KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

Sunflower Connection

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

October 2015 Volume 11, Number 3

2016 Nursing Home Quality Improvement Grant

The Kansas Department for Aging and Disability Services (KDADS) is seeking proposals for consideration to use Civil Money Penalty Funds to support and expand quality improvement initiatives within Medicaid and or Medicare certified nursing homes and long term care units of hospitals in Kansas.

Funding for this grant will be provided through civil money penalties collected from nursing homes participating in Medicaid or Medicare. These funds may be used for projects to improve care for individuals in nursing homes. KDADS is seeking proposals which provide support to resident and family councils, other consumer involvement in assuring quality care in facilities, and facility improvement initiatives in accordance with section 7535 of the CMS state operations manual available here:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf
CMS maintains final approval authority for all projects under this request for proposals.

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Grant funding will not be rewarded for the following:
a) Making capital improvements to a facility;
b) Paying for items or services that are already the responsibility of the nursing home;
c) Funding projects, items or services that are not related to improving the quality of life and care of nursing home residents;
d) Projects for which a conflict of interest or the appearance of a conflict of interest exists;
e) Long term projects (greater than 3 years);

The program proposal shall include the following:

- ◊ Program objectives and deliverables
- ◊ Program outline with time frame for each deliverable
- ◊ Strategies for accomplishing the objectives
- ◊ Qualifications of persons conducting the program
- ◊ Method(s) for evaluating effectiveness of the program
- ◊ Copies of any materials used in the program
- ◊ Number of participants for each program
- ◊ Itemized budget of the anticipated costs of the program.
- ◊ **Estimated cost of program per person served**

Successful applicants must comply with all state and federal regulations. To receive reimbursement the entity must submit complete, typed reports on completion of program objectives and deliverables. The entity must also submit a quarterly evaluation of the progress of the program and participants' response. KDADS will make reimbursements based on program completion or completion of program objectives and deliverables.

Grant applicants must submit an original application and three copies. The application is available on line at: http://www.kdads.ks.gov/commissions/scc/workforce-enhancement-grant

KDADS will review and approve proposals for appropriateness of course content and location at which the program will be offered. Grant proposals must be submitted to KDADS by November 9, 2015, at close of business day. The grant period shall be between January 1, 2016 and December 31, 2016. The grant period may be extended or shortened based on the specific program objectives. Grant proposals must be submitted to the attention of Shirley L. Boltz, RN, KDADS 612 S. Kansas Avenue, Topeka, KS 66603. For questions, please contact Shirley at (785) 296-1282 or via e-mail at Shirley.Boltz@kdads.ks.gov.

Grant funds **shall not** be used to train unemployed individuals, individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus, Boarding Care Facilities, Hospitals, Home Health Agencies or any other type of general employment. The grant will also not fund courses for certification as nurse aide, medication aide, home health aide, dietary manager, or activity director. **Training provided to ineligible persons will not be reimbursed**.

October 1, 2015 Changes to the RAI Manual

CMS has released the changes to the RAI Manual. As expected, the biggest change concerns the new ICD-10 coding for diagnosis, mostly affecting section I. However, there are a number of clarifications where guidance may have been confusing in the past. A few of them are:

Chapter 2, pages 2-4: Newly Certified Nursing Homes

Continued on page 3.

- The completion and submission for OBRA and/or PPS assessments is a requirement for Medicare and/or Medicaid long-term care nursing homes. When a facility is in the process of certification, OBRA and/or PPS assessments are still required to demonstrate compliance with certification requirements. Since these assessments have assessments reference dates (ARDs) prior to the certification dates, CMS does not have the authority to receive them into QIES ASAP, and so they should not be submitted to the QIES ASAP system.
- If facility staff completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment after certification. The nursing home will simply continue with the next expected OBRA and/or PPS assessment even though there may be a sequencing error on the validation report.
- Medicare cannot be billed for any care provided prior to the certification date. Therefore, the nursing home must use the certification date as day one of the covered Part A stay when establishing the ARD for Medicare Part A SNF PPS assessments.

Chapter 2, pages 2-52: COT OMRA

- In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to day seven of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after day seven of the COT observation period, then a COT OMRA would be required if all other conditions are met.
- In cases where the date used to code A2400C is equal to the date used to code A2000 – that is, cases where the discharge from Medicare Part A is the same day as the discharge from the nursing home – and this date is on or prior to day seven of the COT observation period, then no COT OMRA is required. However, the COT OMRA may be combined with the Discharge assessment if that is preferred.

Chapter 3, page A-32 (A2400): CMS has stricken the words "Generic Notice" and replaced them with "Notice of Medicare Non-Coverage (NOMNC)" both in the item itself and in the subsequent example.

Chapter 3, pages 1-4

- When a resident receives aftercare following a hospitalization, a V code is currently assigned in section I. Beginning October 1, 2015; aftercare codes will begin with a Z.
- When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I1800.

Chapter 3, page M-5 (M0210): If a resident had a pressure ulcer that healed during the look-back period of the current assessment but there was no documented pressure ulcer on the prior assessment, code 0. Since the language changed here, CMS deleted coding tips in M0300A, for clarity. They are:

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0.

Chapter 6, page 6-2: The Medicare Short Stay Algorithm has been updated. All references to the Readmission/Return assessment have been removed.

The Nursing Process

The common thread uniting different types of nurses who work in varied areas is the nursing process—the essential core of practice for the licensed nurse to deliver holistic, patient-focused care.

Assessment
A licensed nurse uses a systematic, dynamic way to collect and analyze data about a client, the first step in delivering nursing care. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic, and life-style factors as well. For example, a nurse's assessment of a hospitalized patient in pain includes not only the physical causes and manifestations of pain, but the patient's response—an inability to get out of bed, refusal to eat, and withdrawal from family members, anger directed at hospital staff, fear, or request for more pain medication.

Diagnosis
The nursing diagnosis is the nurse's clinical judgment about the client's response to actual or potential health conditions or needs. The diagnosis reflects not only that the patient is in pain, but that the pain has caused other problems such as anxiety, poor nutrition, and conflict within the family, or has the potential to cause complications—for example; respiratory infection is a potential hazard to an immobilized patient. The diagnosis is the basis for the nurse's care plan.

Outcomes / Planning
Based on the assessment and diagnosis, the nurse sets measurable and achievable short- and long-range goals for this patient that might include moving from bed to chair at least three times per day; maintaining adequate nutrition by eating smaller, more frequent meals; resolving conflict through counseling, or managing pain through adequate medication. Assessment data, diagnosis, and goals are written in the patient's care plan so that nurses as well as other health professionals caring for the patient have access to it.

Implementation
Nursing care is implemented according to the care plan, so continuity of care for the patient during hospitalization and in preparation for discharge needs to be assured. Care is documented in the patient's record.

Evaluation
Both the patient's status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.

Plan of Correction Guidelines for Immediate Jeopardy (IJ):

If you receive notification that your facility is in IJ, first ensure that the residents in your facility are safe. After that, begin working on your plan of correction to abate the IJ immediately. The plan of correction needs to be approved by the state agency before the IJ is considered abated, which needs to be done **ASAP**. If you receive a per day civil money penalty (CMP), a delay in submitting your POC will increase your fine. As with any incident, immediately begin an investigation and complete a root cause analysis.

Questions to answer during the investigation:
What happened?

How did it happen?

What system failed that allowed this to happen?

What does the facility need to change immediately to keep the residents safe and ensure it doesn't happen again?

Continued on page 5.

The plan needs to include:

The immediate corrective action for the situation- what are you implementing immediately to correct the issue?

Training: What was covered? Was the policy revised? Did you complete re-education on the current policy? What date and time was training completed for all staff? Send the sign in sheets for all staff to the state agency by fax or scan and email.

Follow up monitoring: Who is responsible, how often and for how long?

Example:
This example is a rough draft. Each situation will be different. There isn't a one size fits all POC. Follow the general outline to determine the root cause and determine what you will implement to correct it.

What happened? Hot water temperatures in excess of 140 degrees with resident access

How did it happen? The water temps were not checked in the dining room and was tied to the kitchen hot water temps.

What system failed? Routine water checks did not include the dining room sink.

What does the facility need to change to ensure it doesn't happen again? The facility will check every water source daily x 1 week then weekly, including the dining room sink.

The Plan:

Include documentation of the following:

The immediate corrective action for the situation- what are you implementing immediately to correct the issue? Water shut off to that sink until a plumber was able to get a part and come to the facility.

Training:
What is covered? What date and time staff were all trained? Send sign in sheets for all staff. Will educate all maintenance staff of water temperature requirements and documenting on the water temp log. In-service will include the revised policy. What to do if temps are found in excess of 120 degrees. Policy will be revised and discussed during the training.

Follow up monitoring:
Who is responsible, how often and for how long? Maintenance director will review the logs then give a report to the administrator monthly.

What affects a RUG Score

Monitoring temps:

In the Special Care high RUG category, a fever (MDS item J1550A) plus certain characteristics results in a significant RUG score, such as fever plus pneumonia (I1200), fever plus vomiting (J150B), fever plus weight loss (K0300 coded 1 or 2), and fever plus feeding tube (K0510B1 or K0510B2). Examples:

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

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

Assess for shortness of breath while lying flat:

A diagnosis of chronic obstructive pulmonary disease (COPD) coded in I6200 does not result in a significant RUG score usually a Reduced Physical Function category. If a resident has COPD and also has shortness of breath while lying flat (J1100C), they will qualify for a Special Care High.

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It is important to do a true assessment for shortness of breath while lying flat and to document this assessment in the medical record. Of course you can interview the resident to find out if they become short of breath when they lie flat. The interview must be documented in the medical record

Differentiate between septicemia and UTI:

Frequently you get a resident from the hospital with a diagnosis of UTI. After reading the hospital paperwork you see where the resident had septicemia due to a UTI. You need to clarify this with the physician. The diagnosis of UTI does not qualify a RUG, but a diagnosis of Septicemia (I2100) will qualify for a Special Care High.

Resource:

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

Suicide Prevention Toolkit for Senior Center Staff and Volunteers

Dear Colleagues,

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers has just been released. This valuable new online resource was prepared for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) by Education Development Center, Inc.

Suicide rates are especially high among older adults. However, senior center staff and volunteers can play a valuable role in promoting emotional health among older adults and increasing the factors that may protect them from suicide.

This toolkit provides many ideas for integrating suicide prevention into the valuable work senior centers already do. It contains:

- Information, examples, and tools to help 1) promote the emotional well-being of all of a center's participants and 2) recognize and respond to people who may be at risk of suicide
- Ideas for partnering with local mental health providers
- Fact sheets for older adults and their families
- A list of resource materials and organizations

Input and review from professionals working in and with senior centers at the national and local levels were obtained in developing the toolkit.

Please share this toolkit with your staff and other colleagues. Note that some of the information in the toolkit may be useful for other providers serving older adults in the community, including home care providers. Copies can be downloaded free of charge at http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416.

You may also be interested in this related resource for senior living communities: Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities.

If you have any questions about these toolkits, please contact me at lrosenblum@edc.org.

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AP Reduction

In June, McKnight's reported that CMS is pushing for further reductions in antipsychotic use for people living with dementia in nursing homes. The 19.4% nationwide reduction achieved by the end of last year is just short of the 20% target set by CMS in 2012. There is a push for a total reduction of 25% this year and 30% by the end of 2016.

These are laudable goals, but can they be achieved? There is reason for concern. While there is great variation among individual homes, a graphing of the quarterly numbers over the past three years shows a pronounced flattening of the curve over the past year. Both the national numbers and those of most individual states show that they are reaching a plateau.

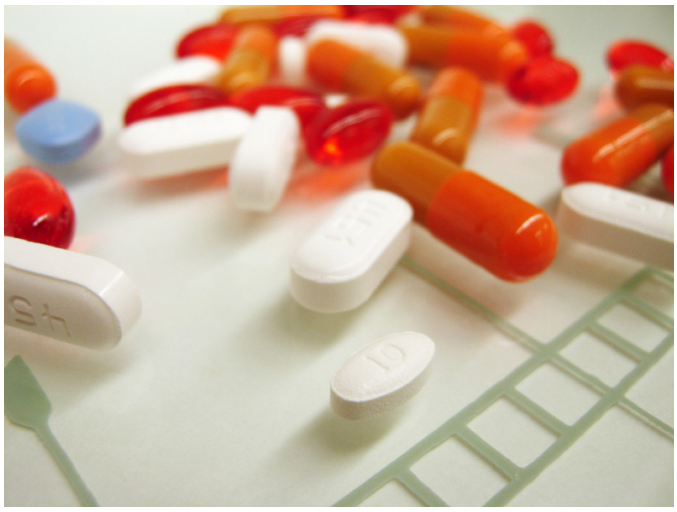
In fact, nearly half of all states found their antipsychotic use to be level or slightly increased over the last two quarters of 2014, and only 8 states had an absolute reduction of 2% or more over the prior year. Clearly, nursing homes have found all of the "low-hanging fruit"—the people whose drugs could be easily stopped—but most are having trouble figuring out how to take it to the next level.

Having been involved in the CMS partnership to reduce antipsychotic use, and in education of nursing homes on this topic, I think there are two important barriers to success that need to be overcome: educational and operational.

From an educational standpoint, there are simply too many seminars being offered that rely on outmoded concepts. Many of the available courses continue to promulgate a deficit-based view of dementia that is highly stigmatizing. Major curricula are being promoted that still state that the person is "disappearing," "demented," or has "problem behaviors" that must be "managed." You would think that Tom Kitwood's book, Dementia Reconsidered, had come out last week, instead of 18 years ago.

Such an approach positions the person's brain changes as being primarily responsible for their distress, without adequately understanding the person's experience within a relational, environmental, or historical context. The focus is on reactive "interventions" that may defuse an acute situation, but do nothing to create sustained success in promoting well-being. And a philosophy that blames the distress on brain changes is a slippery slope to continued use of psychotropic drugs.

This is not just a nursing home problem; this is a basic paradigm problem that permeates society and one that unfortunately is perpetuated by many in the medical profession, media, and advocacy organizations. Evidence of this is demonstrated by recent data that suggests that the total number of people living with dementia who are taking antipsychotics is likely much higher in the community than in nursing homes, a fact which gets little or no attention from media reports or educational initiatives.



Albert Einstein said, "We cannot solve our problems with the same thinking we used when we created them." Sustained success in antipsychotic reduction requires that we shift to innovative educational approaches that are proactive and strengths-based — that focus on creating well-being, not simply calming distress.

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The second barrier that nursing homes face is their inability to heed the advice of CMS' Michelle Laughman, and "embrace culture change." There is plenty of lip service being given to "person-centered care," but talk is cheap. Many homes have adopted the language or transformed their physical layouts, but few have done the important work necessary to operationalize the philosophy. This is where the rubber meets the road.

A perfect example is the number of places that advertise their devotion to individualized care and relationships, and yet continue to rotate their staff assignments on a regular basis. Despite a mountain of evidence showing advantages in quality of care, quality of life, survey results, staff turnover, and even lessened resistance to care in homes using dedicated staff assignments (not to mention the familiarity, trust, and overall sense of security this enhances for people with memory difficulties), many, if not most nursing homes and assisted living communities have made no effort to take this important step.

The way to significantly reduce antipsychotic drugs in a sustainable manner is to embrace an approach that sees the whole person and shifts our operations to fit their needs, rather than demand that people with changing brains conform to ours. This is neither fast nor easy, but it is the only way to get off the drug "plateau." Organizations who have seriously undertaken this journey, such as the Windsor Healthcare homes of New Jersey (2% to 6% antipsychotic use) or Beatitudes Campus in Phoenix (0% - 2%), have set a standard to which everyone should aspire.

PASRR

Resident Reviews and PASRR

Section 1919(e)(7)(B)(iii) of the Social Security Act
(iii) REVIEW REQUIRED UPON CHANGE IN RESIDENT'S CONDITION.--A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

This information has been in the Code of Federal Regulations as a part of the PASRR law for some time but was never been made a part of nursing home regulation.

With the new proposed LTC draft regulations this piece related to resident reviews is being pulled over into nursing home regulation. At this writing we do not know all the final version of these regulations will contain. Until that time we would like to assist nursing homes to understand what a PASRR Resident Review is, **and more to the point, what it is NOT:**

1-**A resident review is most commonly completed when a resident receiving a Level II PASRR Determination Letter has been allowed a "temporary" stay in a nursing home.**

A. You will want to review any Level II Determination Letter to verify the **allowed length of stay**. There will be a paragraph within the body of the letter that specifies the length of stay on all temporary letters.

B. Residents are to be discharged from your building by the **end of the authorized length of stay**. The time frames are determined after consideration of the need and the length of time it should typically

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take for a resident with those needs to recover and be ready to return to a lower level of care. These decisions have been made in consultation with caregivers and case managers.

C.**A resident may leave at any point during that length of stay**: it is not necessary the person remain in a nursing facility the entire allotted time. If a person has reached the point where he/she may safely transition back to a lower level of care the nursing facility should assist the person to do so.

D. If the **person is UNABLE to stabilize to the degree he/she is ready to move to a lower level of care by the end of the allotted temporary stay the NF should contact the state for a "resident review"** to allow for an extension of the allotted time frame.

E. **In most cases of temporary stay letters**, the state PASRR program will contact your building 4-6 weeks prior to the end date 1) to check on the individual, to see if the person continues to be in your building and 2) if the person will be able to discharge or would need an extension of the time frame.

2-A **Resident Review for PASRR Level II is NOT a vehicle to remove a resident from your building** UNLESS the condition for which you are contacting PASRR was NOT PRESENT or was UNKNOWN at the time of admission to your building. Examples of this are as follows:

A. **Mrs. Jones woke up one morning and her left side was very weak; she was unable to dress herself, was extremely tired and feared she would fall if she continued to attempt to ambulate without assistance**. The physician determined Mrs. Jones has had a stroke. She has entered your building with orders for extensive therapies in the hope she will regain her independent function. Mrs. Jones has made good progress but still must use a quad-cane to assist with ambulation and the physician is reluctant to release her to drive. She is now crying uncontrollably and has fallen into a state of depression, refuses further restorative therapies and tries to remain in bed most of the day. This has continued for a period of nearly 60 days. She was admitted to the local geriatric behavioral health unit and returned with a diagnosis of Depressive *episode, situational*. When there seemed to be no improvement in her condition she was readmitted and now has returned with a diagnosis of *Major Depressive Disorder*. Mrs. Jones is 62 years of age and -although frail - appears to be a resident that could come back to some level of further independence from her health event if her mood could improve and she could be encouraged to work with therapies and maintain good nutrition. Her physical health has improved enough the doctor is stating if she could be assisted to improve her mood, she would be discharged to her home with in-home supports.

This would be a situation **in which you would contact the PASRR program requesting a Level II** assessment for this resident to see if 1) she could be connected to mental health support services to support her in the community, or 2) if she should be transitioned to a building that specializes in treatment of mental health conditions such as hers but can also manage her heightened physical condition. This was a 1)major change of condition after admission, 2) the condition was not present/known at admission and 3) she meets the criteria to trigger a Level II assessment.

B. **Mrs. White is an 83 year old resident with mid-stage Dementia, unspecified type**.
Mrs. White has begun to take food from the plates of other residents. She has been seen spitting at other residents and staff. She will come to an activity and begin to yell at some point and staff will assist her to leave in order not to disturb the other attendees. Mrs. White announces multiple times daily that she *"hates this place"* and she is going to find a way to *"get out of here"*. Yesterday she physically assaulted another resident she passed by who is wheelchair-bound.

While the nursing home certainly needs to address the issues with Mrs. White, **calling for a PASRR Level II Determination Letter in an attempt to use it to transfer her to an NFMH or other building will be of no assistance to the building or Mrs. White**.

1-When a behavior is **not rational** addressing the underlying cause with therapy or logic-based practices is not effective.

2-Nursing Homes for Mental Health do not admit residents with **primary diagnoses of Dementia**: Dementia alone is NOT a *mental health disorder*: its etiology is from organic causes. Therefore the treatment developed and delivered for those residents with mental health conditions will not be the same – nor helpful- to a resident with primary dementia.

3-Since Mrs. White is at "mid-stage" in her dementia, it is likely this **condition was present upon admission**. A resident review is done ONLY when a condition is NEW or was UNKNOWN upon admission. You will be asked to supply the initial admission diagnoses prior to the PASRR program accepting your request for a Level II Resident Review in order to verify this is a newly discovered or new diagnosis.

Behaviors connected to diagnoses which begin to manifest after admission are common: this is not the same as the diagnosis being UNKNOWN prior to admission. This is one reason **"why"** is it so vitally important to do a thorough assessment of a resident's condition prior to admission and to understand what some diagnosis entail with regard to the potential care needs when you agree to admit and care for a resident.

Another common misconception is when a resident acquires the standard "triggers" for a Level II assessment, one must be performed. This is not true.

In the case of Mrs. White, above: although she may have several admissions to a behavioral health unit for medication titration/ behavioral overview to gather some information /ideas as to how the nursing home could best provide care for Mrs. White during this time of aggression in the course of the dementia, this would not necessitate a Level II referral: again, dementia is NOT a mental health condition and therefore she would NOT trigger a Level II assessment.

Were we to complete a Level II for this resident the result would be a termination of the PASRR process for the future with a "Dementia Abort" determination: the resident would not be admitted to an NFMH with such a letter.

It should be understood that when a resident has dementia or other multiple health conditions as their "primary" diagnoses" - even if there is a history of a major mental health condition (or a physician in a behavioral health hospital gives such a diagnosis) it will not necessitate or qualify for a Level II assessment. When a person is entered into a unit that reviews the person for psychiatric conditions the person in all likelihood will be released with some psychiatric diagnosis related to their condition. While that condition may have been the primary *"reason"* the person **admitted to that unit**, unless that condition is the ***primary medical condition*** necessitating nursing home placement, it will not trigger a Level II assessment. Level II assessments **are done based on persons with MI/ID/DD/ RC who enter an NF to see if there is sufficient medical necessity for them to require NF level of care or if that care should be provided in a lower level care setting.**

When the PASRR program receives a call from a building wanting to "***qualify a person for Level II***" we immediately ask for appropriate documentation to verify the condition was unknown/ not in existence at the time of admission. Attempting to use the PASRR process to transfer residents out of the building to avoid an involuntary discharge **is an inappropriate use of the PASRR process** and buildings that continue to attempt to do this will have this information forwarded to the nursing home complaint hotline.

The BEST PRACTICE for a nursing home is to thoroughly ASSESS the medical and psychological condition of a resident PRIOR to admission of the resident. In this manner you will be able to most accurately predict if this would be a person with conditions that your building is equipped and train to care for appropriately.

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
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

Facility	City	Type	Date
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
Comfort Care Homes Inc #441	Wichita	HP	6/1/15
Carrington Retirement Community	Pittsburg	RHCF	6/2/15
Assisted Living at Windsor Place	Coffeyville	ALF	6/4/15
Fort Scott Presbyterian Village	Fort Scott	ALF	6/9/15
Woodridge Estates	Parsons	ALF	6/17/15
Trego Co. Lemke Memorial Hospital LTCU	WaKeeney	LTCU	6/18/15
Care Haven Homes - Broadmoor	Overland Park	HP	6/22/15
Gran Villas Atchison	Atchison	ALF	6/23/15
Oswego Home Place Inc	Oswego	RHCF	6/23/15
Country Place Memory Care	Hoisington	HP	6/24/15
Country Place Senior Living	Hoisington	ALF	6/24/15
Gran Villas Pittsburg	Pittsburg	ALF	6/25/15
Midland Care at Linnwood Place	Valley Falls	ALF	7/22/15
Country Place Senior Living of Marysville	Marysville	ALF	7/23/15
Country Place Senior Living of Seneca	Seneca	ALF	8/4/15
Vintage Park at Wamego LLC	Wamego	ALF	8/5/15
Vintage Park at Eureka LLC	Eureka	ALF	8/6/15
Heritage Estates Assisted Living	Harper	ALF	7/14/15
Lawrence Presbyterian Manor	Lawrence	SNF/NF	7/14/15
Vintag Park at Louisburg LLC	Louisburg	ALF	7/14/15
Marion Assisted Living LLC	Marion	ALF	8/27/15
Caritas Center, Inc.	Wichita	SNF/NF	9/3/15

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 _____