



# Sunflower Connection

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## SURVEY AND CERTIFICATION COMMISSION

**Survey and Certification Commission (SCC)** is the now the name for the commission formerly called Licensure, Certification, and Evaluation.

**Greg Reser**, former director, has accepted a position with the Bureau of Health Care Facilities, KDHE. The new Director of Survey and Certification is **Audrey Sunderraj**. She served as the Regional Manager for the Northeast District Office (Topeka and Lawrence consolidated survey region).

Ms. Sunderraj brings with her over 25 years experience in the survey and certification field and quality improvement. Since 2005 Audrey has served as the lead trainer for implementing the Quality Indicator Survey (QIS) process in Kansas.

## LEGISLATION AFFECTING HOME PLUS FACILITIES

During the recent legislative session the legislature passed and the governor signed into law House Bill No. 2147. The law increases the resident capacity for a Home Plus facility from 8 to 12 and requires an adjustment in staffing personnel and resources to maintain the current level of nursing care if capacity is increased. The law also requires annual dementia care training for personnel of any Home Plus facility that provides care to residents with dementia. [http://kslegislature.org/li/b2011\\_12/year1/measures/documents/hb2147\\_enrolled.pdf](http://kslegislature.org/li/b2011_12/year1/measures/documents/hb2147_enrolled.pdf) The law will take effect July 1, 2011.

In response KDOA created a proposed regulation, “Staff Development” that will specify required staff orientation and inservices, including annual dementia care if the facility admits residents with dementia. Please check the KDOA website throughout the summer and early fall for additional information.

Homes Plus deciding to increase their licensed resident capacity need to complete [http://www.aging.ks.gov/Forms/ACH\\_Licensure\\_Forms/Request\\_for\\_Resident\\_Capacity\\_Change.pdf](http://www.aging.ks.gov/Forms/ACH_Licensure_Forms/Request_for_Resident_Capacity_Change.pdf) A floor plan of the facility showing the square footage of its rooms is also requested. Additional questions regarding the physical environment may be directed to Al Gutierrez at 785-296-1247. Facilities should also notify the State Fire Marshal.



## **CHANGES IN RESIDENT CAPACITY OF SNF AND/OR NF**

This article is only a reminder of the current process a Medicare and or Medicaid facility must follow when wanting to change its resident capacity. Form #81500A “Request for Change in Resident Capacity” is available at [http://www.aging.ks.gov/Forms/ACH\\_Licensure/Forms/Request for Resident Capacity Change.pdf](http://www.aging.ks.gov/Forms/ACH_Licensure/Forms/Request_for_Resident_Capacity_Change.pdf)

KDOA will review providers request and notify them in writing of their determination regarding the request, including the effective date of the change in bed size and the bed locations, prior to the start of the cost reporting year or the cost reporting quarter, whichever applies. Please direct your inquiries and requests you may have regarding bed changes to Tina Lewis at 785-296-1260.

Following are excerpts from the State Operations Manual Chapter 3 on the topic. The Transmittals in their entirety are available at <http://www.cms.gov/manuals/downloads/som107c03.pdf>

### **3202B - Changes in Bed Size of Participating SNF and/or NF** (Rev. 1, 05-21-04)

If an institution or institutional complex has an existing SNF and/or NF agreement, it may elect to change the number of beds that are certified to participate in the Medicare or Medicaid program **up to two times per cost reporting year** in accordance with the requirements set out below. ... An institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year. ...

**At no time can** the RO or the SA (KDOA) **approve two decreases** in the bed size of an institution within the same cost-reporting year. The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it

undergoes a change of ownership (CHOW) or because it has been approved to change its cost reporting year.

### **3202C -General Request Filing Requirements** (Rev. 1, 05-21-04)

An institution or institutional complex seeking a change in the number of Medicare and/or Medicaid certified beds must:

- Submit a written request to the RO or SA (as appropriate) for the change 45 calendar days before:

- o The first day of its cost reporting year to effect a change on the first day of its cost reporting year; or

- o The first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.

- Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full participation or distinct part certification, whichever applies.

- Include a reference to the cost-reporting year of the institution or institutional complex. If there has been a change in the cost-reporting year originally selected by the institution or institutional complex at the time of its initial certification, submit a copy of the letter submitted to the fiscal intermediary and the fiscal intermediary’s response to the request.

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## **NO SEMIANNUAL STATISCAL REPORT REQUIRED**

KDOA will no longer require Adult Care Homes to submit semiannual statistical reports. Additional information will be forthcoming regarding the submission of annual statistical reports.

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**SURVEY AND CERTIFICATION  
LETTERS**

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp>

**Subject:** Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act

**Date:** June 17, 2011

**Ref:** S&C: 11-30-NH

**Memorandum Summary**

Reporting Suspicion of a Crime: Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility.

**Subject:** April and July 2011 Changes to Nursing Home Compare - Nursing Homes

**Date:** March 18, 2011

**Ref:** S&C: 11-17-NH

**Memorandum Summary:**

- **Changes to Nursing Home Compare:** Identifies forthcoming changes to Nursing Home Compare required by the Affordable Care Act.
- **Details of Changes:** Changes include information to facilitate reporting of complaints, additional information on residents rights, and facility-specific listing of number of complaints and enforcement actions taken against the facility

**Subject:** Final Rule for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) “Notification of Facility Closure Centers for Medicare & Medicaid Services (CMS)-3230-IFC”

**Date:** April 1, 2011

**Ref:** S&C: 11-18-NH

**Memorandum Summary:**

**Notification of Facility**

- **Closure:** As part of the “Patient Protection and Affordable Care Act” (the Affordable Care Act), Federal Regulations have been released which detail who is to be notified when a Skilled Nursing Facility (SNF) or Nursing Facility (NF) closes and required timeframes. *(Administrator must give notice 60 days prior to the date of closure; or in the case of a facility where the Secretary or the State Medicaid Agency terminates the facility’s participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate.*
- **Relocation:** The new regulations stipulate that a plan for relocation of residents be developed by the facility; this plan must be submitted and approved by the State Agency before closure of a nursing home.
- **Sanctions:** An administrator who fails to comply with the requirements will be subject to a civil monetary penalty.

**Subject:** Quality Assurance and Performance Improvement (QAPI) Initiatives related to Section 6102 (c) of the Affordable Care Act for Nursing Homes

**Date:** April 8, 2011

**Ref:** S&C: 11-22-NH

**Memorandum Summary**

- **The Affordable Care Act:** Section 6102 (c) of the Affordable Care Act requires Centers for Medicare & Medicaid Services (CMS) to establish QAPI standards and provide technical assistance to nursing homes on the development of best practices in order to meet such standards.

- **QAPI Prototype:** A nursing home QAPI prototype will be tested in a small nursing home demonstration project conducted by an independent contractor in the summer of 2011.
- **New QAPI Regulation:** In addition to the existing Quality Assessment and Assurance (QAA) regulation currently found at 42 CFR, Part 483.75(o), CMS will promulgate a new QAPI regulation.

### **SLEEP HYGIENE PROGRAM**

CFR 483.25(l), F329, Unnecessary Drugs requires each resident's drug regimen to be free from unnecessary medications. To promote the intent of the regulation the nursing home should manage and monitor each resident's medication regimen for the use of non-pharmacological interventions in place of or in conjunction with medication. One classification of medication for which nursing home staff should implement non-pharmacological interventions is hypnotics.

The Critical Elements (CE) for Psychoactive Drugs of the Quality Indicator Survey (QIS) process directs surveyors to determine if the staff have considered alternatives for the use of hypnotic medications such as a sleep hygiene program. Staff should identify when the resident is experiencing sleeping difficulty: initially falling asleep, staying asleep or early morning awakening. Interviews of the resident or their family may reveal due to a past work schedule the person likes to be awake at night and sleep during the day. Regulatory compliance does not require maintenance of a 24 hour diary of the resident's wake and sleep times. Sleep hygiene techniques listed in the CE that staff may want to consider implementing include limiting caffeine intake; decreasing noise to the extent possible; providing lighting levels to the tolerance of the resident; providing regular bedtime routine; and maximizing daily activities and encouraging socialization. This is not an all

inclusive list. The CE for Psychoactive Drugs is available at [https://www.qtso.com/download/qis/forms/CMS-20079\\_PsychMedsCE.pdf](https://www.qtso.com/download/qis/forms/CMS-20079_PsychMedsCE.pdf)

**PRESSURE ULCER NON-COMPLIANCE CITATION FINDINGS**  
CFR 483.25(c), F314, Pressure Sores Based on the comprehensive Assessment of a resident, the facility must ensure that-- 1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The following are areas the surveyors found the facility staff to be non-compliant in the provision of care for the residents who had pressure ulcers:

- Physician and/or family were not notified when pressure ulcers increased in number, size, or stage
- Resident was not provided protein drinks as recommended by Dietitian
- The amount of the protein drinks the resident consumed was not documented.
- Occurrence of pressure ulcer not reported to nurse.
- Incomplete wound documentation
- Resident receiving comfort care did not receive continuation of hand cleansing or placement of washcloth splint in hand that was contracted.
- Placement of pillows between the resident's legs resulted in the pressure ulcer area lying directly on the pillow thus providing no relief of pressure.
- Placement of pillow behind resident's back resulted in resident laying directly on pressure ulcer
- No dressings were present on pressure ulcers or dressing edges were loose allowing stool and urine to reach ulcer
- When staff provided incontinence care, urine and stool was placed in contact with the pressure ulcer bed.

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- Resident not repositioned in bed, recliner, wheelchair, or gerichair at intervals as care planned.
- Repositioning of resident exceeded 2 hours intervals.
- Lack of pressure relieving cushion in recliner or wheelchair
- Resident complaining of pain during dressing change did not receive pain medication prior to the treatment.
- Resident's heel that had a pressure ulcer laid directly on the wheelchair foot pedals and recliner foot rest.
- Devices to feet , i.e. ankle ring and heel protector were inadequate in elevating heel to relieve pressure to ulcers.
- Resident continued to wear ill fitting shoe on foot that had pressure ulcers
- Resident's heels with ulcers laid directly on mattress
- Worn, flattened eggcrate foam were used in wheelchair
- Heel protectors were not used as care planned
- Care Plans were not revised when pressure ulcers occurred.
- Care plan interventions for prevention of skin breakdown or to promote pressure healing were not followed.

### **ACCESS AND VISITATION RIGHTS**

KDOA receives questions from residents, family members, friends and nursing homes about persons visiting residents during their stay in LTC. Applicable regulation governing this area of resident care follows:

**CFR 483.10(j)(1) states:** *the resident has the right and the facility must provide immediate access to any resident by the following:... 7-subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and 8-subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.*

The following issues represent concerns expressed by providers in this area:

- 1-A visitor takes possessions from a resident.
- 2-A visitor disrupts care for the resident (or other residents).
- 3-A visitor will not leave.
- 4-A visitor makes questionable requests or demands of a resident
- 5-A resident needs additional support from family or friend

**In this issue is the first in a series of articles to deal with these situations.**

### **A VISITOR TAKES RESIDENT POSSESSIONS:**

Facilities learn at times a visitor has taken a resident possession from the building without the resident's knowledge. The staff responds to the report of misappropriation of resident property but the resident states, *"I don't want to get anyone in trouble"* or says such things as *"I guess my grandson borrowed my computer since his is broken..."* Facilities can feel challenged, because they must protect the resident and his/her possessions, but are told by a reluctant resident to *"let it go"*. This situation must be resolved and possessions safeguarded. Adult Care Home staff particularly struggle when there is a relationship with the offender the resident wishes to maintain.

**CFR 483.13(c)** *the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.* **KAR 28-39-149(d)(1)** instructs nursing facilities *"a written inventory of the residents personal possessions, signed by the resident or the residents legal representative shall be completed at the time of admission and updated at least annually.* Up-to-date possession sheets and a facility policy and written plan in place prior to such situations will give staff a solid basis from which to work through this

issue. Below are good components of such a plan:

**1. Determine that the item is actually missing.**

At times an item(s) is: **a) observed being taken from a resident room by a visitor.** When the item(s) taken is a part of an established routine there is usually no cause for alarm (*family doing laundry, changing clothing with the season, etc.*) Discuss this routine with the resident and document the discussion. This protects the resident/staff / visitor assisting a resident. It may also reveal a practice that was not agreed upon with the resident; **b) items becoming “lost” within the room or facility.** A visitor may be observed carrying clothing out the door and later the resident states, *“the new blouse my daughter gave me for Mother’s Day is missing!”* The staff -with the resident present- should do a quick review of the room. In one such instance the blouse was found under an afghan draped over the foot of the bed. This important step prevents unnecessary accusations and preserves good relationships between residents, staff and visitors; **c) a visitor states the resident has “gifted” the item to him/her, but the resident does not recall doing so.** With some questioning of an alert resident, or call to a responsible party of a resident with some degree of memory impairment, this may have been an appropriate action. At other times such an act may prompt the facility to ask “why” the resident is giving away possessions. Facility staff are held to account for the safeguarding of resident possessions, investigating reports of misappropriation of possessions and protecting possessions while the investigation is in progress. The policy regarding resident possessions should be made clear upon admission to those directly involved with the resident.

**2. Review the facility policy with the resident.**

If a visitor has taken resident property without

knowledge and permission and the facility is made aware of this, the facility must act: **Misappropriation of resident property”** *means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.* CFR 483.13(c) Based on this federal regulation the facility will proceed through its written plan to deal with such situations. Reviewing this plan with the resident promotes: 1) understanding the facility has acted on its’ responsibility; 2) giving the resident back a sense of control; and, 3) the staff and resident deciding together how to manage any future relationship to the offender.

**3. Develop a plan for any future visits.**

Many facilities state they have a “zero tolerance policy” toward the misappropriation of resident possessions. If the offending visitor is to return to the building, the facility must make sure ALL residents’ possessions are safe from this visitor. Attention must then be given to the relationship between the offender, the resident, and the facility. A teenage grandson who “borrowed” his grandfather’s laptop without asking because his was broken, and *“he never uses it anyway”* may be dealt with very differently from the former neighbor found to have taken the laptop and pawned it. In either event, the facility must address the misappropriation of resident property and will need to devise a corrective plan of action for any future visits. In the end no one can be allowed to misappropriate resident property.

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**MINIMIZING IMPACT OF RESIDENT TRANSFER AND RELOCATION**

CFR 483.10 (o) and CFR 483.12(a)(F-177, F-202, F-203, F204); CFR 483.15(e)(F247) speak to issues associated with the transfer and discharge of residents. These regulations discuss resident rights to refuse certain transfers, required notification prior to allowed transfers,

and give guidance regarding facility approaches when transfer is unavoidable.

The terms “relocation stress” or “transfer trauma” refer to a set of symptoms/outcomes that result from moving from one environment to another. Transfer issues can result from both **voluntary** as well as **involuntary** relocations and appear to fall into 3 categories:

1. **Intra-facility transfer** such as for remodeling, maintenance, room change, etc.,
2. **Inter-facility transfer** such as moving between buildings within a complex, and
3. **Relocating**

due to a building closing or a disaster-related evacuation. Facilities must work through both physical and mental issues resulting from transfer.

**Table 1** portrays symptoms and outcomes that can result in transfer situations (study completed by Lakehead University, Ontario, Canada, of **134,200** elderly movers). Transferred residents in this study were shown to have mortality rates 2-4 times higher than comparable residents without transfer.

**Table 1: Symptoms and Outcomes of Transfer Trauma**

<b>Emotive Symptoms</b>	<b>Cognitive/Functional Symptoms and Outcomes</b>	<b>Health Outcomes</b>
Depression	Decreased vigour	Mortality
Anxiety	Thought intrusion	Morbidity
Anger	Perceived loss of control	Weight loss
Fearfulness	Sleep disturbance	Pressure sore formation
Loss of trust	Change in eating habits	Medical visits
Excess need of reassurance	Increased falls	Loss of immune competence
Insecurity		Delirium
Withdrawal		

Additional factors affecting the impact of transfer on residents include: 1) resident input and agreement with the transfer; 2) resident physical and mental well-being, and 3) receiving facility staff follow-up and interventions post-transfer. When planning for a resident’s relocation to a different room or a different unit as a result of remodelling and building projects facilities should communicate ongoing with the resident and their legal representative on issues including seeking input into planning stages, reviewing excepted timelines, and fielding questions and concerns.

Studies on the issue reveal residents who appear to have a healthy mental state work through transfer situations easier than those with poor psychosocial well-being. Facilities can

implement a resilience-building psycho-social component into their programming to assist with the psychosocial issues around unavoidable transfers. Resilience-building interventions and training assist both residents and staff, as staff deal with many similar issues in situations of disaster-related moves. Staff trained in resilience skills can ease resident transitions.

Specialized disaster training may be obtained through the local chapter of American Red Cross or the local area mental health center. An excellent brochure developed by the Wisconsin Ombudsman Program called “Awareness: Relocation Stress Syndrome”, revised 4/11 is available on-line at: <http://longtermcare.wi.gov/docview.asp?docid=21549&locid=123>.

## FOOD SAFETY

*In this article, KDOA provides responses to three food safety questions about preventing contamination from hands and the use of hand antiseptics. The following questions were raised during a KDOA-led session on “Current Survey Elements and Citation Trends” at the Sysco Regional Healthcare Conference in Wichita on April 29, 2011. Regulatory text on which each response is based is also identified.*

### **Question #1: Are staff who do not have communicable diseases or open skin lesions allowed to have bare hand contact with uncooked or unbaked foods?**

**ANSWER:** Yes. Bare hand contact by staff who do not have communicable diseases or open skin lesions is allowed with foods that are not in a ready-to-eat (RTE) form, i.e., foods that will be cooked or baked. Immediately before engaging in any food preparation, employees must clean their hands and exposed portions of arms following every step of proper handwashing included in the (Food) Code.<sup>1,2,3</sup> Any activity which may contaminate the hands must be followed by thorough handwashing.<sup>4</sup> The goal with food that is not in a RTE form is to *minimize* bare hand contact.<sup>2</sup> This term (“minimize”) is not defined in regulatory text, but is cautionary because the hands are a mode in transmitting foodborne pathogens.<sup>4</sup> Foods prepared must also be cooked to a temperature and for a time that complies with one of the methods in the (Food) Code to be effective in eliminating pathogens.<sup>5</sup> The bottom line: Bare hand contact is allowed for food preparation tasks involving food that is not in a ready-to-eat form such as separating strips of uncooked bacon, cracking shell eggs, kneading bread dough, etc.

### **Question #2: Are staff who do not have communicable diseases or open skin lesions allowed to have bare hand contact with ready to eat (RTE) foods?**

**ANSWER:** No. Bare hand contact by any staff with food that is ready to eat (RTE) is strictly prohibited.<sup>2</sup> Instead, food employees must use

suitable utensils such as deli tissue, spatulas, tongs, single-use gloves or dispensing equipment whenever handling RTE foods.<sup>2,3</sup> This also applies to staff who are assisting residents to eat. Proper handwashing – including immediately before engaging in any food preparation and after any activity which may result in contamination of the hands – is critical even when bare hand contact is not allowed and suitable utensils are being used.<sup>1,4</sup> Because **older adults**, people who attend adult day care centers, kidney dialysis centers, hospitals or **nursing homes**, and senior centers are termed “*highly susceptible populations*”, food employees (and other staff) who work in nursing home are never allowed to have bare hand contact with food that is RTE.<sup>6</sup> The people they serve are more likely than other people in the general population to experience food borne disease.<sup>6</sup> The bottom line: Bare hand contact with food that is RTE is not allowed, not even for simple tasks like buttering toast or when assisting residents to eat.

### **Question #3: Are food employees allowed to use hand antiseptics?**

**ANSWER:** Yes. Prior to the FDA Food Code 2009, food employees were prohibited from using “hand sanitizers.” Following every step of proper handwashing in the Food Code, food employees are allowed to use a hand antiseptic as a topical application; a hand antiseptic solution as a hand dip; and a hand antiseptic soap.<sup>1,7</sup> Hand antiseptics are *never* allowed as a replacement for handwashing. Because of the need to protect residents and employees and to ensure safe food, hand antiseptics *also must comply with both the human drug and the food safety provisions* of the Code.<sup>8</sup> The bottom line: Hand antiseptics are allowed after food employees have completed every step of proper handwashing. Not even the food employee responsible for loading and unloading a dish machine is allowed to use a hand antiseptic on hands that have not been cleaned.

**In summary** – These food safety questions about *preventing contamination from hands* and the *use of hand antiseptics* are a good reminder



of three interdependent, critical factors in reducing foodborne illness transmitted through fecal-oral route: (1) exclusion/restriction of ill food workers; (2) proper handwashing; and (3) no bare hand contact with RTE foods.<sup>9</sup> KDOA recommends food service operators continually monitor employee health, handwashing and food handling practices to:

- Minimize bare hand contact with food that is not in a RTE form;
- Ensure no bare hand contact with food that is in a RTE form; and
- Ensure employees complete every step of proper handwashing:
  - Immediately before engaging in any food preparation;
  - After any activity which may result in contamination of the hands; and
  - Before using approved hand antiseptics, hand antiseptic solutions and hand antiseptic soaps.

#### REGULATORY TEXT:

FDA Food Code 2009. Chapter 2 – Management and Personnel. Part 2-3 Personal Cleanliness. Subpart 2-301.12 Cleaning Procedure and Subpart 2-304.14 When to Wash.

- <sup>1</sup> FDA Food Code 2009. Chapter 3 – Food. Part 3-3 Protection From Contamination After Receiving. Subpart 3-301.11(A),(B),(C) Preventing Contamination from Hands.
- <sup>2</sup> State Operations Manual (SOM). Appendix PP. Guidance to Surveyors for Long Term Care Facilities. 42 CRF §483.35(i) Sanitary Conditions under Tag F371. Employee Health. Hand Washing, Gloves, and Microbial Gel
- <sup>3</sup> FDA Food Code 2009. Annex 3 – Public Health Reasons / Administrative Guidelines – Chapter 2, Management and Personnel. Subpart 2-301.11 Clean Condition.
- <sup>4</sup> FDA Food Code 2009. Chapter 3 – Food. Subpart 3-401 Cooking.
- <sup>5</sup> FDA Food Code 2009. Chapter 1 – Purpose and Definitions. Subpart 1-102.10 Statement of Application and Listing of Terms.
- <sup>6</sup> FDA Food Code 2009. Chapter 2 – Management and Personnel. Part 2-3

Personal Cleanliness. Subpart 2-301.16 Hand Antiseptics.

- <sup>7</sup> FDA Food Code 2009. Annex 3 – Public Health Reasons / Administrative Guidelines – Chapter 2, Management and Personnel. Subpart 2-301.16 Hand Antiseptics.
- <sup>8</sup> FDA Food Code 2009. Annex 3 – Public Health Reasons / Administrative Guidelines – Chapter 3, Food. Subpart 3-301.11 Preventing Contamination from Hands.

The website for accessing the FDA Food Code 2009 on-line is:

<http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/>

#### ASK AL

**Question:** What are the space requirements for living, dining and recreation areas in a new construction of a Nursing Facility?

**Answer:** According to **KAR 26-40-302 (f) Common rooms and areas in resident units (1) Living, dining, and recreation areas.** Each resident unit shall have sufficient space to accommodate separate and distinct resident activities of living, dining, and recreation. (A) Space for living, dining, and recreation shall be provided at a rate of at least 40 square feet per resident based on each resident unit's capacity, with at least 25 square feet per resident in the dining area.

**Question:** Is a night light switch required in a resident room in a Nursing Facility?

**Answer:** Yes. **KAR 26-40-304 (b) Details (10) Lighting. (D)** Each resident room shall have general lighting and night lighting. The nursing facility shall have a reading light for each resident. At least one light fixture for night lighting shall be switched at the entrance to each resident's room. All switches for the control of lighting in resident areas shall be of the quiet-operating type.

**Question:** Is an outdoor recreation area needed in an Assisted Living Facility/Residential Health Care Facility?

**Answer:** Yes. **KAR 28-39-254 (f) General building exterior (3) Outdoor recreation**

areas shall be provided and available to residents.

**Question:** Is a public telephone required in an Adult Day Care Facility?

**Answer:** Yes. **KAR 28-39-289 (f) Common use areas (5) Public telephone.** There shall be a public telephone locally accessible to individuals with disabilities in a private area that allow a resident or another individual to conduct a private conversation.

#### USE OF "SOCIAL WORKER" TITLE

Upon completion of the Social Services Designee course approved by the Kansas Department of Health and Environment, Health Occupations and Credentialing, persons are allowed to fill a social service position in a nursing facility of less than 120 beds. This course does not qualify a person as a "social worker". That designation comes only after completing educational requirements, testing and obtaining an appropriate license through the Kansas Behavioral Sciences Regulatory Board.

KAR 26-39-100 Definitions clarifies social services designee at section (ppp) and goes on to specify at (qqq) of the same section who may use the title of "Social Worker." KAR 28-39-153 Quality of Life, section (f) reiterates the qualifications of a social service designee as spelled out in the federal nursing home regulations and specifies a minimum number of hours of social services weekly to be available for residents of any nursing facility. See below:

F251, CFR. 483.15(g)(2) and (3) states, (2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (3) Qualifications of a social worker. A qualified social worker is an individual with:

(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(ii) One year of supervised social work experience in a health care setting working directly with individuals.

The book of State Statutes Governing Social Work, Behavioral Sciences Regulatory Board, revised April 2010:

KSA 65-6307. Use of title by licensee; designation thereof by board; penalty for violation.

(a) Any person who possesses a valid, unsuspended and unrevoked license issued under the provisions of this act shall have the right to practice and use the title and the abbreviations prescribed by the board for use by persons holding the license held by such person. The board shall establish a title and prescribe abbreviations for use by persons holding each class or type of license issued under the provisions of this act. No other person shall assume such titles; use such abbreviations, or any work or letter, signs, figures or devices to indicate that the person using the same is licensed as such under the provisions of this act.

(b) Any violation of this section shall constitute a class C misdemeanor.

[http://www.ksbsrb.org/statutes\\_regs/sws-rbook.html](http://www.ksbsrb.org/statutes_regs/sws-rbook.html)

Facility staff and social services personnel need to be clear as they identify their roles. Only those persons who have completed the educational and licensing requirements for social work as defined by the state of Kansas may rightfully be called a "social worker."

#### RESOURCES

*References to non-KDOA sources or sites are provided as a service and do not constitute or imply endorsement of these organizations or their programs by KDOA. KDOA is not responsible for the content of pages found at these sites. The uniform resource locators for internet addresses were current as of the date of this publication.*

Many excellent resources are available to nursing facility staff. A key to assisting residents with issues or resolving some challenging situations is the ability to 1) locate information in a timely manner and 2) have it available in a usable format in your facility. Please notify Sue Schuster, LTC Social Work Consultant of any materials you have found to be helpful for use with their residents and families. You may contact Sue at KDOA at 1-785-291-3090 or [Sue.Schuster@aging.ks.gov](mailto:Sue.Schuster@aging.ks.gov).

*Parkinson's Across the Lifespan: A Roadmap for Nurses* is a free online course designed by Parkinson's nurse specialists to help other nurses better understand how to deliver comprehensive care to people and families living with Parkinson's disease (PD). CEUS available. <http://support.pdf.org/nursing>

A listing of KDOA reference material is posted at the KDOA Provider Resource Site at [http://www.aging.ks.gov/Forms/Other\\_LCE\\_Forms/av\\_library\\_catalog.pdf](http://www.aging.ks.gov/Forms/Other_LCE_Forms/av_library_catalog.pdf).

### **Promoting Mental Health and Preventing Suicide: A Toolkit for Senior Living Communities**

*"A Guide to Promoting Emotional Health and Preventing Suicide in Senior Living Communities"* has been recently released from the U.S. Department of Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services.

The guide is presented in a binder with 3 sections: 1) **Getting Started**; 2) **Goals and Action Steps**; and 3) **Tools for Implementing Action Steps**. A *Trainer's Manual* and CD of *Power points for the Trainer's Manual* is included with the Guide.

Three areas surrounding suicide are addressed in this tool: 1) successful suicide and dealing with the act that led to it; 2) suicide attempts and how to prevent future injury; and 3) what is suicidal

ideation, how to recognize and intervene before harm is done.

Sections dealing with **Risk Factors** and **Protective Factors** can assist nursing facilities as they develop their quality of life programming. Types of issues covered include: current life circumstances, health care and emotional health care, mental illness, access and means of suicide and physical illness, disability and pain to name a few. Each section can function as a stand-alone facility staff in-service or could serve as information to assist in updating facility policy and practice.

The Guide is available for viewing at <http://www.samhsa.gov/shin>. You may call SAMHSA's Health Information Network at 1-877-726-4727 to request a free copy. KDOA has 2 copies that will be available for facility use added to their lending library on line at:

[http://www.aging.ks.gov/Forms/Other\\_LCE\\_Forms/av\\_library\\_catalog.pdf](http://www.aging.ks.gov/Forms/Other_LCE_Forms/av_library_catalog.pdf). You may request a copy for use by completing and faxing the AudioVisual Request and Loan Agreement at the KDOA Provider Resource Site: [http://www.aging.ks.gov/Forms/Other\\_LCE\\_Forms/av\\_request\\_form.pdf](http://www.aging.ks.gov/Forms/Other_LCE_Forms/av_request_form.pdf)

If you have difficulty accessing the form or have additional questions please contact Sue Schuster at 785-291-3090 [Sue.Schuster@aging.ks.gov](mailto:Sue.Schuster@aging.ks.gov).

### **MRSA AND CDC WEBSITE**

Methicillin-resistant *Staphylococcus Aureus* (MRSA) is a type of staphylococci (staph) bacteria that is resistant to certain antibiotics including methicillin, oxacillin, penicillin, and amoxicillin. Potentially life-threatening MRSA infections occur frequently among patients in healthcare settings. While 25% to 30% of people are colonized\* in the nose with staph, less than 2% are colonized with MRSA (Gorwitz RJ et al. Journal of Infectious Diseases. 2008;197:1226-34.). (\*Colonized: When a person carries the organism/bacteria but shows no clinical signs or

symptoms of infection. For *Staph aureus* the most common body site colonized is the nose.)

The U.S. Food and Drug Administration has cleared the first test for *Staphylococcus aureus* (S.aureus) infections that is able to quickly identify whether the bacteria are methicillin resistant (MRSA) or methicillin susceptible (MSSA).

The KeyPath MRSA/MSSA Blood Culture Test determines whether bacteria growing in a patient's positive blood culture sample are MRSA or MSSA within about five hours after any bacterial growth is first detected in the sample. Aside from blood culture equipment, the test does not require any specific instruments to get results, which makes it useful in any laboratory.

"Clearing this test gives health care professionals a test that can confirm S.aureus and then identify whether the bacteria is MRSA or MSSA," said Alberto Gutierrez, Ph.D., director of the Office of In Vitro Diagnostics Device Evaluation and Safety in the FDA's Center for Devices and Radiological Health. "This not only saves time in diagnosing potentially life-threatening infections but also allows health care professionals to optimize treatment and start appropriate contact precautions to prevent the spread of the organism."

The Centers for Disease Control has developed a website with excellent information on a variety of topics, <http://www.cdc.gov/>. When one follows the alphabetical guide to topics to the site discussing MRSA, under the section titled "Symptoms of MRSA" a pictorial display can be found titled "Photos of MRSA skin infections" that can alert nursing staff to a variety of presentations of MRSA.

<http://www.cdc.gov/mrsa/symptoms/index.html>

## Culture Change

### NURSING COMPETENCIES FOR NURSING HOME CULTURE CHANGE

Through a collaborative effort of the Pioneer Network and the Hartford Institute for Geriatric Nursing the following concepts were developed to identify specific skills needed by nurses working in care setting involved in culture change.

1. Models, teaches and utilizes effective communication skills such as active listening, giving meaningful feedback, communicating ideas clearly, addressing emotional behaviors, resolving conflict and understanding the role of diversity in communication.
2. Creates systems and adapts daily routines and "person-directed" care practices to accommodate resident preferences.
3. Views self as part of team, not always as the leader.
4. Evaluates the degree to which person-directed care practices exist in the care team and identifies and addresses barriers to person directed care.
5. Views the care setting as the residents' home and works to create attributes of home.
6. Creates a system to maintain consistency of caregivers for residents.
7. Exhibits leadership characteristics/ abilities to promote person-directed care
8. Role models person-directed care
9. Problem solves complex medical/psychosocial situations related to resident choice and risk
10. Facilitates team members including residents and families, in shared problem-solving, decision-making, and planning. A complete copy is available at:

<http://www.pioneernetwork.net/Providers/ForNurses/> and <http://www.aacn.nche.edu/Education/gercom>.

## MDS Corner

### MDS 3.0 UPDATE RELEASED JUNE 2, 2011

Please be sure you have the latest revision. It is available for download at:

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[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage). Many changes are clarifications but there are a few changes in coding of which you need to be aware.

### Reports Available

Staff from the Myers and Stauffer (MS) Help Desk want you to know “Validation reports and monthly delinquent reports are still available at the same site as they were for the MDS 2.0 .” Remember to contact the MS Help Desk with your questions on transmission and reports. 785-228-6770.

### Upcoming Education

- The Kansas Culture Change Coalition and several other entities in the state are hosting a MDS Webinar Series by the Pioneer Network on Integrating the MDS 3.0 into Daily Practice. More information is available at the Kansas Culture Change Coalition website. Preregistration is not necessary.

<http://www.kansasculturechange.org/>

- KDOA MDS 3.0 Education. Please check the website for new postings. [http://www.aging.ks.gov/AdultCareHomes/Education\\_Info/Education\\_index.html](http://www.aging.ks.gov/AdultCareHomes/Education_Info/Education_index.html)

### CMS MDS 3.0 Update Websites

Periodically check the following websites for CMS MDS 3.0 Updates:

- [www.qtso.com](http://www.qtso.com), - Review the information on the page itself and also click on MDS 3.0 in the left hand column
- <https://www.qtso.com/mds30.html> Click on each of the Headings, especially MDS 3.0 Training Material.

### Unplanned Discharge Assessments Interview Completion

(Excerpt from CMS Memo 6/2011)

<http://www.cms.gov/NursingHomeQualityInits/Downloads/MDS30TheUseOfDashes.pdf>

CMS’s initial analysis of the first five months of MDS 3.0 data for the discharge assessment shows a large percentage of dashes (up to 40%), especially for quality measure items such as pain and pressure ulcers. CMS is asking providers to take steps now to immediately correct inappropriate coding of dashes. Inappropriate use of a dash (-) has implications for the accuracy of quality measures and for communicating resident status at discharge to support coordination and continuity of care. Excessive use of dashes in any assessment item affects the accuracy of the quality measures reported on Nursing Home Compare and the 5-Star Nursing Home Quality Rating System.

Several quality measures use data from the sections of the MDS 3.0 that assess mental status, depression, and pain. These measures also use data from the discharge assessment under certain circumstances. It is therefore important on all assessments, including discharges, that facilities make every effort possible to complete the resident interviews and, if this is not feasible, to complete the staff assessments.

The following coding instruction is applicable for coding resident interviews on unplanned discharge:

- **For the BIMS, PHQ-9 and Pain interviews, if the resident is discharged unexpectedly and the resident interview has not yet been completed the staff assessment should be completed if appropriate clinical record information is available. In this case the gateway questions, C0100, D0100 and/or J0200 should be coded No (0) and the staff assessment should be completed.**

Future manual updates will provide more detailed guidance and training to appropriately code clinical items to accurately reflect care provided. In the meantime, we stress to all providers that the assessments must be fully

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completed with all available information at the time of assessment

### **Revised Item Subsets effective October 1, 2011**

CMS released revised printable item subsets V1.00.5 that will take effect October 1, 2011. The revised subsets correct skip patterns in O0400A3, O0400B3, and O0400C3. An earlier revision that took place in May included correction of a typographical error to include a box at for I7900 on the All Items Subset. Revised Subsets are available at [http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp)

### **Proposed Rules for Changes in PPS Assessment**

CMS is proposing several changes to the MDS 3.0 that would take effect October 1, 2011 related to Medicare/Prospective Payment (PPS). The proposed changes would affect primarily therapy. Some of the changes are: an increase in ARD date intervals between PPS assessments; calculation of group therapy minutes; and revised guidance for completion of current assessments (End of Therapy and Start of Therapy) and new assessments (Change of Therapy and End of Therapy Resumptive) when there is a break of at least 3 consecutive days in the provision of therapy. Facilities may want to meet discuss the proposed changes with their therapy providers. The rule in its entirety is available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/html/2011-10555.htm>

### **Resident Interviews – Revised answer from April, 2011 SF Connection**

Please note the revision to the answer to the question “What is the criteria for not performing the structured resident interviews for Section C, D, F, and J?” in the April, 2011 SF Connection. CMS clarified that there are only two reasons why the resident interview should not be attempted. The answer to the question “Should the \_\_\_ Interview be Conducted?” is based on whether or not the person is never or rarely understood or need an interpreter and one is not available, not that they refuse to answer the questions. Different interviews do provide rules

at different points of the interview if the resident refuses to participate in the interview. For example, for the Section C. Brief Interview for Mental Status (BIMS), the rules for stopping the interview before it is complete (RAI Users’ Manual Chapter 3, C-4) state that the interview should be stopped if after completing C0300C if “there has been no verbal or written response to any of the questions up to this point.” It goes on to say how to code the rest of the interview section and directs the assessor to move on to the Staff Assessment. For the PHQ9, RAI Users’ Manual Chapter 3, D-9 states to Code 9 in column 1 if the resident chose not to complete the assessment. When code 9 is used in Column 1, Column 2 is left blank. The interview is deemed non-complete if the resident interview is blank for 3 or more items. The total severity score would then be coded with a 99 and the staff assessment would be conducted.

**Question:** If a resident was admitted on 3/30/11 and discharged to the hospital on 4/3/11, how do I code the admission assessment if I only completed the MDS? I could not find the code of a selection that said “Discharged prior to completion of Initial Assessment, as was on the MDS 2.0.

**Answer:** You will find the information in Chapter 2, 2-17 helpful. For the MDS 3.0, the MDS and CAAS must be completed for submission as an admission assessment Chapter 2, 2-18. If you have completed the MDS but not the Care Area Assessments (CAAs), you have the option of completing the CAAs if the resident returns within the time frame for completion of the CAAS (14 days from the date of their first entry). The cleanest process if only the MDS or part of the MDS was completed is to put the MDS on the chart and start an admission assessment when the resident returns. You will also need to complete an Entry tracking form.

**Question:** When completing an admission assessment must the Care Area Assessments be completed the same day as the MDS?

**Answer:** No, you have up to Day 14 to complete the MDS and Care Area Assessments. If a resident enters your facility on March 1 and

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you set the ARD (Assessment Reference Date) for March 7, you still have up March 14 to complete the CAAs. If the resident enters your facility on March 1 and you set the ARD for March 14, the CAAS will need to be completed on March 14<sup>th</sup> also. The chart on Chapter 2, 2-15 is a good guide.

**COMMISSION CHANGES**

- **Lawrence District and Northeast District** are combined. Contact numbers are 785-296-1023 (phone line with voice mail) and 785-296-0256 (fax).
- **West District** office moved to Garden City. The new phone numbers are 620-275-3154

(phone line with voice mail) and 620-275-3148 (fax).

- **South Central District** Office has a different address. It is now 130 S. Market, Suite 7170, Wichita, KS 67202.
- Survey District Office Map and Contact Information  
[http://www.aging.ks.gov/Forms/Other\\_LCE\\_Forms/LCE\\_Region\\_Map.pdf](http://www.aging.ks.gov/Forms/Other_LCE_Forms/LCE_Region_Map.pdf)
- **Tamara Tiemann**, LRD, from the Community Programs will assist with technical assistant questions on Food Safety and Sanitation. Please direct call to the Long Term Care Division Staff.

<b>2011 EXEMPLARY AND NO DEFICIENCY FACILITIES</b>					
<b>FACILITY</b>	<b>CITY</b>	<b>TYPE</b>	<b>EXEMPT LETTER</b>	<b>NO DEF CERT/LET</b>	<b>SURVEY DATE</b>
Country Place Senior Living of Seneca	Seneca	ALF		x	1/5/11
Fifth Avenue Place	Emporia	ICF/MF		x	1/6/11
Assisted Living at Windsor Place LLC	Coffeyville	ALF		x	1/11/11
The Gansel House	Independence	RHCF		x	1/12/11
Bethel Home	Montezuma	NF		x	2/14/11
Bethel Home	Montezuma	NF	x		2/14/11
Lindsborg House II	Lindsborg	ICF/MF		x	2/24/11
Guest Home Estates IV	Pittsburg	RHCF		x	2/28/11
Deer Park Senior Group Home North	Meriden	HP		x	3/2/11
Conser House	Overland Park	ICF/MF		x	3/1/11
Vintage Park at Neodesha	Neodesha	ALF		x	3/2/11
South Maple House	McPherson	ICF/MF		x	3/8/11
Vintage Park at Osage City	Osage City	ALF		x	3/8/11
Cooper Home Care #2	Lawrence	HP		x	3/10/11
Vintage Park at Louisburg	Louisburg	ALF		x	3/10/11
Brookside Retirement Community	Overbrook	ALF		x	3/10/11
DSNWK Grant Home	Norton	ICF/MF		x	3/15/11
Sterling House of Junction City	Junction City	ALF		x	3/17/11
Guest Home Estates VI	Fort Scott	RHCF		x	3/24/11
Lakepoint Assisted Living at Crestview	Wichita	ALF		x	3/30/11
The Autumn Place	Columbus	RHCF		x	3/31/11

ALF: Assisted Living Facility; RHCF: Residential Health Care Facility; BCH Boarding Care Home; HP: Home Plus; NF: Nursing Facility; SNF: Skilled Nursing Facility

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**2010-2011 Enforcement Actions**

	2nd Quarter April-June 2010	3rd Quarter July-Sept. 2010	4th Quarter Oct.-Dec. 2010	1st Quarter Jan.-March 2011
Abuse, Neglect and Exploitation	0	0	0	0
Adult Day Care	0	0	0	0
Administration	15	30	5	16
Admission, Transfer, Discharge	0	1	1	0
Delegation of Duties	6	6	1	2
Dietary Services	2	3	4	2
Emergency Preparedness	13	22	12	15
Employee Records	0	1	0	1
Environmental Issues	5	2	3	2
Functional Capacity Screen	5	10	3	6
Health Care Services	3	2	5	6
Inadequate Staffing	0	0	0	0
Infection Control	10	7	8	9
Medication Management	26	36	26	17
Negotiated Service Agreement	21	21	13	8
Professional Standards of Quality	0	0	0	0
Quality Care Issues	0	0	0	0
Resident Funds	0	0	0	0
Resident Records	2	3	3	2
Resident Rights	0	1	0	1
Restraints-- Chemical, Physical	0	0	0	0
Special Care Unit	0	1	0	1
Staff Development	0	0	0	0
Staff Qualifications	0	2	5	0
Civil Money Penalties	3	5	1	1
Correction Orders*	36	43	29	23
Ban on New Admissions	4	7	1	5
<b>FEDERAL REMEDIES</b>				
Civil Monetary Penalties Recommended	6	9	3	7
Denial of Payment for New Admissions Imposed**	7	16	4	8
Terminations	0	0	0	0
No Opportunity to Correct	11	20	0	13

\* A correction order on civil penalty may consist of multiple issues summarized.

\*\* Total figures for previous quarters are updated as this remedy becomes effective.