

Sunflower Connection

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



October 2014

Volume 10, Number 6

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Press release: National Partnership to Improve Dementia Care exceeds goal to reduce use of antipsychotic medications in nursing homes: CMS announces new goal.

Date: September 19, 2014

The National Partnership to Improve Dementia Care in nursing homes, a public-private coalition, today established a new national goal of reducing the use of antipsychotic medications in long-stay nursing home residents by 25 percent by the end of 2015, and 30 percent by the end of 2016. The coalition includes the Centers for Medicare & Medicaid Services (CMS), consumers, advocacy organizations, providers and professional associations.

Between the end of 2011 and the end of 2013, the national prevalence of antipsychotic use in long-stay nursing home residents was reduced by 15.1 percent, decreasing from 23.8 percent to 20.2 percent nationwide. The National Partnership is now working with nursing homes to reduce that rate even further.

“We know that many of the diagnoses in nursing homes do not merit antipsychotics but they are being used anyway,” said Patrick Conway, M.D., deputy administrator for innovation and quality and the CMS chief medical officer. “In partnership with key stakeholders, we have set ambitious goal to reduce use of antipsychotics because there are

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– for many people with dementia – behavioral and other approaches to provide care more effectively and safely.”

Coalition members, including AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Health Care Association (AHCA), LeadingAge and Advancing Excellence in America’s Nursing Homes, are committed to achieving these new goals. The groups set these goals because they are challenging, yet achievable with the continued hard work of many stakeholders. These goals build on the progress made to date and express the coalition’s commitment to continue this important effort. The National Partnership seeks to optimize the quality of life for residents in America’s nursing homes by improving care for all residents, especially those with dementia.

“We have created many tools for nursing homes to use to help achieve these goals,” said Dr. Conway. “Ultimately, nursing homes should re-think their approach to dementia care, re-connect with the person and their families, and use a comprehensive team-based approach to provide care.”

While the initial focus is on reducing the use of antipsychotic medications, the Partnership’s larger mission is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices. CMS will monitor the reduction of antipsychotics as well as the possible consequences. For example, CMS will review prescriptions of anxiolytics and sedative/hypnotics to make sure nursing homes do not just replace antipsychotics with other drugs. In addition, CMS will review the cases of residents whose antipsychotics are withdrawn to make sure they don’t suffer an unnecessary decline in functional or cognitive status as a nursing home tries to reduce its usage.

Some states have achieved significant reduction in their rate of antipsychotic usage. For example, Georgia reduced its rate by 26.4 percent and North Carolina saw a 27.1 percent reduction. CMS released a fact sheet today with full state-by-state data as well as other data from the program.

CMS and its partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care and promote goal-directed, person-centered care for every nursing home resident. The Partnership has engaged the nursing home industry across the country around reducing use of antipsychotic medications with momentum and success in this area that is expected to continue. In 2011, Medicare Part D spending on antipsychotic drugs totaled \$7.6 billion, which was the second highest class of drugs, accounting for 8.4 percent of Part D spending.

In addition to posting a measure of each nursing home’s use of antipsychotic medication on the CMS Nursing Home Compare website, in the coming months CMS plans to add the antipsychotic measure to the calculations that CMS makes for each nursing home’s rating on the agency’s Five Star Quality Rating System.

What does this mean for Kansas?

Currently Kansas has a documented reduction of 9% so we have a lot of work to do!

Cardio-pulmonary Resuscitation - Follow Up

The article published in the July 2014 Sunflower Connection was related to the CMS Survey and Certification Letter and the information is applicable to nursing facilities. For state licensed only facilities (assisted living, residential health care, home plus and adult day care), there is no requirement that you have a policy that directs staff to initiate CPR.

All certified facilities must have a policy and procedure that addresses how they would handle CPR in their facility. It is ONLY when the assisted living, residential health care, home plus or adult day care facilities includes in their policy that they will initiate CPR as appropriate, that the facility has the responsibility to ensure that a CPR certified staff is available at all times and that documentation of current CPR certification is maintained the personnel file.

Tuberculosis Update

This communication is to provide an update to earlier recommendations regarding a nationwide shortage of tuberculin used for tuberculosis skin testing (TST). The shortage involved both commercial products: TUBERSOL® (Sanofi Pasteur Limited), and APLISOL® (JHP Pharmaceuticals, LLC). In addition the shortage of Isoniazid used for treating both TB infection and disease as also been resolved.

Both shortages appear to be resolved. Please resume normal best practice activities and regulatory requirements in regards to screening for tuberculosis and for treating for TB Infection.

It is important to remember that low risk testing is not recommended by the Kansas Department of Health and Environment as it can produce false results. Please refer to the following lists of guidance related to best practices.

For Healthcare Workers and Health Care Facilities:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e

For Correctional Institutions:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm>

General Population and targeted Testing:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4906a1.htm>

Using IGRA as an alternative to PPD and sometimes preferred screening tool:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5905a1.htm?s_cid=rr5905a1_e

Treatment of TB Infection:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6048a3.htm?s_cid=mm6048a3_w

AND

<http://www.cdc.gov/tb/topic/treatment/ltbi.htm>

Questions should be directed to Phil Griffin, KDHE TB Controller (pgriffin@kdheks.gov or 785-296-8893).

Unanswered Call Lights

July 21, 2014 by Kathleen Mears

One morning last week, I awoke with a start at 2:30 a.m. It seemed like an alarm clock had gone off, but no alarm was ringing. I felt strange and uncomfortable. I am a light sleeper. But, even with earplugs in, whatever woke me up had to have been loud.

I tried to relax and go back to sleep. But my subconscious was on alert. I would doze for a few minutes and then wake again. A half hour later, I fell asleep and woke at 4:30 a.m. Since I have requested not to be bed checked, I put on my call light.

When my call light was not answered in 10 minutes, I wondered if there was an emergency elsewhere in the facility. After 15 minutes, I could feel fear rising in my throat. I wondered if I should call "Nurse" for help. Then, I realized it would be difficult for staff to hear me through my closed door in my room at the end of the hall.

I decided not to disturb myself or anyone else by calling for help. As my sleep fuzz wore off, I noticed my left pinky was throbbing. My hand splints had been on since bedtime and needed to come off. My mouth felt dry. Since I cannot move much on my own, I managed to wiggle to make myself a bit more comfortable. My roommate was asleep.

When my light went unanswered for 20 minutes, I became more anxious. I considered possible scenarios that could cause my light to go unnoticed. I also wondered if my breath-activated call light even came on. That is a scary situation—and it has happened before.

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After the alarm on the light had been ringing for 30 minutes, my heart was beating fast. I reasoned that, wherever the nurse and aides were, they were not able to hear my light's alarm ringing. I reasoned that is why I was still waiting. Thirty-five minutes after I put my light on, the nurse and an aide calmly came in. Although I wanted to ask what had held them up, I resisted the urge. When there was no apology, I decided they must have just noticed my light.

After they left, I thought about the call light waits I have experienced in more than 18 years living in nursing homes. Some causes were resident falls, illnesses and death. But there must have been times when aides were in the break room eating lunch and had no idea my call light was on.

I do not think aides and nurses realize how fearful I become after waiting 15 minutes for assistance. There is no way for me to deactivate the light or forget why I put it on in the first place.

Kathleen Mears has been a nursing home resident in Ohio for more than 18 years. She is an incomplete quadriplegic and uses a power wheelchair to get around. Her computer is her "window on the world." This blog shares her thoughts and view of life as a nursing home resident as well as ideas of how it might be improved in the future.



Completion of the MDS 3.0 and CAAs - 2014

The Resident Assessment process addressed in 42 CFR 483.20 (b)(1)(xviii) (g) and (h) respectively states that the assessment must accurately reflect the resident's status and a registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

The Kansas Board of Nursing staff has determined the process of the Resident Assessment which includes completion of the Minimum Data Set (MDS), Care Area Assessments (CAAs), and care plan development requires nursing judgment. As coordinator of the process, a registered nurse (RN) is responsible to ensure each person who completes sections or items on the MDS and CAAs has the expertise to do so. Designated health professionals may be assigned to complete sections and items on the MDS and the CAAs within their professional scope of practice.

K.S.A. 60-3-100. Unprofessional Conduct. Prohibits a registered nurse from delegating nursing judgment to anyone who is not a nurse. It states, "Any of the following shall constitute "unprofessional conduct": delegating any activity that requires the unique skill and substantial knowledge from biological, physical, and behavioral sciences and judgment of the nurse to any unlicensed individual in violation of the Kansas nurse practice act or to the detriment of patient safety"

The RN is responsible for ensuring the completion of the Resident Assessment process. The following health professionals may assist the process by completing portions of the MDS and CAAs that fall within their scope of practice:

- Registered Nurse
- Physical Therapist
- Occupational Therapist
- Speech Language Pathologist
- Registered Dietitian
- Therapeutic Recreation Specialist

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- Licensed Social Worker
- Social Service Designee who has a bachelor's degree in a human services field
- Licensed Practical Nurse who has attended an MDS workshop and has received additional assessment education on the sections or items or care area conditions they are completing either directly from an RN in the work place or through another means of education. There must be documentation in their personnel file of the additional education.
- The RN coordinator may assign other facility staff to complete specified sections of the MDS determined to require only the collection of data and specific Care Area Assessment if reviewed and also signed by designated health professionals. The staff includes:
 - Activity Director (AD) who has completed the Activity Director State Training Course approved by Health Occupations Credentialing, Kansas Department for Aging and Disability Services. They may complete Section F. Preference for Customary Routine and Activities and the Activities Care Area Assessment and Summary when documentation is present in their personnel file and they have received education from a Therapeutic Recreation Specialist, Social Worker, or Registered Nurse on Section F and its application. A Therapeutic Recreation Specialist, Social Worker, or Registered Nurse must review and also sign the Activities Care Area Assessment Summary.
 - Social Service Designee (SSD) who does not have a bachelor's degree in a human services field and has completed the Social Services Designee State Training Course approved by Health Occupations Credentialing, Kansas Department for Aging and Disability Services. They may complete Sections C-Cognitive Patterns, D-Mood, E-Behavior, F-Preference for Customary Routine and Activities, and Q-Participation in Assessment and Goal Setting, when documentation is present in their personnel record that they have received education from a Therapeutic Recreation Specialist, Social Worker, or Registered Nurse. The SSD may also complete the Care Area Assessments. A Therapeutic Recreation Specialist, Social Worker, or Registered Nurse must review and also sign the Care Area Assessments and Summaries.

- Certified Dietary Managers (CDM) may complete Section K Swallowing and Nutritional Status Items 0200-0700, when documentation is present in their personnel file that they have received additional education from a Licensed Dietitian on those items and their application. They may provide input into the CAAs but cannot complete them or the summaries.

**Kansas Department for Aging and
Disability Services
Survey, Certification and Credentialing
Commission
612 S. Kansas Avenue
Topeka, Kansas 66603**

CARE Certificates and the Medical Record

The KDADS CARE office has received several requests and concerns from the local ADRC offices these past months indicating nursing homes have requested duplicate copies of a CARE certificate due to these being "thinned" from their paper charts or scanned to electronic medical records and then disposed of, making them no longer available.

KDADS has identified (2) situations as points where nursing homes can lose track of original CARE certificates:

1. When the resident enters the hospital for a fairly extended stay and the chart is closed, then re-opened upon the resident's return and,
2. When a resident is transferred from one nursing home to another nursing home.

BOTH of these are situations in which the CARE certificate should follow the resident.

1. In the event of a hospital stay the original CARE certificate will continue to be valid and retained on either the existing chart or re-entered on any new chart developed for a returning resident.

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2. In the case of a transfer to another nursing home the CARE certificate should accompany the resident to the new facility; the discharging nursing home is responsible to forward the CARE certificate.

Nursing home medical records/admission staff should treat the CARE Certificate (their “proof of PASRR”) in the same manner as you would Advance Directives/medical cards/do-not-resuscitate orders, etc. These are records should always kept available for any resident on your census. You are expected not only to maintain this record while the resident resides with you, but it is YOUR responsibility to forward this with any resident transitioning to another nursing home.

3. The CARE assessment remains “valid” so long as a person does not leave the nursing home/hospital cycle of care for a period of more than 30 days.
4. There appears to be some confusion between the federally mandated PASRR process called ‘CARE’ in the state of Kansas and the care reviews done by MCO’s for Medicaid residents. Policies governing MCO’s and their assessments are a separate function and to not impact the Federal PASRR program.
5. When a resident enters a hospital then returns to your nursing home you do not need a “new’ CARE assessment; even if you closed a chart and opened a new one when the person returned you are expected to retain their CARE certificate. PASRR will update only if the person breaks the nursing home/hospital cycle for a period of longer than 30 days; or in the case of a Level II individual with a temporary letter, a new letter is issued.

The local ADRC will have copies of certificates for assessments they have completed in the past 7 years. The local ADRC should be contacted for any CARE certificate needed when the assessment was completed by their local assessor.

The state CARE office will have only assessments completed by hospitals since January 2013 on file. The state CARE office will also have a copy of Level II Letters.

It is a “*best practice*” to be sure the CARE certificate is on file in the Medical record and a copy is maintained in a business file as well. When using electronic medical records be sure this document is backed up on your system on a secure server so it will continue to be available in the event files are lost, etc.

THANK YOU! For your assistance in maintaining CARE certificates for your residents.

“Gluten Free” Labeling of Foods

In this article, KDADS highlights a federal rule which defines and sets conditions on the use of the term “gluten-free” in foods.

Question: Is a food bearing a “gluten-free” claim acceptable to use in a gluten-free diet (i.e., one free of wheat, barley and rye or their crossbred hybrids)?

Answer: The Food and Drug Administration (FDA) established a uniform definition of the term “gluten-free” on September 4, 2013 (see insert). This definition is codified under the Food, Drug and Cosmetic Act (the FD&C Act) at [21 CFR Part 101.91](#) and also applies to food that bears the claim “free of gluten”, “no gluten”, and “without gluten”. It means a food bearing a gluten free claim inherently does not contain gluten AND any unavoidable presence of gluten in the food is below 20 parts per million (ppm).

This is good news for people with celiac disease, and for those who responsible for their care.

The federal rule applies to all FDA-regulated packaged foods, including dietary supplements. All FDA-regulated foods that are labeled gluten-free on or after August 5, 2014 (the compliance date established in the rule) must meet this definition. This includes both domestically produced and imported food.

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The federal rule does not apply to foods regulated by the U.S. Department of Agriculture (USDA). These include: *meat products* (e.g., hotdogs, packaged deli-style meat), *poultry products* (e.g., canned chicken, frozen chicken fingers), *certain egg products* (e.g., dried, frozen or liquid eggs with or without added ingredients), and *mixed food products* containing more than 3% raw meat or 2% or more cooked meat or poultry (e.g., some stews and some chili). Nor does it apply to almost all alcoholic beverages (e.g., all distilled spirits, wines that contain 7% or more alcohol by volume, and malted beverages made with both malted barley and hops). These beverages are regulated by the Alcohol and Tobacco Tax and Trade Bureau (TTB).

Gluten-free is a voluntary claim that manufacturers may elect to use in the labeling of their foods.

The use of alternative statements like “made from gluten-free ingredients”, “made without gluten-containing ingredients” or “no gluten added” is not prohibited in the federal rule, but these statements are NOT synonymous with a gluten free claim. Therefore, it should not be assumed that foods labeled with these or similar statements meet all FDA requirements for the use of the “gluten-free” claim unless the food also bears a “gluten-free” claim on its label.

“Gluten-free” does not mean “wheat-free.” An FDA-regulated food labeled “gluten-free” may potentially contain up to 20 ppm gluten from wheat (see insert). Wheat is one of eight foods or food groups designated as a “major food allergen” under the Food Allergen Labeling and Consumer Protection Act (FALCPA) of 2004. Whenever an FDA-regulated food labeled “gluten-free” is made with an ingredient that contains any wheat protein, the term “wheat” must appear in the ingredient list or in a separate “Contains wheat” statement to comply with allergen labeling requirements. Under the FD&C Act, the word “wheat” must be followed immediately by an asterisk (or other symbol) that refers to this clarifying language found in close proximity to the ingredient list: “The wheat has been processed to allow this food to meet the Food and Drug Administration requirements for gluten-free foods.”

An FDA-regulated food will be deemed misbranded if its label bears the claim “gluten-free”, “free of gluten”, “no gluten”, and “without gluten” but the food fails to meet the FDA requirements (see insert).

In addition, it will be deemed misbranded if the label bears a gluten-free claim and also bears the term “wheat” in the ingredient list or in a separate “Contains wheat” statement, but fails to include an asterisk (or other symbol) immediately after the term or statement that refers to the clarifying language necessary to meet FDA requirements for a “gluten-free” claim.

Failure to provide a gluten-free diet – as prescribed by the physician – to a resident with known celiac disease who develops persistent gastrointestinal symptom is an example of a finding of noncompliance at Severity Level 3, Tag 325. For people with celiac disease, eating foods that contain gluten stimulates an abnormal immune response which damages or destroys the villi that line the small intestine and function to absorb nutrients from food. Acute gastrointestinal symptoms include weight loss, chronic diarrhea and vomiting. A strict gluten-free diet is the only treatment at this time; there is no cure.

This new definition of “gluten-free” and conditions for its use will help ensure that people with celiac disease and/or those responsible for their care are not misled and are provided with truthful and accurate information with respect to foods labeled gluten-free.

If a resident becomes ill after eating a food labeled gluten-free, first seek appropriate medical care. Complaints about an FDA-regulated food (including misuse of the “gluten-free” claim on food labels) should be reported to an FDA Consumer Complaint Coordinator at 855-202-9780 (toll free). The “gluten-free” regulation is binding and has the full force and effect of law -- FDA could take regulatory action.

Read more about [Gluten-Free Labeling of Foods](#) on the FDA website.

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REGULATORY TEXT:

State Operations Manual (SOM). Appendix PP. Guidance to Surveyors for Long Term Care Facilities. 42 CFR §483.25(i) Nutritional Status under Tag F325. Investigative Protocols, Nutritional Status. Deficiency Categorization (Part IV, Appendix P)

REFERENCES:

Food Labeling; Gluten-Free Labeling of Foods, 78 Fed. Reg. 47154 (Aug. 5, 2013) (codified at 21 CFR Part 101.91).

- Website for final notice: <https://www.federalregister.gov/articles/2013/08/05/2013-18813/food-labeling-gluten-free-labeling-of-foods>
- Website for codified Part 101.91: http://www.ecfr.gov/cgi-bin/text-idx?SID=1a42029366fdf2bccd9052117c873a86&node=se21.2.101_191&rgn=div8

FDA, Guidance for Industry, Gluten-Free Labeling of Foods: Small Entity Compliance Guide. June 2014.

- Website for guidance document: <http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/ucm402549.htm>

FDA Facts: Gluten-Free Labeling. August 5, 2014.

- Website for document: <http://www.fda.gov/downloads/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/Allergens/UCM407878.pdf>

FDA Website – Guidance and Regulation: Allergens. FDA Gluten and Food Labeling: FDA’s Regulation of “Gluten-Free” Claims: FOOD FACTS. Web page updated 06/05/2014.

- Website for document: <http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/Allergens/ucm367654.htm>

FDA Website – Guidance and Regulation: Allergens. Questions and Answers: Gluten-Free Food Labeling Final Rule. Web page updated 02/05/2014.

- Website for document: <http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/Allergens/ucm362880.htm>

DRAFT Revised September 29, 2014

Award Letters

Facility	City	Type	Date	Exempt	NO DEF LETTER
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
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

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Award Letters - Continued

Facility	City	Type	Date	Exempt	NO DEF LETTER
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

SNF/NF - Skilled Nursing Facility/Nursing Facility; ALF - Assisted Living Facility; 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 _____				