KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Sunflower Connection

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

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MDS Training Webinars

The MDS Training Webinars are recorded. The sessions that were presented in June are posted on the Providers website at this link:

http://www.aging.ks.gov/AdultCareHomes/Education_Info/Education_index.html

The right column has the recordings and the left column has the slide presentations that you can print.

Kansas Partnership for Improving Dementia Care

The Partnership now has a website at www.kpidc.org.

The website has contacts, resources, and useful links.

Date Marking and Disposition

In this article, KDOA provides a response to a food safety question about cold holding of ready-to-eat, potentially hazardous foods that are: (1) prepared on-premises and held for more than 24 hours; and (2) commercially processed, opened and held for more than 24 hours.

Question: Can food workers rely on the refrigerator and freezer storage chart found on this website when deciding whether to serve or discard refrigerated, ready-to-eat, potentially hazardous foods: http://www.fda.gov/downloads/Food/ResourcesForYou/HealthEducators/ucm109315.pdf

Answer: No. This and other similar storage charts – whether published by a federal food safety agency, university extension office or food manufacturer – are generally intended to provide guidance and tips to individual consumers.

A food worker must decide whether to serve or discard refrigerated, ready-to eat, potentially hazardous foods based on **date marking**.

Date marking is the mechanism by which the Food Code 2009 requires active managerial control of the temperature and time combinations for cold holding.[1] Food is controlled by date marking to ensure its safety based on the total amount of time it is held at refrigeration temperature and the opportunity for **Listeria monocytogenes** to multiply, before freezing and after thawing. [1]

This means food workers are required to clearly mark the date or day by which food that is held more than 24 hours must be consumed or discarded when held at a temperature of 5ºC (41ºF) or less, for a maximum of 7 days.[2] Date marking applies to:

- Food prepared and held
- Food prepared, frozen, and thawed and
- Containers of processed food opened by a food establishment, at the time it is opened and counting the day the original container is opened as Day 1. [2] The day or date marked may not exceed a manufacturer's use-by date if it was determined based on food safety. [2]

There are a few exceptions to date marking requirements. Deli salads such as ham salad, seafood salad, chicken salad, egg salad, pasta salad, potato salad and macaroni salad, *manufactured* in *accordance with 21 CFR 110* Current good manufacturing practice in manufacturing, packaging or holding human food are exempted from the date marking requirement.[3]

Even though potentially hazardous foods are not required to be date marked until the 24 hour mark, it is a good idea to mark all products when they are opened or prepared. This ensures compliance with date marking requirements and allows for proper product rotation.

The Food Code also specifies refrigerated, ready-to-eat, potentially hazardous food must be discarded if it:

- Exceeds the temperature and time combination (see above);
- Is in a container or package that does not bear a date or day; or
- Is appropriately marked with a date or day that exceeds a temperature and time combination. [4]

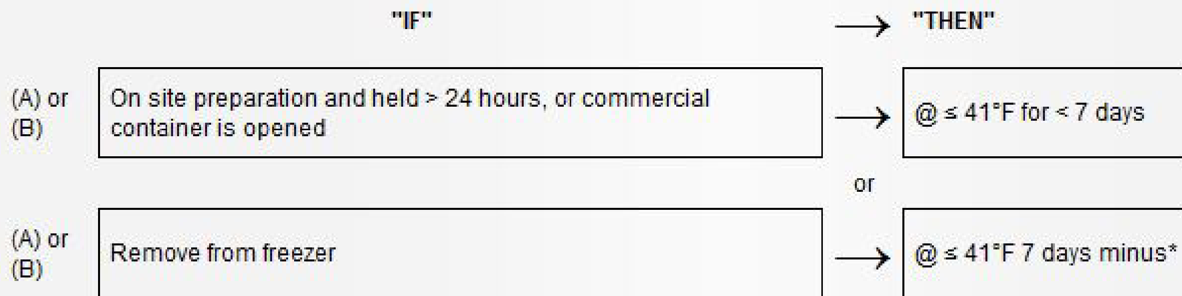
The date marking system adopted by a facility may use calendar dates, days of the week, color-coded marks, or other effective means.[5] The facility's operating procedures should ensure food workers are trained to use the date marking system that has been adopted. Training may employ educational tools such as the fact sheet published by the Kansas Department of Agriculture.

The best practice is to designate workers to check the refrigerators daily to ensure that all potentially hazardous foods in cold storage are date marked, stored at 5ºC (41ºF) or less for a maximum of 7 days, and discarded if the 7-day period has passed.

For an illustration and example of the date marking and disposition requirements contained in the Food Code 2009, see the chart [6] below:

Continued on page 3.

Chart 4-C Summary Chart Ready-to-Eat, Potentially Hazardous Food (Time/temperature, Control for Safety Food)
Date Marking § 3-501.17(A) – (E) and Disposition § 3-501.18



*Time from preparation, or opening commercial container, to freezing.

Example: The morning of October 1, a chicken was cooked, then cooled, refrigerated for 2 days at 41°F and then frozen. If the chicken is thawed October 10, the food must be consumed or discarded no later than midnight of October 14.

Date	Shelf Life Day	Action
Oct. 1	1	cook/cool
Oct. 2	2	cold hold at 41°F
Oct. 3		freeze
Oct. 10	3	thaw to 41°F
Oct. 11	4	cold hold
Oct. 12	5	cold hold
Oct. 13	6	cold hold
Oct. 14	7	consume or discard

REGULATORY TEXT:
1 FDA Food Code 2009. Annex 3 – Public Health Reasons / Administrative Guidelines – Chapter 3, Food. Subpart 3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking. Subpart 3-501.18 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Disposition.
2 FDA Food Code 2009. Chapter 3 – Food. Part 3-5 Limitation of Growth of Organisms of Public Health Concern. Subpart 3-501.17(A)-(B) Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking
3 FDA Food Code 2009. Chapter 3 – Food. Part 3-5 Limitation of Growth of Organisms of Public Health Concern. Subpart 3-501.17(F) Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking
4 FDA Food Code 2009. Chapter 3 – Food. Part 3-5 Limitation of Growth of Organisms of Public Health Concern. Subpart 3-504.18(A) Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Disposition.
5 FDA Food Code 2009. Chapter 3 – Food. Part 3-5 Limitation of Growth of Organisms of Public Health Concern. Subpart 3-501.17(D) Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking
6 FDA Food Code 2009. Annex 7 – Model Forms, Guides and Other Aids – 4) Summary information. Chart 4-C Summary Chart – Ready-to-Eat, Potentially Hazardous Food (Time/Temperature, Control for Safety Food) Date Marking 3-501.17(A)–(E) and Disposition 3-501.18.

RN coverage

F 354 CFR 483.30(b) states ….the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

A facility is in compliance with this requirement if they have services of a Registered Nurse 7 days a week for 8 consecutive hours. It is acceptable even if the shift the RN is working goes past midnight into the next day as long as the hours are consecutive and for 8 hours.

Ask Al

Question: In a Home Plus Facility is an address number required on the facility?

Answer: Yes. According to KAR 28-39-437 Construction; general requirements (d) General building exterior (4) Each facility house address number shall be posted on the exterior of the facility using at least three-inch-high numbers. Address numbers shall be posted on any mailbox located away from the facility.

Question: In a Home Plus Facility how many toilet rooms are required for 12 residents?

Answer: According to KAR 28-39-437 Construction; general requirements (e) General building interior (2) Toilet facilities (A) There shall be at least one toilet room with a lavatory, and a shower or tub, for each five individuals living in the facility. Therefore, three toilet rooms with a lavatory and a shower or tub are required for 12 residents.

Question: In an Adult Day Care Facility, what is the temperature for hot water?

Answer: According to KAR 28-291 Details and finishes (c) Mechanical requirements (2) Plumbing and piping systems (B) Water distribution systems shall be arranged to provide hot water at hot water outlets at all times. The temperature of hot water shall range between 98° F and 120° F at showers, tubs, and lavatories accessible to residents.

MDS Q & A

Q: Needing some clarification on resetting the 7 day rolling COT check on an EOT-R. Is day 1 of the next COT check the same day that therapy resumes (date entered in O450B) or is day 1 the day following what is entered in O450B?

A: The COT count starts on the day following the previous ARD in all cases, except in the case of the EOT-R. The EOT-count starts the day of resumption.

Q: Resident is discharging 4/28; that is also the ARD for COT which we already know will lower the RUG. Should the COT be combined with the DRNA?

A: See page 2-52 in the RAI Manual. It says "In cases where a resident is discharged from the SNF on or prior to Day 7 of the COT observation period, then no COT OMRA is required".

Q: Regarding ointments/medications M1200H; can barrier cream, A&D Ointment, and/or Eucerin cream or lotion be coded here?

A: Yes when they are specifically used to prevent or treat skin conditions. See RAI Manual page M-40.

Q: Can a resident be receiving skilled therapy services and be carried under Hospice at the same time? A respite stay under Hospice was admitted to facility (within a 30 day hospitalization) and the family wants her to receive skilled therapy for admitting diagnosis s/p hip fracture under Medicare A.

A: See Medicare Benefit A Policy Manual, Chapter 9, Section 20.3. It says "A beneficiary could be in a SNF under the SNF benefit for a condition unrelated to the terminal condition and simultaneously be receiving hospice for terminal condition."

Continued on page 5.

Q: Do I need to complete a Significant Change assessment if the resident was admitted and then canceled Hospice before the 14 days (in this case it was day 8)? Do I have to complete two Significant Change assessments for being admitted and discharged from Hospice?

A: No, you would not be required to complete a (or 2) SCSAs in this case. We have 14 days to determine whether a change is significant. The main reason a SCSA is required when a resident elects Hospice is to integrate the care plans with Hospice. In this case, the resident revoked Hospice in a week. I would enter a note in the medical record reporting the resident revoked Hospice prior to the 14th day from Hospice election so the SCSA will not be completed.

Q: In a short stay SNF, if a resident is admitted on 5/22 and only stayed an hour and went home AMA, do I still do a 5 day for that hour or just a DC?

A: The day can be billed, since the resident went home, but you wouldn't have much info to put on the MDS. With a stay less than 8 days, you can bill the day at the Default rate without having a 5 day.

Q: Part A resident went to the ER on day 20, was under observation for 48 hours and returned. Do I start a 5 day PPS or should I continue the previous schedule (30 day and skip 2 days due to the fact they weren't in the facility)?

A: Since they were at the hospital more than 24 hours, you must complete a Discharge MDS. Upon return, you must complete an Entry Tracking Form (reentry) and start the PPS schedule again at day 1 upon readmission.

Q: What is the rule about carrying over interviews for a COT? For example; a 14 day MDS was completed 7 days prior to the COT. Can the 14 day interviews be used for sections C and D?

A: When coding a COT, EOT, or SOT, the interview items may be coded using the response provided by the resident on a previous assessment only if the DATE of the interview responses from the previous assessment (as documented in Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (Z0400) for which those responses will be used.

Q: LTC resident was scheduled for a Quarterly assessment on 2/28, day 90. The resident went to the hospital on 2/11 and was out of the facility for 16 days. Resident returned within 30 days on 2/27 skilled. A Significant Change/5 day was done with ARD 3/6. When this was transmitted, got a message: current target date, edit type 3/6, Quarterly warning assessment completed late. What should I do?

A: When an OBRA assessment is due while the resident is in the hospital, you have 14 days after reentry to complete the assessment. The Quarterly requirement may be fulfilled by either a Quarterly or a comprehensive assessment. When the Significant Change was submitted, that requirement was met. The system always issues a warning in these situations just to remind you to check to make sure nothing is wrong.

Q: The resident was admitted 5/15 and therapy started 5/17. On 5/21, the resident decided to leave unexpectedly. Therapy did provide treatment on 5/21. This does not qualify for a Short Stay. Are we able to use the therapy minutes and count the day of discharge as a treatment day when coding? Would I combine a 5 day with a Discharge assessment for ARD with 5/21?

A: Yes, combine the 5 day with the Discharge since it was not a planned discharge.

Q: What should the ARD be of the DC MDS if the resident was admitted to the hospital while on a LOA? Is it the day the resident left the facility or the day they were admitted to the hospital?

A: The RAI Manual defines discharge as "the date a resident leaves the facility". See RAI Manual pages 2-9 and A-27.

Bed Alarms

Here is a study I ran across regarding the use bed alarms. It is interesting and makes s person stop and think.

GAINESVILLE, Fla. — Equipping hospital beds with alarms does not decrease patient falls and related injuries, according to University of Florida researchers and colleagues. The findings, published today (Nov. 20) in the Annals of Internal Medicine, cast doubt on the merits of the widely touted alarms as a patient safety tool.

"The idea that hospitals can magically eliminate the problem of falls by investing a lot of money and effort into bed alarms is not well-founded," said lead researcher Dr. Ron Shorr, a professor of epidemiology in the UF College of Public Health and Health Professions and College of Medicine and director of the Geriatric Research, Education and Clinical Center at the Malcom Randall Veterans Affairs Medical Center. "Does that mean bed alarms should never be used in hospitals? No — I think that alarms may have a use within the context of a well-developed fall prevention program."

Funded by the National Institute of Health's National Institute on Aging, the study adds to the sparse data that exist on the effectiveness of alarms in fall prevention in hospitals, and could help inform the design and application of fall-reduction strategies.

About one-quarter of falls among hospitalized patients result in injury, according to an analysis in the journal Clinics in Geriatric Medicine. Older adults are particularly at risk. Accidental falls lead to complications in 2 percent of hospital stays, according to various studies, including from the Agency for Healthcare Research and Quality. And falls extend hospital stays and raise treatment costs by more than $4,000 per patient, on average, according to an analysis in the American Journal of Medicine. In 2008, the Centers for Medicare and Medicaid Services stopped paying hospitals for excess costs incurred for treating injuries related to inpatient falls.

Bed alarms are thought to be useful in heading off falls by alerting staff when patients are attempting to move about unaided. And researchers acknowledge that some nurses point to alarms as a valuable tool based on their particular experiences.

Use of alarms also could potentially reduce the use of physical restraints, which have been shown to increase medical complications and, in some cases, actually raise the risk of falls and related injury. But despite widespread bed alarm use, a 2010 Cochrane Database of Systematic Reviews analysis found little evidence justifying the practice.

"The question is, if you're the chief nurse in a hospital, are you wasting your time buying these alarms for your units?" said Dr. David Oliver, an internationally noted geriatrics expert who is the national clinical director for Older People's Services in England's Department of Health. Oliver was not involved in the study.

To help answer that question, UF's Shorr and colleagues at the University of Tennessee and Vanderbilt University conducted a clinical study of almost 28,000 patients at Tennessee's Methodist Healthcare University Hospital. The 18-month study involved 349 patient beds in 16 general-medical, surgical and specialty units.

Units were randomly assigned to use commercial bed alarms or not. The alarm, made of weight sensors embedded into a flexible pad, could be placed on a bed, chair or toilet. When the patient's body broke contact with the sensor, a noise alerted the nurse. Patients did not know in advance whether they would be in units where alarm use was promoted, and neither did study personnel who assessed patient outcomes.

In one group, nurses were given educational materials and trained to use the bed alarms. Technical support providers also promoted use of the alarms and helped with setup and troubleshooting. In the second group, bed alarms were made available, but their use was not formally promoted or supported.

Continued on page 7.

Among nursing units where bed alarm use was encouraged, the use of alarms was almost 36 times higher than among other units. But the increased usage did not translate into a decrease in the overall rate or number of falls, fall-related injuries or physical restraints used.

"That says to me that if we are relying on only one intervention to prevent falls, it's very unlikely to be successful," said co-author Lorraine Mion, the Independence Foundation professor of nursing at Vanderbilt University School of Nursing. "We're not saying don't ever use bed alarms — we're saying that if you think this intervention in and of itself is going to take care of the problem, then you're sadly mistaken."

Not counting alarms, both sets of hospital units in the study had various fall-prevention techniques in place. So because the study did not strictly contrast alarm use with the absence of any fall-prevention strategy, the results must be interpreted cautiously, the researchers said. Also, studies in which individual patients rather than hospital units are randomly assigned to alarm use might help clarify the role of alarms.

"I don't think from the paper you could say definitively that alarms don't prevent falls," said Oliver, also a visiting professor of medicine for older people at City University, London. "The question has not been settled. There needs to be more research. You can see the jury is very much out on the use of alarms."

PASRR Level II Reminder

Please remember when considering the admission of a prospective resident with a Level II PASRR Determination Letter:

1-**There is no FFP available until PASRR is completed**. This means you **MAY NOT ADMIT** this resident <u>until the Determination Letter has been completed and faxed to you</u>.

Many of you have allowed hospitals or assessors to tell you they *have completed the assessment and the person is ready to admit*. This is NOT TRUE.

I have had some of you tell me, "*Well, Medicaid won't pay us but the person is coming "skilled" and Medicare will pay us; by the time we need anything from Medicaid the letter will be issued, so there is no problem*." **You need to REMEMBER**: <u>PASRR is not about how the payor source of the PERSON</u>: it is about how <u>YOUR BUILDING is certified and licensed</u>: you are required to follow Federal PASRR regulation if you are building that is licensed as a nursing home and certified to accept Medicaid payment.
Not following the regulation has the potential for repercussions from CMS on your Medicaid program.

2-**Here are results that can come from admitting someone prior to PASRR being completed**:

a-If Medicaid will be the payor source you will caring for the person **FOR FREE** until the PASRR Determination Letter is completed: <u>the date on the Determination Letter will be the date Medicaid will be allowed from the functional eligibility side if someone enters your building prior to PASRR completion</u>.
This is a Federal law and the state is unable to override it. This is due to the **PURPOSE of PASRR** being to **determine PRIOR TO ADMISSION** whether this resident will be in the least restrictive environment available to them when entering a nursing home.

b-You may receive a tag at survey when the team sees the admission date is prior to the date on the letter.

c-**PASRR programs will be audited soon**. We have had PASRR for over 20 years without a Federal audit; but when PASRR Technical Assistance Center completes their review of state PASRR programs shortly Federal audits will begin. If a person has been admitted to your nursing home out of compliance with Federal PASRR regulation and Medicaid has paid any portion of the cost of their care you need to realize it is possible that could be recouped from you back to the date of admission. The last such situation I am aware of that happened in Kansas was during a Federal audit of Medicaid and the nursing home was requested to return in excess of $90,000 for one person who had been in their building for many years without a Level I assessment.

d-This is perhaps the outcome with the most harm attached: you could admit a person whose Level II Determination is that "***Nursing Home or NFMH Level of care is NOT NEEDED***".
As a result you would have a person in your building for whom it has been determined you are an inappropriate level of care. There would be no payment received for the care of this person and you would be in a position of having to continue to care for the individual until you could locate and appropriately discharge to an appropriate placement.

Should the person be unwilling to move –remember- having ***already accepted*** this person- you would be in a situation of having an involuntary discharge that meets none of the acceptable reasons for doing so. It could be weeks or months before you would be able to appropriately discharge the person, all the while, no way to receive payment.

PLEASE – be sure you wait to ADMIT persons with a PASRR Level II assessment and Determination Letter until AFTER THE DETERMINATION LETTER is completed and sent to you.

2015 - Exemplary Facilities

Exemplary letters are awarded to facilities that have designated care programs resulted in exemplary resident care and quality of life outcomes

SNF/NF: Skilled Nursing Facility

LTCU: Long Term Care Units

Facility	City	Type	Date
Arkansas City Prebyterian Manor	Arkansas City	SNF	5/26/15

2015 - Zero Deficiency Surveys

Facility	City	Type	Date
The Homestead of Manhattan	Manhattan	ALF	1/8/15
Avita Senior Living at Derby	Derby	ALF	1/14/15
The Heritage of Overland Park	Overland Park	RHCF	1/14/15
Reflection Living of Hidden Lakes LLC	Wichita	HP	1/15/15
Meadowlark Adult Care Home 3	Wichita	HP	1/15/15
Sterling House of Great Bend	Great Bend	ALF	1/15/15
Seniorcare Homes Nantucket House	Overland Park	HP	1/21/15
Seniorcare Homes Newport House	Leawood	HP	1/22/15
Kelly House of Meriden North	Meriden	HP	1/28/15
Bridge Haven Memory Care Residence I	Lawrence	HP	1/29/15
Progressive Care Home Plus LLC	Alton	HP	2/3/15
Care Haven Homes - Overbrook	Overbrook	HP	2/5/15
Country Place Home Plus Scandia	Scandia	HP	2/5/15
Heart to Heart Home Plus	Pomona	HP	2/9/15
Guest Home Estates IV	Pittsburg	RHCF	2/10/15
Homestead of Augusta	Augusta	ALF	2/10/15
Alderbrook Village LLC	Arkansas City	ALF	2/12/15
Oakview Estates	Frontenac	RHCF	2/12/15
Vintage Park at Lenexa LLC	Lenexa	ALF	2/12/15
Seniorcare Homes Vineyard House	Overland Park	HP	2/17/15
Sunflower Meadows #2	Wichita	HP	2/17/15
Winter Meadow Home I	Topeka	HP	2/17/15
Pine Village	Moundridge	SNF/NF	2/24/15
Bridge Haven on Alvamar	Lawrence	HP	3/2/15
Comfort Care Homes Inc. #219	Wichita	HP	3/5/15

2015 - Zero Deficiency Surveys

Facility	City	Type	Date
Graystone Residential Care	Iola	RHCF	3/17/15
Arrowood Lane	Humboldt	RHCF	3/19/15
The Wheatlands	Washington	SNF/NF	3/30/15
Quaker Hill Manor	Baxter Spring	SNF/NF	4/2/15
Bickford at Mission Springs II	Mission	ALF	4/8/15
Bridge Haven Care Cottage	Lawrence	HP	4/8/15
Kenneth L. Caldwell Assisted Living Manor	Wichita	ALF	4/9/15
The Autumn Place	Columbus	RHCF	4/14/15
Shawnee Heartland Assisted Living	Shawnee	ALF	4/14/15
The Autumn Place	Baxter Spring	RHCF	4/21/15
Comfort Care Homes of Baldwin City	Baldwin City	HP	4/28/15
Sterling House of Abilene II	Abilene	ALF	4/28/15
Joy Home	Oxford	HP	4/30/15
Sug's Home Care	Conway Springs	HP	5/4/15
Vintage Park at Neodesha LLC	Neodesha	ALF	5/19/15
Asbury Village	Coffeyville	RHCF	5/21/15
Vintage Park at Osage City LLC	Osage City	ALF	5/21/15
Parkwood Village	Pratt	ALF	5/27/15
Vintage Park at Ottawa LLC	Ottawa	ALF	5/27/15
Stratford Home	Wichita	HP	5/28/15

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

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