In This Issue

SunFlower Connection Index - Updated

The Sunflower Connection Index http://www.aging.ks.gov/AdultCareHomes/Newsletters/Sunflowerconnectionindex.pdf is now updated. The Sunflower Connection quarterly newsletter is designed to keep you abreast of current information regarding KDOA and long term care in Kansas. Please be sure all managerial-level staff have access to the information contained.

Residential and Staffing Annual Reports
Due January 20, 2012

NF and NFMH, ICFMR, ALF, RHCF and Home Plus facilities must submit their Annual Residential and Staffing Reports of facility by January 20, 2012. The reference week for the reports is December 4 – 10, 2011. A link to the form instructions, including a blank form, is available on the KDOA Provider Information Resource Site at www.aging.ks.gov in the NEW OR UPDATED INFORMATION region in the middle of the page, and on each page of the web-based report.

Accessing Annual Reports

The reports are electronic and are accessible on the Facility Home Page under the Facility Statistical Reports region within KDOA Web Applications. If you do not currently have security access to the KDOA Web Application system, you will need to complete the KDOA Security Agreement. The facility administrator or operator will need to authorize the Security Agreement for each individual who will need access to the Annual Reports and return it by mail or FAX as indicated at the bottom of the form. KDOA will then issue the individual a personal user name and an initial password. The login information will be e-mailed to the address provided on the Security Agreement. The KDOA Security Agreement is located on the KDOA Provider Information Resource Website www.aging.ks.gov below the NEW OR UPDATED INFORMATION region. **Please** call the KDOA Computer Help Desk at 785-296-4987 with web application log-in or security access questions. For questions on the report content, contact Tina Lewis with the Survey and Certification Commission at 785-296-1260.

Workforce Enhancement Grants

The Kansas Department on Aging has awarded the Workforce Enhancement Grants for 2012. Under the grant educational programs are provided for all unlicensed staff and limited licensed staff in nursing homes and long term care units of hospitals. The objective of the grant program is to improve the quality of life and quality of care for residents in these facilities. Those receiving grants for 2012 include:

1) Kansas Health Care Association- *The Importance of Oral Health for LTC Residents*;
2) Kansas Advocates for Better Care - *Ensuring Dignity and Creating Home;*
 3) Alzheimer's Association Central and Western KS - *Foundations of Dementia Care;*
4) Alzheimer's Association, Heart of America - *Neuro-Psychiatric Symptoms of Dementia;*
5) Evergreen Living Innovations - *Grow with Evergreen Resources for Transforming Innovations.*

Facilities and organizations are encouraged to contact these entities for presentations to their staff

Survey and Certification Letter

http://www.cms.gov/SurveyCertificationGeneralInfo/PMSR/list.asp

Subject: Alert: Smoking Safety In Long Term Care Facilities
Ref.: S&C: 12
Date: November 10, 2011
Memorandum Summary

- **Interpretive Guidelines:** This memo reviews current interpretive guidelines for F323, reemphasizing adequate supervision of all residents.
- **Facility obligations:** Facilities must include assessment of smoking areas and provision of emergency equipment in the designated smoking areas. Facilities should also document the means by which individual residents are assessed as safe to smoke without supervision.
- **Known Hazards:** Oxygen use and smoking.

Monitoring Medications

Nursing homes need to have a system to show the staff are monitoring for side effects and efficacy of all medications. The staff need to be able to show or explain the home's system. The information does not need to be in more than one place. The care plan must cover those medications with a potential for significant impact upon the resident and those that require ongoing monitoring of their use. A nursing home may focus the care plan on those medications that, based on a comprehensive assessment, have the potential for a clinically significant impact upon the resident or have side effects for which the resident is at particular risk. When a medication (for example, amiodarone, digoxin, or warfarin) is known to present a clinically significant risk, the nursing home would have to justify not including it in the care plan.

The nursing home staff should be able to tell or show a surveyor the goal and objectives for medications being used and how they are monitoring the resident for efficacy and adverse consequences. The nursing home is not required to list each and every medication, but the care plan must have sufficient information to assure that the care is provided; the medication use is monitored as necessary; and that the location of the information regarding dose and duration is on the clinical record, i.e.in the physician's orders. A drug that has a black box warning (if relevant to the resident) could have a significant impact on the resident. A nursing home should have a care plan that addresses how nursing home staff are going to monitor for or prevent an adverse reaction from that drug. **483.20 Resident Assessment, F272; 423.35(l) Unnecessary Drugs**

Free Education for Eligible Nursing Home Staff

Kansas Health Profession Opportunity Project
As a recipient grantee from the Administration for Children and Families division of Health and Human Services, the State of Kansas Department of Commerce has launched the Kansas Health Profession Opportunity Project (KHPOP) to

assist in providing health care education, training and employment for TANF and SNAP recipients and other low-income

individuals. The $15.3 million grant will provide supportive services and assist in

removing barriers that prevent clients from successfully completing education and employment goals. The objective of the grant is to help clients attain jobs and address the needs of employers facing shortages of workers for in-demand health care occupations. For more information, please refer to www.kansascommerce.com/khpop

Focus on Statutes/Regulations from the Kansas Nurse Practice Act

(This article was taken from the January, February, March 2012 Kansas Board of Nursing Kansas Nursing Newsletter.)

65-1120. Grounds for disciplinary actions; proceedings; witnesses; costs; professional incompetency defined; criminal justice record information.

(a) Grounds for disciplinary actions. The board may deny, revoke, limit or suspend any license, certificate of qualification or authorization to practice nursing as a registered nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or as a registered nurse anesthetist that is issued by the board or applied for under this act or may publicly or privately censure a licensee or holder of a certificate of qualification or authorization, if the applicant, licensee or holder of a certificate of qualification or authorization is found after hearing: …

(6) to be guilty of unprofessional conduct as defined by rules and regulations of the board; …

60-3-100. Unprofessional conduct. Any of the following shall constitute "unprofessional conduct":

(a) Performing acts beyond the authorized scope of the level of nursing for which the individual is licensed:

In the regulatory practice realm we often see cases involving a violation of this regulation. The typical violations involve an LPN that is

practicing without supervision, an LPN performing an IV therapy task that is prohibited, an RN/LPN/APRN that is providing medical treatments without an order/protocol/collaborative agreement to do so, or an RN that is crossing into the protected practice of an APRN. Not only can a nursing license be disciplined for a violation but in a civil malpractice action if it is proven that a nurse is functioning outside of the lawful scope of practice an insurance company can deny coverage for the act and a plaintiff is almost assured a judgment in their favor. It is very important for licensees to understand and stay within their scope of practice that is authorized by statute. Nurses should remember also that the authorized scope of practice varies from state to state. What is allowed in one may not be allowed in another. Nurses should always study and know the scope of practice for any state in which they are working.

Addendum:
Related Adult Care Home Regulations:
The Adult Care Home (Residential Homes) regulation on Staff Qualifications (KAR 26-[41, 42, or 43]-103) references the requirement for LPNs to have RN supervision: "*A registered professional nurse shall be available to provide supervision to licensed practical nurses, pursuant to KSA 65-1113 and amendments thereto*". There are also regulations in Resident Records (KAR 26-[41, 42, 43]-105), Health Care Services (26-[41,42,43]-204) and Medication Management (KAR 26-[41,42,43]-205) related to providing medications and treatments according to physician orders.

Nursing facilities regulation regarding the need for RN supervision of LPN's is found in KAR 28-39-154 Nursing Services (a)(3)(B). If a licensed practical nurse is the only licensed nurse on duty, a registered nurse shall be immediately available by telephone.

MYTHS ABOUT COMPLAINT INVESTIGATIONS

Myth: *"I should complete the investigation first and then decide if I should report the incident to KDOA"*

Fact: The regulation requires all allegations of abuse, neglect, misappropriation of resident property or injuries of unknown origin be reported **IMMEDIATELY** to the State Survey and Certification agency. The facility ANE Policy should also direct staff to report immediately and then investigate.

Myth: *"If I work in a hospital LTCU, the Risk Manager decides if I should report it or not. There might be a delay of several weeks, but its okay since we sent it to Risk Management"*

Fact: Hospital based LTCU's are not released from the obligation to report all allegations of ANE or injuries of unknown origin to the State Survey and Certification agency immediately. The requirements are the same for LTCUs as they are for free-standing facilities.

Myth: *"No one looks at the investigation anyway so it doesn't really matter what I send to the Regional Manager"*

Fact: A significant amount of time and effort is put into reviewing facility self-investigations. The Regional Manager will contact the facility for additional information if it's not included with the original investigation. Communication will continue between the Regional Manager and the facility until enough information is obtained to determine if an allegation of ANE is substantiated or unsubstantiated.

Myth: *"I know the regulation says I should have my investigation completed and sent to the Regional Manager within 5 working days, but it doesn't' really matter if it's days/weeks/months late"*

Fact: Per regulatory requirements, the completed investigation should be sent to the Regional Manager within 5 working days. If for some reason that is not possible, please call the Regional Manager and ask for an extension. In some cases you may be asked to submit the portion of the investigation you have completed and send the remainder later.

Myth: *"If I call the hotline, someone from KDOA is automatically going to come out to see us"*

Fact: There are some situations where a call from a facility will trigger an onsite visit to the facility, but this is the exception. Typically, when a facility reports an incident to the hotline, KDOA staff knows you were aware of the problem and are working on fixing it. When the completed investigation is received and reviewed by the Regional Manager, you have demonstrated the facility's ability to take care of the situation without KDOA onsite involvement. This might be considered a "win-win" for KDOA as well as the provider.

Myth: *"I don't know if I should report certain things. I have no one to ask about it and no way to find out if certain situations are reportable"*

Fact: Staff at KDOA hotline is there to assist you. If you call and give them your information, they will advise you if the situation in question is reportable. Likewise, your Regional Manager is available to assist you in making a determination if something is reportable. Hotline staff as well as the Regional Manager will make their determinations based on regulations. Please be reminded that some corporations/facilities have their own reporting requirements which are more stringent than Federal/State regulations.

Myth: *"I should send the whole care plan and the complete MDS"*

Fact: The Regional Manager only needs the pertinent care plan and the relevant sections of the MDS.

HOC Corner
Health Occupations Credentialing Contacts

Health Occupations Credentialing (HOC) continues to work toward the transition of Certified Nurse Aide test processes to computer based testing (CBT), and toward the conclusion of the Kansas Home Health Aide training course revision process. CBT is nearing the testing stage of implementation, and the HHA course will soon move to the approval process.

Staff changes have resulted in the realignment of some responsibilities. Currently, contact numbers for HOC are as follows:

- Steve Irwin, Certification and licensure processes: 785-296-6647, sirwin@kdheks.gov
- Brenda Kroll, Licensing: 785-296-0061, bkroll@kdheks.gov
- Mary Flin, Education, course approvals, CEU questions: 785-296-0058, mflin@kdheks.gov
- Betty Domer, Certification and testing, instructor applications, reciprocity:
- 785-296-1250, bdomer@kdheks.gov
- Melinda Reynard-Lindsay, CRC online issues and prohibitions: 785-296-8628, mreynard@kdheks.gov
- Sarita Everett, CRC: 785-296-6958, severett@kdheks.gov
- Sheila Seymour, Nurse Aide Registry; replacement certificates: 785-296-0060, sseymour@kdheks.gov

As processes are evaluated and streamlined, changes are being implemented that will enable HOC to continue to ensure quality training in cooperation with the many programs and organizations involved in allied health training in Kansas. Programs are encouraged to continue to call or email when questions arise.

MDS Corner
Upcoming Education

MDS 3.0, CAA, and Care Planning – The Basics. This two day workshop is appropriate for **new** MDS Coordinators and nursing home staff who have had no prior education in the MDS, CAAs, and Care Plan. It will be held February 2 and 3 in Salina. There is no charge. Attendees must bring a current RAI Manual. Check KDOA link for detailed information http://www.aging.ks.gov/AdultCareHomes/Education_Info/Education_index.html

Transition for Implementation of FY 2012
SNF PPS Policies

The SNF PPS FY2012 Final Rule (76 FR 48486) outlined several policy changes in the SNF PPS effective for FY 2012. These changes include: a revised MDS assessment schedule, the Change of Therapy (COT) Other Medicare Required Assessment (OMRA), a resumption of therapy option for the End-of-Therapy OMRA, the allocation of group therapy time, and a revised student supervision policy. Transition guidelines for these policies can be found in the Downloads or Related Links inside or Outside CMS at http://www.cms.gov/snfpps/03_RUGIVedu12.asp#TopOfPage.

National Provider Call

-Follow-up and clarifications to the November 3, 2011 Call (is must read for the most recent information. Posted 11/30/11)
-Transcript to the November 3, 2011 Call
-Audio transcription to the November 3, 2011 Call
-Training slides to the November 3, 2011 Call

RAI Manual and CMS MDS Education/ YouTube Videos available at:

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

Question: May a LPN who completes a MDS Certification Course sign Z0500: *Signature of RN Assessment Coordinator Verifying Assessment Completion* and/or V0200B. *Signature of RN Coordinator for CAA Process*?
Answer: No. While it is wonderful for LPNs and all staff to increase their knowledge of the

RAI tool: MDS, CAAs, and Care Planning, only a RN may sign as the RN Coordinator at Z0500 and V0200. (Reference RAI Manual, Chapter 3 Z-7 and V-5) CFR 483.20(h), F278, states "*A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.*" It is this person who signs Z0500 and V0200.

Question: What are the requirements if the MDS is maintained electronically with electronic signatures?

Answer: Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record. Nursing Homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g. a facility with five units may maintain all records in one location or by unit, or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. (RAI Manual Chapter 2-2-6,7).

Advancing Excellence Campaign
KS LANE to Focus on Pain Reduction

The national average pain rate in October 2010 was 7.43%. The Kansas' nursing home rate at that time was 9.37%. This rate has increased in Kansas from November 2009 when it was 8.67%. The KS LANE's proposal to assist the nursing homes in Kansas to decrease the aggregate average for worst pain on the numerical scale of the MDS by 10% for long stay residents by July 31, 2012 was accepted by the Advancing Excellence Campaign "Accelerating LANE Performance Challenge".

To accomplish its goal, selected nursing homes will be asked to participate in the project by tracking data of the pain measurement monthly. The LANE is also in the process of arranging two PAIN Webinars for all nursing homes in Kansas. They will focus on Pain Interventions:

pharmacological and non-pharmacological; and MDS Coding and CAAs on Pain.

Quality Assurance and Performance Improvement

With the passage of the Affordable Care Act In March, 2010, CMS was directed to develop standards for a Quality Assurance and Performance Improvement (QAPI) Program and to provide technical assistance on the development of best practices for QAPI. (S&C Letter 11-23-NH) Since that time CMS contracted with the University of Minnesota and Stratis Health, the Quality Improvement Organization for Minnesota, to conduct a demonstration program and pilot test material in 4 states. Two tools recently released to help nursing homes review and development of their QA programs are *Five Elements of QAPI and Tips for Preparing For QAPI – Suggestions for Senior Leadership.* These documents are located at the closing pages of the SF Connection. A link with additional information is http://www.cms.gov/SurveyCertificationGenInfo/05_QAPI.asp In the next phase CMS has contracted with Abt Associates to develop a questionnaire for administration to 4200 nursing homes to collect baseline. It will collect information as well as identify barriers to quality and areas where technical assistance will be beneficial.

Realizing the CMS project will be ongoing for a few years, KDOA has recognized to assist the Kansas nursing homes now in improving their QA programs as required by CFR 483.75(o) Quality Assessment and Assurance F250. A workgroup is currently compiling tools of frequently cited F-tags and related best practices. Please consider sending your tool and/or best practices to Vera VanBruggen at vera.vanbruggen@aging.ks.gov. or representatives from your respective organizations, Kathi Beeton, Susan Fry, KJ Langlis, Marie Vogel, Terry Pierce, and Darlene Smikahl. for the following F tags:.

- F279 Develop Comprehensive Care Plans
- F280 Right to Participate in Planning Care and Revising Care Plan
- F253 Housekeeping and Maintenance Service

- F309 Provide Care and Services for Highest Well Being
- F314 Treatment and Services to Prevent/Heal Pressure Sores
- F323 Free of Accident Hazards/Supervision /Devices
- F327 Sufficient Fluids to Maintain Hydration
- F329 Drug Regimen Free From Unnecessary Drugs
- F371 Food Procurement, Store/Prepare/Serve – Sanitary
- F425 Maintain Nutritional Status unless Unavoidable
- F428 Drug Regimen Review, Report and Act on Irregularity
- F441 Infection Control, Prevent Spread, Linens

Visitors in the Nursing Facility
part 3

The end of the holiday season wraps up a most challenging time for dealing with visitors to the nursing facility. Family "home" for a few days are often new to LTC and come filled with questions, challenging behaviors, etc. The first responsibility of staff concerning visitors is to ensure each resident is safe and comfortable when the visitor is present. The second task when interacting visitors is to utilize their energy/expertise/information to create a better experience for those residing in the facility. This New Year gives us an opportunity to apply a fresh perspective toward visitors. Suggestions coming from residents and their families- when combined with the facility staff – can be blended into the creation of a facility culture unique and special for residents. Strive to keep these principles in mind:

1-Stakeholder expertise: **CFR483.15g**
…maintain the highest practicable physical, mental, and psychosocial well-being of each resident… what better opportunity is there to achieve this than taking the opportunity to listen while close relatives and friends tell us about their lives together during the holiday visits? Incorporating this information into the daily living environment can re-create treasured memories for residents and provide a contentment and comfort only such knowledge

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can make possible. Many a facility staff member has left the funeral of a well-loved resident saying, "I didn't know he/she was known for doing "this or that! Don't let this be you. Capture the opportunity visitors present to illuminate the roles residents played in their family and community and help them continue in them.

2-Nearly everyone has someone…who brings our residents joy and/or make their lives "interesting", **CFR483.10**
"The resident has a right …and communication with and access to persons and services inside and outside the facility… We must be professional and appropriate with all! Our ability to incorporate these valued friends and family into resident lives can be the single most important issue we address during our days with an individual. A resident who knows family is welcome will suggest attendance at special events, dinners together, etc. The better the family and friends know your building and staff, the easier working together with the resident can become. When stressful situations arise these positive interactions have us already on good footing for working through the situation.

3-Everyone needs to feel useful, needed, important and successful: CFR483.15a
The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life… Those who visit our residents give us a keen understanding of what and who was important to residents prior to their life with us. How can we reconnect the resident to these people, activities, events, etc.? Can the visitors help us do that? Whether it's a willingness to transport a resident to church with them or hold a social group's meeting at the facility family meeting room, the people who are important in the life of a resident can "make or break" quality of life for those who live in the building. Utilize the connections with visitors to keep your residents connected to their community, organizations and families.

4-All people are at their best when the feel others have a positive view of them…CFR483.15
(a) *promote care in a manner that maintains or enhances each residents dignity and respect in*

full recognition of his or her individuality. This applies both for visitors and residents. When staff promote resident/visitor interaction the resident benefits by continuing to feel wanted, needed and important enough to include; when a visitor feels welcome in a building it's easy to return, maybe to become a volunteer – who knows?

5-Everyone longs for accurate and complete information when a decision must be made…CFR483.10(d)(3)..

the resident has the right to—unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment… One of the primary reasons family members avoid visiting a loved one in long term care is, "I don't know what to say if he/she asks me about…" People who do not deal with chronic/terminal conditions on a routine basis often struggle to understand "how" to interact appropriately: staff can be a model/resource. Confronting incapacity or serious illness triggers emotions and issues that many people have yet to resolve. One role senior generations fill in families is teaching about the seasons of life: how to adjust, how to move through each with confidence, grace and dignity. Our residents need to know family and friends will be "OK" if they can no longer "be there" for them as much as these family/friends are needed for support to the elder navigating what may be their final season of life.

Whatever natural conflicts that may come out of the diversity visitors introduce to our environments, they can be offset by the richness added to resident lives and the resources they can be to staff as we deliver services to enhance daily living. Utilize interactions with visitors to

1) eliminate ignorance, fear and anxiety about long-term care living;

2) educate these caring friends and family about what supports and assists the resident to have a quality experience during the days they spend with you,

3) help them make practical choices in gift-giving such as:

- -a certificate to a favorite fast food for a special treat after facility shopping trips;

- -a certificate to the hair dresser so anytime an unexpected event comes along the resident has access to looking "sharp";
- -a bird feeder or special shrub or flower outside a window if the resident enjoys nature/gardening;
- -bring in a favorite family recipe for supper;
- -non-skid shoes; -record church or choir and provide a way to watch/play it back

Visitors delight in being able to do something meaningful for people they love. One of the foundational pillars of Culture Change care model is that of leading a meaningful existence. Any one of these mentioned ideas can bring immeasurable joy to the recipient – but it is often staff who must educate/suggest/facilitate to make it all happen. Visitors can be a tremendous asset for a building. *I challenge you in this New Year to make the most of the opportunity!*

New Series for Recognizing and Treating Depression Available

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a tool entitled ***Treatment of Depression in Older Adults Evidence-Based Practices "KIT"*** (**K**nowledge **I**nformation **T**ransformation). There are 10 booklets in the series covering various aspects of developing a program for dealing with Depression in Older Adults. Each booklet is targeted for use with a specific task. These include:

How to use the tool KIT
Key Issues in Depression and Older Adults
How to choose a EBP for working with
Depression in Older Adults-Implementation Guides (4):
   a-Family and Care Giver guide
   b-Practitioner's Guide
     Agency Administrators and Program
   c.Leaders Guide
     Leadership Guide for MH, Aging and
   d.General Medical Health Authorities
Evaluation of Program
The Evidence behind this Program
Using Multimedia to Introduce the EBP

Per CMS, effective October 14, 2011, Medicare covers annual screening for adults for depression *(depression series con't page 8)* in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment and follow-up. Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illnesses including cancer, arthritis, stroke, chronic lung disease and cardiovascular disease. Other stressful events, such as the loss of friends or loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated.

MDS 3.0 includes the PHQ9 screening tool as a part of section D, Mood. Residents who are struggling with depression will be identified through this screening and action will need to be taken to address this issue. This series of booklets can be helpful to the facility to not only assist residents in an informal manner but to understand when to alert the physician to what is a more serious matter that may need to be addressed through medication or referral to a mental health professional.

All of the booklets, printed in 2011, can be downloaded at the SAMHSA website at www.samhsa.gov . All the material is public domain and may be reproduced or copied without permission so long as no fee is attached to distribution.

Trauma Informed Care

The Kansas Consumer Advisory Council for Adult Mental Health, Inc. is providing information and leadership to create a *Trauma-Informed Care system in Kansas*. The SAMHSA Consumer Statewide Consumer Network Grant project, "*RECOVERY FOR REAL*" is a 3 year project for development of a Trauma-Informed Care model. The end result will be to take the model to (4) pilot sites. The developed curriculum and self-assessment scale will be utilized and training and implementation of the model will take place. The basis for the Kansas model comes out of materials first developed by Beth Filson for the Georgia Mental

Health Consumer Network, with updates and adaptations made for Kansas.

The premise of Trauma-Informed Care is that many people being treated for mental health issues have experienced trauma. The National Center for Trauma Informed Care *defines "trauma" as a "singular or multiple compounding events (one experience after another) over time that can be shocking or terrifying, often including betrayal by a trusted person or institution and a loss of safety.*

Trauma can result from experiences of violence, abuse, neglect or disasters that induce powerlessness, fear, recurrent hopelessness and a constant state of alert. It can impact spirituality, relationships to others, community and environment and often results in recurrent feelings of shame, guilt, rage, isolation and disconnection. The curriculum is built around the concept that healing is possible.

The process of personal transformation culminating in healing from trauma begins in the place of greatest loss, grief and fear; the experiences are faced with the assistance of whatever supports may be necessary until they can be incorporated into the natural progression of life, moving from the feelings a person current is experiencing forward to re-establishing a sense of safety in relationships, community and environment.

In a nursing facility it is a simple thing to reassure a resident that he will be safe. Residents respond to a loss of control in some common ways: 1)Seeking Power, 2)Keeping Power, or Exercising Power (these can set up confrontation with staff and other residents). Other common responses are to 4)Give up power, 5) Give in to whomever has power (both setting up potential for abuse) or 6) Refuse to engage in relationships at all (isolating). If prior experiences have left the resident feeling insecure and hopeless or the present health situation is triggering anger or helplessness it is common to respond by becoming angry, suspicious, defensive or withdrawn with staff, setting off an interaction style that becomes his "norm" in care routines. Staff can learn to approach such a resident in a manner that will not "trigger" these issues. As

time goes on a trust relationship can be built. The resident relaxes and realizes that this staff does care and will meet the needs as they present. BOTH the resident and staff must work to create an environment which will help the resident heal and feel safe.

Culture change standards and the core principles of trauma informed care merge well. The 3 core statements of trauma informed care are 1)voice – I am the expert of my experience; 2)choice – rather than coercion;   and 3) trust - creates a sense of safety and allow for healing and hope. Facility staff benefit from being aware of the impact of trauma, understanding long-term consequences possible from it and taking appropriate action in care routines and choices to encourage trust, healing and hope. Culture Change has at its core "person-directed" values of choice, dignity, respect, self-determination and purposeful living.

Ask Al

QUESTION: What is the requirement for the resident's personal storage space in in new construction of nursing homes and additions to existing nursing homes?

 ANSWER: According to KAR 26-40-302 Nursing facility physical environment; applicants for initial licensure and new construction. (d) Resident unit. (1) Resident rooms. (E) Each resident's room shall include personal storage space in a fixed closet or freestanding wardrobe with doors. This storage shall have minimum dimensions of one foot 10 inches in depth by two feet six inches in width and shall contain an adjustable clothes rod and shelf installed at a height easily reached by the resident. Accommodations shall be provided for hanging full-length garments.

QUESTION: Do windows in the resident's rooms need to be operable in new construction of nursing homes and additions to existing nursing homes?

ANSWER: According to KAR 26-40-302 Nursing facility physical environment; applicants for initial licensure and new construction. (d) Resident unit. (A) Each resident room shall meet the following requirements: (v) provide each resident with direct access to an operable window that opens for ventilation. The total window area shall not be less than 12 percent of the gross floor area of the resident room.

(**QUESTION:** What is the requirement for equipment storage new construction of nursing homes and additions to existing nursing homes?

ANSWER: According to KAR 26-40-302 Nursing facility physical environment; applicants for initial licensure and new construction. (e) Resident unit care support rooms and areas. (7) Equipment storage rooms or areas. Each resident unit shall have sufficient rooms or enclosed areas for the storage of resident unit equipment. The total space shall be at least 80 square feet plus an additional minimum of one square foot per resident capacity on the unit, with no single room or areas less than 40 square feet. The width and length of each room or area shall be at least five feet.

Nursing Home Laundry Requirement

September 30, 2009, CMS revised the infection control regulation for Long Term Care Facilities, CFR 483.65 Infection Control, F441. The regulation is www.cms.gov/manuals/Downloads/som107ap_**pp**_guidelines_ltcf.pdf

The interpretative guidelines that follow the regulation clarify what is needed to meet regulatory compliance. Section *"**Handling Linens to Prevent and Control Infection Transmission"** s*tates *"Detergent and water physically remove many microorganisms from the linen through dilution during the wash cycle. An effective way to destroy microorganisms in laundry items is through hot water washing at temperatures above 160ºF (71ºC) for 25 minutes.100 Alternatively, low temperature washing at 71 to 77 degrees F (22-25 degrees C) plus a 125-part-per-million (ppm) chlorine bleach rinse has been found to be effective and comparable to high temperature wash cycles."*

When state regulations are written, they cannot be less stringent than the federal regulations, thus KDOA included the CMS requirements in its January 7, 2011 regulations for Laundry Services in Physical Environment; Applicants for Initial Licensure and New Construction and Physical Environment; Existing Nursing Facilities, KAR

26-40-302(g)(6) and KAR 26-40-303(f)(8) respectively the federal regulations were included. The state regulations are available at http://www.aging.ks.gov/PolicyInfo_and_Regs/ACH_Current_Regs/ACH_Reg_Index.html The state regulations provide more detailed requirement to allow a nursing home to monitor and tell surveyors how it is meeting the regulatory requirements.

If nursing home processes one or more than one resident's personal laundry (comingle) or contaminated laundry defined in KAR 26-39-100 (r) as clothes or linens that have been soiled with body substances including blood, stool, vomitus, or other potentially infectious material, the following requirements must be met:

- If high-temperature washing is used, the washing machines shall have temperature sensors and gauges capable of monitoring water temperatures of at least 160°F and manufacturer documentation that the machine has a wash cycle of at least 25 minutes at 160°F or higher.

- If low-temperature washing is used, the washing machines shall have temperature sensors and gauges capable of monitoring water temperatures to ensure a wash temperature of at least 71°F and manufacturer documentation of a chlorine bleach rinse of 125 parts per million (ppm) at a wash temperature of at least 71°F. Oxygen-based bleach may be used as an alternative to chlorine bleach if the product is registered by the environmental protection agency

Mental Health/Behavioral Health Resource Listing

January 2012

Resident interviews and PHQ-9 added to MDS 3.0 have a number of providers requesting direction to resources to be used by staff on behalf of residents to enhance quality of life and meet needs. Following is a topical listing of some of the most current and helpful resources available to LTC providers. **This is not a comprehensive listing** but instead strives to make providers aware of new or current materials that are easily accessed.

"Stigma" is a very real phenomenon when speaking in terms of mental and behavioral health. While topics listed below fall under the category of "behavioral health issues" many people may not identify them as such. Examples of this are moderate depression and admission adjustment issues. The sadness, anger, etc. at the crux of these issues dramatically impacts quality of life and is often fairly easy to reverse if staff, family and residents are educated as to the cause and can bring some basic interventions into play quickly. Please contact Sue Schuster, LMSW at KDOA, 785-291-3090, if you have additional materials for inclusion in this resource; additional listings will be published at a later date.

It is to be remembered that few nursing facility staff are clinically licensed to do therapy. These resources assist those who are staff and caregivers to enhance the quality of life for residents and to address issues that often, when dealt with early in their progression, can be moderated and often overcome without further treatment. For those issues progressed beyond this point a referral to a competent All data was available and all links were working at printing time. It is to be remembered that items on the web often "come and go". You are encouraged to download information you find helpful.

Adjustment Issues
Mental Health and Nursing Home Residents is a short handbook designed to assist staff and family to support residents as they acclimate to nursing home living. If adjustment prolongs and sadness/ loss/anxiety/anger issues do not diminish staff need to look at interventions to assist the resident to move through this stage on to a positive long-term care experience. This booklet was compiled by Lauren Ungar MSW, PsyD For Wayne State University Institute of Gerontology with help from Family Caregivers at DMC West Nursing home, Southfield, MI. and can be accessed on line at: http://www.iog.wayne.edu/pdfs/mental_health.pdf. An excellent resource originally developed through the efforts of the Kansas Mental Health and Aging Coalition and their partners to address a multitude of issues associated with life changes

is the *Kansas Department on Aging Mental Health Guide*, it is available in hard copy from the Kansas Department on Aging as well as among the KDOA on-line publications at: http://www.agingkansas.org/Publications/Other/2008MentalHealthGuide.pdf.

*Tips for Helping a Person Living in an Nursing Home.*http://www.dibbern.com/nursing-homes/love-for-nursing-home-residents.htm. This on-line "blog" type document discusses admission from a family member's perspective.

Alzheimer/Dementia

The Neuropsychiatric Symptoms of Dementia: a visual Guide to Response Considerations. Alzheimer Association–Heart of America Chapter. Michelle Niedens (contact person) 1-913-831-3888. This little booklet is divided into 5 sections and covers general information through specific behavioral challenges and interventions, resources and services. Formatted in flip-chart fashion and laid out as a flow-chart it is a compact reference tool that serves both as a reference and education tool for staff and caregivers.

Anger Issues

Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Manual. This updated version produced by the Center for Substance abuse Treatment within SAMSHA is particularly helpful when working with residents who continue ingrained behaviors from lifelong habits even if they no longer actively involved with the product. Fact sheets are published quarterly with extensive bibliographic date to direct caregivers to additional information and resources located at www.kap.samhsa.gov/products/brochures/pdfs/saib.

Anxiety

Anxiety is a normal human emotion that can escalate when unchecked into panic attacks or an anxiety disorder. It is one of the most common under-addressed issues for nursing facility residents and is seldom thought of in the arena of "mental health". More familiar anxiety issues in our population are *post-traumatic stress*, *social phobias, hoarding, obsessive-compulsive disorder.* It will be important to understand the underlying causal factors behind any anxiety being exhibited by a resident in order to address it appropriately. The issues of adjusting to a nursing facility, adapting to loss of control in areas of life, etc. often lead to despair if intervention does not happen. These issues can greatly impact resident quality of life and therefore are important to identify and address timely.

Anxiety Issues in Older Adults is a 27 page posting from NIMH (National Institute of mental Health), updated 12/2010. This is a good, basic overview of symptomology and some FAQ's (frequently asked questions) to help direct caregivers to possible intervention and resolution. http://nihseniorhealth.gov/anxietydisorders/toc.html. Follow instructions at the site to download. *The DAWN Report*: *Emergency Department Visits Involving Adverse Reactions to Medications among Older Adults*, February 2011. This 4 page brief is a "wake up" alert to providers to be aware that behaviors may be triggered by medication toxicity. http://www.oas.samhsa.gov/2k11/DAWN013/AdverseReactionsOlderAdults_HTML.pdf.

Eleanor Feldman Barera, PhD. *Nursing Home Bathing Transformed,* LTC Living 10/2011. This article addresses what continues to be a most challenging area of care provision and one of high anxiety to residents. Additional information on psychological issues in LTC can be found from this author at: www.mybetternursinghome.com.

BiPolar Disorder

Bipolar Disorder by KDOA CARE Division, SF Connection, 1/2010. This was developed by the CARE Level II team to assist providers in understanding how this disorder manifests and what interventions are effective in care interactions.

Depression

Practitioners' Guide for working with Older Adults with Depression. Another in the series from SAMHSA of the EBP(Evidence Based Practices) KIT (Knowledge Informing Transformation) series, it can be viewed on-line or downloaded for future use. All the information is public domain and may be used in any manner appropriate with the exception of

being disseminated for a fee. http://store.samhsa.gov/shin/content//SMA11-4631CD-DVD/SMA11-4631CD-DVD-CareGiversGuide.pdf.

Older Adults Depression and Suicide Fact Sheet. This fact sheet from the National Institute of Mental Health gives basic symptomology, suggested interventions and a listing of resources for further information. View or download at: http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml.

End of Life Issues
Palliative Care: Improving quality of life when you're seriously ill. A brochure developed by the National Institute of Nursing Research this tool defines palliative care, differentiates it from "hospice" care and encourages working together with the whole support system to increase quality of life outcomes. http://www.ninr.nih.gov/NR/rdonlyres/01CC45F1-048B-468A-BD9F-3AB727A381D2/0/NINR_PalliativeCare_Brochure_508C.pdf.

Guardianship Issues
Find here a guide to Kansas laws on guardianship and conservatorship. *http://www.ksgprog.org/Publications/Guide%20to%20KS%20Law.pdf*. At this location find links to information regarding forms, court procedures and annual reporting. *http://www.ksgprog.org/*.

Prolonged Grief/Complicated Grief
Good Grief by Granger E. Westberg, Fortress Press, 2011. This is a classic updated. It is also now available in DVD.   Very simple and basic to work through with a resident or resident spouse and family.

Handling the Holidays by Conley Productions. This is a short booklet is now out of print but contains an excellent template for designing a way to cope with holiday and special day issues in the aftermath of loss. Contact Sue Schuster at KDOA for further information on this resource.

This web-based article gives a good overview of prolonged grief symptoms and suggested interventions. http://www.grief-healing-support.com/complicated-grief.html.

Substance Abuse
A most difficult behavior to manage in any adult care home is that of someone who has abused alcohol for a lifetime and finds ways to continue. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (November 15, 2011). *The TEDS Report: Older Adult Admissions Reporting Alcohol as a Substance of Abuse: 1992 and 2009*. Rockville,MD: http://www.samhsa.gov/data/2k11/WEB_TEDS_021/TEDS021OlderAlcUseWeb.pdf.

Suicide Prevention
This excellent series works with Family Councils and assists an adult care home to develop protective factors for their environment. DVD's are included in free hard copies that may be requested at 1-877-726-4727. *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities.* HHS Publication No. SMA 4515, CMHS-NSPL-0197. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2011. http://www.hhd.org/resources/publications/promoting-mental-health-and-preventing-suicide-toolkit-senior-living-communit.

MainStream, *Crisis and Suicide.* The information in this manual is available through the KDOA office (contact Sue Schuster) and contains good information to utilize for inservice/staff education to assist in recognizing suicidal ideation, prevention strategies, and resources for further assistance.

Trauma –Informed Care
So you Want to Change the World: Creating a Trauma-Informed Mental Health System. This is material developed by the Kansas Consumer Advisory Council for Adult Mental Health, October 2011. Four pilot locations will hold trainings with grant funding. The CAC is happy to share information regarding how to develop a better understanding of the impact of trauma on people and how care should be adjusted to allow for this. Further information is available by contacting **Chris White**, Kansas CAC TIC Grant Coordinator , kscacgrants@sbcglobal.net or by phone at 913-240-8667.

Feeding Difficulties Associated with Dementia: Consequences and Strategies

Declining capacity to eat and drink independently, and subsequent malnutrition and dehydration, have long been recognized as serious problems for institutionalized elderly, particularly for those with impaired mobility and cognition.[1] Based on a September 2011 report, 48.3% of the state's nursing home residents have dementia.[2] Some dementias are reversible, particularly those that are nutrient related (e.g., such as vitamin deficiency). However, dementia tends to be progressive and is often irreversible.[3] More than half of the people with dementia lose some ability to feed themselves.[4] Losses may include: decreased recognition of hunger and thirst; loss of ability to communicate hunger and thirst; declining perceptions of smell and taste; dysphagia (swallowing difficulty); inability to recognize dining utensils; loss of physical control; apraxia (impairment of ability to move); and depression.[5] The ability to recall having eaten may also be lost.[3] Feeding is the last activity of daily living lost with disability and is a common problem for older adults, especially those with dementia.[5]

Dementia in which a resident forgets to drink or forgets how to drink is a risk factor for dehydration.[6] Likewise, eating behavior associated with dementia may be sporadic, unpredictable and unusual. Such behaviors may include repetitive chewing, pocketing foods, or an unwillingness to allow someone to assist them.[3] Other behaviors, such as pacing or wandering, may alter energy needs.[3]
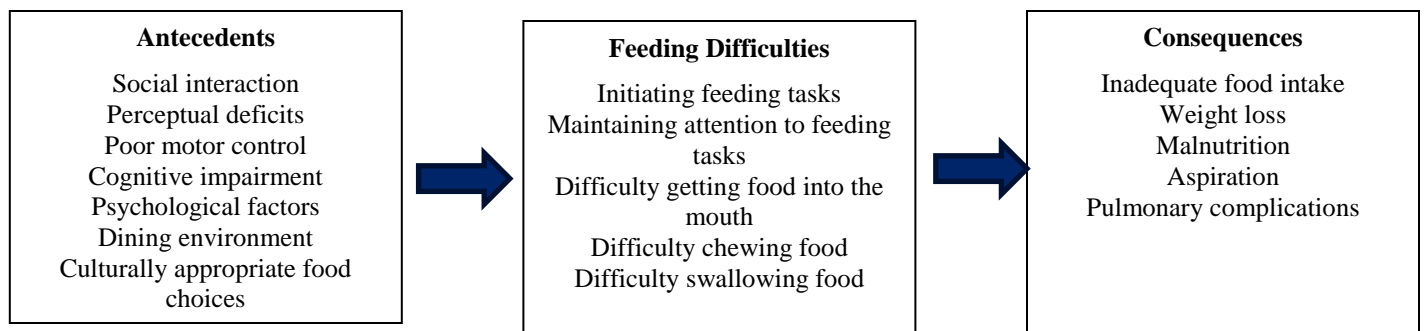
Unintended weight loss is a common problem.[7] There are many theories about why this happens; it has been hypothesized that there is a change in metabolism associated with dementia.[3] Changes in body weight associated with dementia may be significant.[3] An unplanned weight loss of 5% or more in 30 days often results in protein-energy under-nutrition as critical lean body mass is lost. It is a significant risk factor for mortality and a loss of 10% in six months is a strong predictor of mortality in older adults.[8]

Facilities are required to maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates this is not possible.[9]
Each resident with dementia has a unique symptomatology and must be treated accordingly. The goal of nutrition care for older adults with Alzheimer's disease or other forms of dementia is to develop an individualized diet that considers food preferences, utilizes nutrient-dense foods, and offers feeding assistance as needed to achieve the individual's goals.[7] Dementia care practice recommendations for adequate food and fluid consumption, including comprehensive assessment and care planning, were released by the Alzheimer's Association in 2009.[10] [An electronic link is listed with the citation below.]

A conceptual model for defining characteristics of feeding problems in dementia and delineating them from their antecedents (contributing factors) and consequences (adverse outcomes) was proposed in 2008 and is shown here.[5]

Model of Feeding Difficulty[5]

Antecedents	Feeding Difficulties	Consequences
Social interaction Perceptual deficits Poor motor control Cognitive impairment Psychological factors Dining environment Culturally appropriate food choices	Initiating feeding tasks Maintaining attention to feeding tasks Difficulty getting food into the mouth Difficulty chewing food Difficulty swallowing food	Inadequate food intake Weight loss Malnutrition Aspiration Pulmonary complications

Earlier this year, the same researchers proposed tactics or strategies that formal caregivers in nursing homes can use to overcome the five general types feeding difficulties.[4] Although not validated in clinical trials, the

strategies have been presented to help caregivers individualize assessment and intervention practices in residents with dementia.[4] [An electronic link is listed with the citation below; strategies are summarized on Table 1. Assessing and Managing Feeding Difficulties in Patients with Dementia, which is found on pages 40 and 41.] Such strategies require a multidisciplinary approach that includes dietitians, nurses, CNAs, occupational, physical and speech therapists, resident's family members and possibly non-nurse feeding assistants.[4] Ongoing monitoring and assessment of the consequences (adverse outcomes) is important and can allow for intervention before significant weight loss has occurred. When is the use of nutritional supplements indicated? Medical foods supplementation (nutritional supplements) is a recommended method for providing energy and nutrient intake, promoting weight gain and improving nutritional status or preventing under nutrition for older adults who have early to moderate dementia.[11] Although studies support the benefits of enteral nutrition via tube feeding for older adults who are undernourished or at risk, enteral nutrition (via tube feeding) may not be appropriate for terminally ill older adults with advanced disease states, such as dementia, and should be considered carefully and in accordance with advance directives.[11,12]

New Etiology-Based Terminology for Adult Malnutrition

Two major factors contribute to the development of malnutrition: semi starvation and the systemic inflammatory response.[13]

A simplified strategy for diagnosing malnutrition in clinical settings was proposed by an international committee in 2010. The new etiology-based terminology recognizes the importance of inflammation on nutritional status.[14] With this approach, each person affected by malnutrition falls into one or more of three categories: (1) starvation related, (2) chronic disease related or (3) acute disease/injury related.

If inflammation is absent then even advanced malnutrition due to starvation can be readily treated with appropriate nutritional resuscitation. The presence of inflammation often limits the effectiveness of nutritional interventions and the associated malnutrition may compromise the clinical response to medical therapy. [14]

Reed PS, Zimmerman S, Sloane PD, Williams CS, Boustani M. Characteristics associated with low food and fluid intake in long-term care residents with dementia. Gerontologist; 2005 (45): 74-80.

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Niedert KC, Dorner B. Nutrition care of the older adult. 2nd ed. Chicago, IL: American Dietetic Association; 2004:85-86.

Chang CC, Roberts BL. Strategies for feeding patients with dementia: How to individualize assessment and intervention based on observed behavior. Am J Nurs. 2011;111:36-44. Electronic link: http://journals.lww.com/ajnonline/Fulltext/2011/04000/Strategies_for_Feeding_Patients_with_Dementia.18.aspx See Article Tools to open in pdf format.

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Position of the American Dietetic Association: Individualized nutrition approaches for older adults in health care communities. J Am Diet Assoc. 2010;110:1549-1553.

Practice Paper of the American Dietetic Association: Individualized nutrition approaches for older adults in health care communities. J Am Diet Assoc. 2010;110:1554-1563.

State Operations Manual (SOM). Appendix PP. Guidance to Surveyors for Long Term Care Facilities. 42 CRF §483.25(i) Nutrition under Tag F325. Nutritional Status.

Alzheimer's Association.   Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes. 2009. Electronic link: http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf

Dietetics in Health Care Communities, a practice group of the American Dietetic Association. Unintended weight loss in older adults: ADA evidence-based practice guidelines. Connections; 2011;35(3):2-11.

State Operations Manual (SOM). Appendix PP. Guidance to Surveyors for Long Term Care Facilities. 42 CRF §483.25(i) Nutrition under Tag F325. Feeding Tubes.

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Jensen GL, Mirtallo J, Compher C, Dhaliwal R, Forbes A, Grijalba RF, Hardy G, Kondrup J, Labadarios D, Nyulasi I, Pineda JCC, Waitzberg D. Adult starvation and disease-related malnutrition: A proposal for etiology-based diagnosis in the clinical practice setting from the International Consensus Guideline Committee. Clin Nutr. 2010;34(2):156-159.

2011 EXEMPLARY AND NO DEFICIENCY FACILITIES				
FACILITY	**CITY**	**TYPE**	**NO DEF CERT/LET**	**SURVEY DATE**
Marquis Place	Concordia	ALF	x	7/13/11
Housatonic Place	Burlington	ICF/MF	x	7/14/11
Monterey Way House	Lawrence	ICF/MF	x	7/26/11
Bickford of Overland Park	Overland Park	RHCF	x	8/4/11
Emeritus at Overland Park	Overland Park	RHCF	x	8/4/11
Bickford at Mission Springs I	Mission	ALF	x	8/18/11
Medicalodges Gardner	Gardner	SNF/NF	x	8/18/11
Vintage Park at Waterfront	Wichita	ALF	x	8/18/11
Guest Home Estates II	Chanute	RHCF	x	8/24/11
Dooley Center	Atchison	NF	x	8/25/11
DSNWK Eisenhower Home	Norton	ICF/MF	x	9/12/11
Lakeside Terrace	Sabetha	ICF/MF	x	9/12/11
Blackhawk Assisted Living	Spring Hill	ALF	x	9/19/11
Freedom Pointe of Overland Park	Overland Park	ALF	x	9/22/11
Vintage Park at Fredonia LLC	Fredonia	ALF	x	9/22/11
Reflection Living of Timber Lakes	Wichita	HP	x	9/29/11
Vintage Park at Tonganoxie LLC	Tonganoxie	ALF	x	9/29/11

ALF-Assisted Living Facility

HP-Homes Plus

ICF/MF – Intermediate Care Facility/Mental Health Facility

RHCF –Residential Health Care Facility

SNF/NF – Skilled Nursing Facility/Nursing Facility

Year – 2010/11	4th Quarter Oct – Dec 2010	1st Quarter Jan – March 2011	2nd Quarter April – June 2011	3rd Quarter Jul – Sept 2011
Abuse, Neglect, Exploitation				1
Adult Day Care				21
Administration	5	16	7	1
Admission, Transfer, Discharge	1			
Delegation of Duties	1	2	2	3
Dietary Services	4	2	1	3
Emergency Preparedness	12	15	9	15
Employee Records		1	4	
Environmental Issues	3	2	2	6
Functional Capacity Screen	3	6	7	3
HealthCare Services	5	6	2	3
Inadequate Staffing				
Infection Control	8	9	5	4
Medication Management	26	17	22	8
Negotiated Service Agreement	13	8	17	17
Professional Standards of Quality				
Quality of Care Issues				
Resident Funds		2		
Resident Records	3	1	1	10
Resident Rights				
Restraints – chemical, physical				
Special Care Unit		1		
Staff Development				
Staff Qualifications	5			
Civil Money Penalties	1	1	1	9
Correction Orders	29	23	24	26
Ban on New Admissions	1	5	2	9
FEDERAL REMEDIES				
Civil Monetary Penalties Recommended	2	8	3	6
Denial of Payment for New Admissions Imposed	4	8	8	14
Terminations	0	0	0	1
No Opportunity To Correct	0	13	14	12

Five Elements of QAPI

Element 1: Design and Scope
A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the program should address clinical care, quality of life, resident choice, and care transitions. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes

Element 2: Governance and Leadership
The governing body and/or administration of the nursing home develops and leads a QAPI program that involves leadership working with input from facility staff, as well as from residents and their families and/or representatives. The governing body assures the QAPI program is adequately resourced to conduct its work. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed for QAPI. They are responsible for establishing policies to sustain the QAPI program despite changes in personnel and turnover. The governing body and executive leadership are also responsible for setting priorities for the QAPI program and building on the principles identified in the design and scope. The governing body and executive leadership are also responsible for setting expectations around safety, quality, rights, choice, and respect by balancing both a culture of safety and a culture of resident-centered rights and choice. The governing body ensures that while staff are held accountable, there exists an atmosphere in which staff are not punished for errors and do not fear retaliation for reporting quality concerns.

Element 3: Feedback, Data Systems and Monitoring   The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)   The facility conducts Performance Improvement Projects (PIPs) to examine and improve care or services in areas that are identified as needing attention. A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.

Element 5: Systematic Analysis and Systemic Action   The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Tips for Preparing for Quality Assurance Performance Improvement (QAPI)
Suggestions for Senior Leaders

1.Know the facts about QAPI for nursing homes.
• Review the QAPI language in the Affordable Care Act (handout)
• Review the CMS survey and certification letter that discusses QAPI (handout)
• Review the five elements of QAPI (handout)
• Review additional information from CMS:
https://www.cms.gov/SurveyCertificationGenInfo/05_QAPI.asp

2.Help key stakeholders such as your board of directors, leadership team, and staff learn more about QAPI. Get buy in now!
• Provide education on QAPI
• Review or get up to speed on the key concepts and principles of performance improvement
• Review your organization's current improvement or problem solving model, or identify a model
that you will use (examples: IHI's model for improvement with PDSA cycles; Baldrige/AHCA
Quality Program, Six Sigma/DMAIC, Lean, FMEA, etc.)

3.Meet with other leaders about QAPI.
• Think about some of your provider partners that have QAPI programs in place (hospitals,
hospice programs, renal networks, etc.). Visit them and hear more about how they have already
implemented QAPI.
• Think about other nursing homes that have performance improvement programs in place. Visit
them to learn more about their approach to improvement.
• Meet with your corporate office to discuss your approach to QAPI, if applicable.

4.Think about how you might (re)structure your QAPI program.
• Who will lead the program? Will you use a steering committee? Will you adapt your QAA
committee to fulfill this function? What process will you use to develop your QAPI plan?

5.Consider your current culture and how it will promote performance improvement.
• Do all staff, residents, families feel free to speak up to identify areas that need improvement?
How do you know if they feel free to speak up?
• Do you need to promote awareness of performance improvement and create the expectation
that everyone in the nursing home needs to be involved?
• How well do your staff work in teams? How do you know?
• How good is your organization at drilling down to identify the underlying causes of problems, so
that you can effectively prevent them from recurring?
• Have your previous improvement efforts been successful? What contributed to the success?
What were the challenges/barriers?
• How good are you at using data to drive your improvement efforts? What data sources are or
could be used to assist in future improvement efforts?

6.Think about a potential project that can get you an early success.

KANSAS DEPARTMENT ON AGING

Survey and Certification Commission	
Joe Ewert, Commissioner (785) 296-8366 joe.ewert@aging.ks.gov	Overall operations of the Commission including state licensure of all adult care homes as defined in Kansas statutes, federal certification of nursing facilities not licensed as part of a hospital, and certification surveys of long term care units of hospitals.
Tina Lewis (785) 296-1260 tina.lewis@aging.ks.gov	Medicare enrollment, change of ownership (Medicare Certified Facilities). Medicare bed changes. Program support to Commissioner and Division Directors.
Michelle Hickling (785) 296-3695 michelle.hickling@aging.ks.gov	State Quality Improvement Director
Irina Strakhova (785) 368-7055 irina.strakhova@aging.ks.gov	Enforcement Coordinator; Plans of Correction
Mary Jane Kennedy (785) 296-1265 maryjane.kennedy@aging.ks.gov	Complaint Coordinator

Survey and Certification	
Audrey Sunderraj, Director (785) 296-1023 audrey.sunderraj@aging.ks.gov	Licensure and certification survey process of nursing homes, attached assisted living facilities, nursing facilities for mental health and long term care units of hospitals through supervision of 5 Regional Managers; informal dispute resolution and state agency survey operations.
Dianna Swords (785) 296-1257 dianna.swords@aging.ks.gov	State Training Coordinator
Rita Bailey (785) 296-1259 rita.bailey@aging.ks.gov	Oversight of initial and annual licenses. Initial contact for processes including issuance of licenses. Maintains changes of licensed beds, ownerships, administrators and required rooms.
Kathie Jack (785) 296-1261 kathie.jack@aging.ks.gov	Licensure and certification support (for facility names A-L)
LaNae Workman (785) 296-1281 lanae.workman@aging.ks.gov	Licensure and certification support (for facility names M-Z)

Long Term Care Division	
Vera VanBruggen, RN, Director (785) 296-1246 vera.vanbruggen@aging.ks.gov	Development, revision and interpretation of state regulations of adult care homes. RAI Coordinator. Consultation and education on Federal and state regulations, and long term care issues
Sue Schuster, LMSW (785) 291-3090 Sue.schuster@aging,ks.gov	Consultation and education on federal and state regulations, long term care issues and RAI, SunFlower Connection, mental health in LTC, WEG grants.
Al Gutierrez, MPA MUA Environment Specialist (785) 296-1247 al.gutierrez@aging.ks.gov	Physical environment licensure of adult care homes. Consultation related to physical environment regulations. Site and floor plan review.

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