Inman	HP	7/8/14		x
Kenwood Plaza Inc	St. John	ALF	7/10/14		x
Village Estates	Nortonville	ALF	7/17/14		x
Majorie's Home LLC GP	Garden Plain	HP	8/7/14		x
MTM Boarding Care Home	McPherson	BCH	8/18/14		x
Comfort Care Homes Inc #641	Wichita	HP	8/21/14		x
Sterling House of Hays	Hays	ALF	8/21/14		x
Maria Court	Mulvane	ALF	8/26/14		x
Guest Home Estates II	Chanute	RHCF	8/28/14		x
Moundridge Manor	Moundridge	NF	9/11/14		x
Satanta District Hospital LTCU	Satanta	LTCU	9/24/14	x	
The Homestead of Olathe North	Olathe	ALF	10/30/14		x
Bethel Home	Montezume	SNF/NF	11/6/14	x	
Clearwater Village	Clearwater	ALF	11/13/14		x
Dignity Care Home	Salina	ALF	11/13/14		x
Vintage Park at Stanley LLC	Overland Park	ALF	11/26/14		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 _____