



KANSAS DEPARTMENT ON AGING
LICENSURE, CERTIFICATION AND EVALUATION
COMMISSION

SUNFLOWER CONNECTION

CONNECTING KDOA WITH LONG TERM CARE PROVIDERS
Volume 2, Number 4 <http://www.agingkansas.org/index.htm> October 2005

In This Issue...

- Quality Practice Fall Guidelines
- Medical Director
- Achieving Compliance
- RUG-III
- Hospice Care
- Nutrition Notes – Pressure Ulcers Diabetes
- HOC-PNA

Please route Sunflower Connection to nursing staff and other interested parties in your facility. This publication may be copied or accessed through the internet address above.

QUALITY PRACTICE FALL GUIDELINES

The KDOA Quality Practice Work Group, which consisted of representatives from the KDOA, provider organizations, and KU, has completed Guidelines for Fall Management. The guidelines and sample tools were developed to assist facilities in their fall management programs. Facilities are not mandated to use the guidelines and the tools. The guidelines include the need for assessment of the person, care planning, and implementation of the care plan prior to and after a fall, and these are areas surveyors also look at during the survey process. In the near future, copies of the guidelines and tools will be posted on the KDOA Website. Currently, you may receive them by contacting dianeslover@aging.state.ks.us

Overview Guidelines

Prior to a fall:

- when possible, preadmission assessment of person;
- within 24 hours of admission assess person, develop initial Care Plan, and communicate plan to staff;
- by 14th day of admission, complete Fall Risk Assessment and team evaluation of person (MDS and RAPS or Functional Capacity Screen (FCS)). Review and revise initial Care Plan, if needed and communicate changes to staff;
- complete MDS Assessments and FCS per schedule and review Fall Risk Assessment at same time. Revise Care Plan, if needed, and communicate changes to staff.
- When a fall occurs:
- assess person and environment; provide appropriate care and treatment; alert staff;
- document in clinical record; notify family and physician;
- revise Care Plan and communicate changes to staff;
- initiate investigation report; notify KDOA, if abuse or neglect is a causative factor;
- follow up with assessment, monitoring, and documentation;
- review of incident by team or safety committee;
- QA process and evaluation of individual falls and facility - wide falls.

The Sunflower Connection
published by The Kansas
Department on Aging

Kathleen Sebelius,
Governor

Pamela Johnson-Betts,
Secretary

**Licensure, Certification
and Evaluation
Commission**

New England Building
503 S. Kansas Avenue
Topeka, KS 66603-3404

F501- MEDICAL DIRECTOR – REVISED INTERPRETATIVE GUIDELINES

The Interpretive Guidelines in the State Operations Manual, Appendix PP for 42CFR 483.75(i), F501, Medical Director, have been revised and will become effective in November 2005. The entire S&C letter–05-29 Nursing Homes-Advanced Issuance of Revised Interpretative Guidelines for Tag 501, Medical Director, can be downloaded at <http://www.cms.hhs.gov/medicaid/survey-cert/sc0529.pdf>

The following summarized information has been taken from the letter:

The **intent** of the regulation F501 – Medical Director is:

- The facility has a licensed physician who serves as the medical director to coordinate medical care in the facility and provide clinical guidance and oversight regarding the implementation of resident care policies;
- the medical director collaborates with the facility leadership, staff, and other practitioners, and consultants to help develop, implement, and evaluate resident care policies and procedures that reflect current standards of practice; and
- the medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that affect resident care, medical care or quality of life; or related to the provision of services by physicians and other licensed health care practitioners.

A medical director may be both a resident(s) attending physician and the facility’s medical director. When serving in the dual role, the physician as medical director must coordinate the facility–wide medical care, in addition to the primary responsibility of providing medical care to his/her individual resident(s).

Definitions of attending physician, current standards of practice, medical care, medical director, and resident care policies and procedures are provided in the letter to assist in understanding the provision of medical director services.

Overview

The medical director’s leadership role is to actively assist the nursing facility in the provision of quality care. The medical director needs to have knowledge of the current standards of practice in caring for long term care residents and needs to have the ability to coordinate and oversee related practitioners. The American Medical Directors Association website at www.amda.com contains nationally accepted statements of a medical director’s roles, responsibilities, and functions.

As part of the survey process the medical director may be requested to provide information about physician issues, individual resident’s clinical issues and the facility’s clinical practices.

The medical director must have a current physician’s license in the state he/she is serving as medical director. The facility needs to work with the physician to identify its expectations of the medical director for assistance with implementing resident care policies and coordinating medical care. The medical director’s signature on resident care policies and procedures is not

required, but the facility must be able to show the medical director had input into development, review, and approval of the policies.

Implementation of Resident Care Policies and Procedures

Resident care policies that require the medical director's involvement of guidance, approval and oversight include but are not limited to:

- admission policies and care practices addressing the types of resident admitted and retained based on the facility's ability to provide the needed care and services to the residents;
- integrated delivery of care and services, i.e: medical, nursing, pharmacy, social services, rehab, and dietary. Included are assessment, care planning, its implementation and modification, infection control, transfers, and discharge planning;
- use and availability of ancillary services, i.e. x-ray and lab services;
- availability, qualifications and clinical functions of staff necessary to meet resident care needs;
- formulation and implementation of advanced directives and end of life care;
- enhanced resident decision making and choices, including medical care;
- methods and means for communication and resolutions of issues related to medical care;
- conducting of research in the facility;
- provision of physician services:
 - availability of physician services 24 hours a day;
 - review of resident's overall condition and program of care at each visit, including medications and treatments;
 - documentation of progress notes with signatures;
 - frequency of visits, as required;
 - signing and dating all orders; and
 - review and response to consultant recommendations.
- Systems ensuring other licensed practitioners, i.e. NP, PA, who perform physician delegated tasks, are practicing within the regulations and their scope of practice.
- Procedures and clinical guidelines for facility staff regarding when to contact the physician and what information should be gathered prior to contacting the physician.

Coordination of Medical Care

The medical director's coordination and evaluation of medical care within the facility can be done through review and evaluation of physician care and practitioner services, and assisting the facility to identify, evaluate, and address health care issues related to quality of care and quality of life. Participation in the facility QA committee often provides this opportunity.

This includes, but is not limited to:

- ensuring residents have a primary attending physician and backup physician coverage;
- ensuring physician and practitioner services are available to help residents attain and maintain their highest level of functioning consistent with regulations;
- developing a process to review a physician and practitioner's credentials, i.e. licensure and pertinent background;
- addressing and resolving concerns and issues between physicians, practitioners, and facility staff; and
- resolving issues related to continuity of care and transferring of medical information between the facility and other care settings.

Additional areas for Medical Director Input

- Facilitation of feedback to physicians and other health care professionals about their performance and practices.
- Review of individual resident cases as requested or as indicated.
- Review of consultant recommendations.
- Discussion and intervention with other health care practitioners about medical care that is inconsistent with applicable current standards of care.
- Assurance a system is present to monitor the performance of practitioners.
- Guidance of physicians regarding specific performance expectations.
- Identification of facility and practitioner educational and informational needs.
- Provision of current clinical information to facility practitioners from recognized medical care societies and organizations.
- Assistance in education of staff, practitioners, resident, families, and others.

Compliance Determination

During the survey process, surveyors may ask the facility leadership if the facility has a licensed physician as medical director and his/her role in the facility's clinical practices and care, and coordination of medical care.

When the surveyors identify an actual or potential noncompliance issue of resident care or medical care, they may review the appropriate policies and procedures, conduct additional interviews with the facility leadership staff, and interview the medical director as to his/her input into the issue.

In order for F501 to be cited, when noncompliance has been identified at another tag, the team must demonstrate a relationship between the deficient practice and failure of medical direction. The citing of F501 does not necessarily reflect the performance of the medical director.

RESIDENT FUNDS

Q: Can a facility maintain the personal funds of both assisted living and nursing facilities residents in one account?

A: Yes

Q: Must the surety bond be large enough to cover the personal funds of both the residents living in ALFs and NFs?

A: Yes

Q: Can a facility maintain the personal funds of assisted living and nursing facilities residents and the personal funds of people living in independent housing in one account?

A: No

ACHIEVING COMPLIANCE FOLLOWING A RECERTIFICATION SURVEY

Nursing facilities certified for Medicare and Medicaid must assure that each resident receives the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. The federal regulations expect that providers remain in substantial compliance with the program requirements. The regulations emphasize the need for continual, rather than cyclical compliance. When the survey process finds non-compliance, the plan of correction should emphasize the provider's ability to achieve and maintain compliance leading to improved quality of care for not only the resident(s) identified in the deficiency but all the residents actually or potentially affected by the deficient practice.

When surveyors from the Kansas Department on Aging complete a survey, complaint investigation, or revisit at a facility, if deficiencies are found, a list of the deficiencies is given to the administrator. It is expected that a plan of correction will be submitted to KDOA within 10 calendar days. The plan of correction serves as the document which describes the facility's efforts to remedy cited deficiencies. The document, among other things, tells the date when the corrective action will be accomplished. Surveyors leave a *Plan of Correction Instructions* brochure at the facility at the time of survey, complaint investigation or revisit.

The determination of when a revisit will be conducted at a facility depends upon a number of factors, including the facility's documented date a deficiency(s) will be corrected; the type of enforcement action proposed, if any; the facility's designation as an "opportunity to correct" or "no opportunity to correct" facility; and other survey priorities (resurveys, complaint surveys, etc.)

When scheduling revisits, the KDOA policy is to give first priority to "opportunity to correct facilities." A "no opportunity to correct facility" is one that has received a "G" level or higher deficiency on the current survey **and** a "G" or higher deficiency on the previous survey or any intervening survey (i.e. complaint survey, revisit, etc.). An enforcement remedy is imposed on a "no opportunity to correct" facility immediately, following proper notification.

If a facility demonstrates compliance with the regulations on the first revisit, the date of compliance can be certified as the latest correction date on the approved plan of correction. If a facility is found not to be in compliance at the time of the first revisit, a new plan of correction must be submitted, a second revisit conducted, and the earliest correction date then allowed would be the date of the revisit. A failed second revisit would require approval from CMS for conducting a third revisit.

The applicable CMS policy regarding revisits is in S & C Letter 01-10, dated May 3, 2001. This can be downloaded at: <http://www.cms.hhs.gov/medicaid/survey-cert/050301.asp>. This policy clarifies that revisits must continue until compliance is achieved or the facility is terminated. The policy also states that only **two** revisits may be conducted by the state agency at its own discretion. If a third revisit is needed, the state agency must submit the request to and receive approval from the CMS Regional Office for Medicare/Medicaid certified facilities. CMS may contact the facility about the plan of correction and the facility's inability to achieve compliance prior to granting a third revisit.

RUG-III REFINEMENTS ARE HERE

The Centers for Medicare and Medicaid Services (CMS) has released a final rule that will update the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for FY2006. The most significant policy change implements a refinement to the current Resource Utilization Groups, Version III (RUG-III) case mix classification system. Beginning January 1, 2006, the current RUG-III 44 groups will be expanded to 53 groups for SNF PPS. There will be no change to the state's Medicaid RUG-III 34 groups.

Vendors will need to have facility software updated and ready for use by November 22, 2005. Medicare facilities will bill the fiscal intermediaries for Medicare days of service using the RUG-III 44 groups until December 31, 2005. Days of service beginning January 1, 2006, will use the RUG 53 groups.

The 53-group model adds 9 new groups to the 44-group model for high cost residents who qualify for both the Rehabilitation and Extensive Services categories. These combined Rehabilitation/Extensive groups are placed at the top of the hierarchy. The nursing case mix indices (CMI) have also been recalibrated for the additional RUG groups but the therapy case mix indices will not change. Training on the new RUG 53 will be provided by KDOA during the October 20-21 MDS training.

The following table is a crosswalk between the existing RUG-III Rehabilitation groups and the 9 new Rehabilitation/Extensive services groups in RUG 53.

	Current Rehabilitation Groups	New Combined Extensive Plus Rehabilitation Groups
Rehab Ultra High	RUC – ADL 16 - 18 RUB – ADL 9 - 15 RUA – ADL 4 - 8	RUX – ADL 16 - 18 RUL – ADL 7 - 15
Rehab Very High	RVC – ADL 16 - 18 RVB – ADL 9 - 15 RVA – ADL 4 - 8	RVX – ADL 16 - 18 RVL – ADL 7 - 15
Rehab High	RHC – ADL 13 - 18 RHB – ADL 8 - 12 RHA – ADL 4 - 7	RHX – ADL 13 - 18 RHL – ADL 7 - 12
Rehab Medium	RHC – ADL 15 - 18 RHB – ADL 8 - 14 RHA – ADL 4 - 7	RMX – ADL 15 - 18 RML – ADL 7 - 14
Rehab Low	RLB – ADL 14 - 18 RLA – ADL 4 - 13	RLX – ADL 7 - 18

A copy of the final SNF PPS rule appeared in the August 4 Federal Register. A copy is available on the CMS website at: <http://www.cms.hhs.gov/provider/snfpps/>

CMS has also added an additional 306 Health Insurance PPS (HIPPS) codes to accommodate the 9 new RUG-III groups. The document containing the new HIPPS codes is posted on the following website: http://www.cms.hhs.gov/manuals/pm_trans/R630CP.pdf

MINIMUM DATA SET 2.0 BASIC TRAINING

KDOA and KDHE will be presenting a MDS 2.0 The Basics on October 20th and 21st via interactive tele-video conferencing. The presentation will be broadcast to KDHE district offices in Salina, Hays, Wichita, Lawrence, Chanute, Topeka and Dodge City. The Salina, Wichita and Lawrence sites are full. Please contact Caryl Gill at carylgill@aging.state.ks.us or at (785) 296-4222 if you need more information.

SURETY BONDS

42 CFR 483.10 (c)(7) The facility must purchase a surety bond, or otherwise provide assurance to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

Facilities must send to KDOA the original resident surety bond, any new surety bonds, and any riders. Please remember this when changing companies or when changing the amount of coverage. The originals can be sent to Rita Bailey. The facility may keep copies of the items.

REPORTING ANE

The CMS S&C Letter 05-09 dated December 16, 2004, clarifies the reporting requirements for alleged violations of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriations of resident property. It is recommended facilities refer to this letter for information as to the required time frames for reporting incidents and the followup investigation. The letter can be downloaded at <http://www.cms.hhs.gov/medicaid/survey-cert/sc0509.pdf>

It is important for facilities to remember the Kansas definitions and statutory requirements KSA 39-1401 must also be followed. The statute can be downloaded at <http://www.agingkansas.org/kdoa/lce/regs/statutes/statutes.htm>

THE USE OF HALOPERIDOL IN HOSPICE CARE

by

Thomas I. Clemens, M.D. and Kevin Hawker, ARNP

Some staff members of Kansas' Long Term Care (LTC) facilities have been curious, and perhaps concerned, about the use of haloperidol (brand name Haldol) for hospice patients who reside in their community/facility. LTC staff know that haloperidol is an anti-psychotic medication that is potentially dangerous and clearly listed as a drug of concern in the Beers' List, the Kansas LTC facility regulations and the Centers for Medicare and Medicaid Services (CMS) Requirements for States and Long Term Care Facilities (Part 483). Both the Kansas and the Federal regulatory agencies have long been concerned that haloperidol-like medications may have been used in excess at elderly, institutionalized members of our society. Despite the history of possible overuse, and the regulatory concerns about "chemical restraint," haloperidol remains an extremely useful drug for many reasons not related to its primary categorization of "anti-psychotic." This article is intended to remind the reader of the drug's value for many people, including hospice patients.

It is important to remember the primary mission of hospice care. Dr. Cicely Saunders, the founder of modern hospice care, summarized its purpose. She said, "...you matter until the last moment of your life. We will do all we can, not only to help you to die peacefully, but also to live until you die." Hospice practitioners believe that caring for the dying is the greatest honor a healthcare provider can have. In this regard, medications and other treatments that facilitate comfort and palliation ought to be offered. Haloperidol is just such a drug.

Haloperidol is an anti-psychotic medication from the butyrophenone class. Haloperidol has sedative, anxiolytic, and antiemetic properties that will be further discussed. However, it was developed to treat patients with dementia, delirium, amnesic, and other cognitive disorders. It was used only for these purposes and was especially effective because it was available in tablet, intramuscular, and intravenous form, and the gap between the therapeutic and toxic concentrations was quite wide. Its frequent use created a database, which showed it to be relatively safe, effective, and the price of the drug decreased. As haloperidol use increased, it was noted that low doses of the oral preparation had a unique side effect: nausea was relieved and the churning of the GI tract relaxed. This effect was found to be related to treating the chemoreceptor trigger zone of the brain, which senses changes in the blood. Since this area mediates the most common causes of nausea, low-dose haloperidol was used in palliative care. Haloperidol is now used to treat nausea from metabolic causes, like liver or renal failure or tumor products, and for nausea following radiation therapy, tumor infiltration, or infection of the GI tract.

Haloperidol as a tablet is available in strengths of 0.5, 1, 2, 5, 10, and 20 milligrams, and as an oral concentrate of 2 mg per milliliter formulations. Additionally, haloperidol can be compounded as a topical gel, to achieve therapeutic dosage levels. Rarely does a palliative care practitioner need to use dosages that utilize tablets greater than 5 milligrams to treat nausea. Though haloperidol can be given in a subcutaneous bolus or drip, it is rarely necessary. The reader will note that none of the aforementioned modalities involve invasive techniques, such as needles or suppositories. The aim of the practitioner is, according to Dr. Dennis Tietze, "to be minimally intrusive."

When writing about haloperidol, it is important to include a few words about “delirium.” Delirium is characterized by the following DSM-IV criteria:

Clouding of consciousness or reduced ability to focus, sustain, or shift attention.

Perceptual disturbance, disorientation, or memory deficit that is not better accounted for by an established dementia.

Acute onset (hours to days) and fluctuating course.

General evidence from the history and physical or laboratory findings of a medical condition related to the disturbance.

There are three subtypes of delirium:

Hyperactive: characterized by confusion and agitation and may include myoclonus and hyperalgesia.

Hypoactive: characterized by confusion and somnolence and may involve withdrawal.

Mixed: features of both.

Commonly, terminally ill patients accumulate metabolic breakdown products from tumors, and organ disease, medications, and electrolyte imbalance. Anecdotal evidence suggests that brain function can be severely impaired by these conditions. The common result is delirium. Hyperactive delirium is often manageable by the use of haloperidol. Treatment of these patients with haloperidol is most appreciated by family and staff. The patient rarely recovers enough to realize the difference in their behavior, but haloperidol is often the difference between “a good death” and a terrible ordeal of dying.

For these reasons, haloperidol has become an effective intervention for physicians in the treatment of terminally ill patients. Though many other drugs are available and have lower risk of adverse effects, they are quite expensive, have fewer uses, and are not available in as many modalities of administration. The “Beers List” raised everyone’s sensitivity to similar medications for good reasons. As with most psychoactive medications, haloperidol has side-effects (especially anticholinergic). However, the keys to using haloperidol are thorough documentation and monitoring for side-effects. With proper attention and staff experience, hospice patients can expect a peaceful and pain-free death among those that they love and who, in turn, love them.

NUTRITION NOTES

NUTRITION GUIDELINES FOR PRESSURE ULCERS

At the August, 2005, joint provider training on pressure ulcers, speaker Diane Atchinson, RN-CS, MSM, ANP, stressed the importance of nutrition and hydration for residents with a pressure ulcer, and monthly involvement of the facility licensed dietitian in the care of a resident with pressure ulcers.

“Nutrition Care of the Older Adult: A Handbook for Dietetics Professionals Working throughout the Continuum of Care” 2nd edition, 2005, provides the following nutrition guidelines for pressure ulcers.

Energy: minimum of 30 kcal/kg to 35 kcal/kg body weight

Protein: 1.2g to 1.5g of protein/kg body weight

Fluid: minimum of 1,500 ml (unless medically contraindicated) or 30 ml/kg body weight or an amount equal to kilocalorie requirements

Vitamin A: daily dietary source is recommended

Vitamin C: daily supplement of 500 mg to 1,000 mg may be beneficial if a patient is deficient in vitamin C or has a stage III or IV pressure ulcer

Zinc: 50 mg/day (for example, twice-daily supplements of 220 mg of zinc sulfate) is often recommended for older adults with poor intake or weight loss, who have a stage III or stage IV pressure ulcer. Long-term supplementation is discouraged.

Arginine/

Glutamine: no specific recommendations are given

Q. What is to be done when a Dietary Manager with an equivalency certificate has a name change?

A. A copy of the marriage certificate, a court decree evidencing the change, or a Social Security card with the name change needs to be in the employee's personnel file in the facility so the name change may be tracked to the equivalency certificate.

When the dietary manager sends continuing education documentation for renewal to the Kansas Department on Aging in 2011, a copy of the same name change documentation also needs to be included so the new equivalency certificate will have the current name.

Q. The term Dietary Reference Intakes (DRIs) is now frequently used. How is it different from RDAs?

A. Federal regulations refer to the RDA's. Since the regulations were written there have been two changes. 1) The Food and Nutrition Board is now part of the Institute of Medicine not the National Research Council. 2) The Food and Nutrition Board of the Institute of Medicine has replaced the Recommended Dietary Allowances (RDAs) with the Dietary Reference Intakes (DRIs). The Dietary Reference Intakes (DRIs) include four dietary nutrient-based reference values: Intake (RDA), Estimated Average Requirement (EAR), Adequate Intake (AI), and Tolerable Upper Intake Level (UL). The use of all four is important in dietary assessment of individuals and groups. A summary is found at <http://www.iom.edu/includes/dbfile.asp?id=4120>

Q. Federal regulation states “483.35(c) Standard Menus and Nutritional Adequacy Menus must: (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council (now the Institute of Medicine), National Academy of Sciences. Where can I find the current recommended dietary allowances (RDAs and AIs) for older adults?

A. A complete 3 page summary of RDAs (Recommended Dietary Intake) and AIs (Adequate Intakes) for only older adults may be found at the website of the National Policy and Resource Center on Nutrition, Physical Activity and Aging http://www.fiu.edu/~nutreldr/SubjectList/D/DRI_RDA.htm This website also has links to all Institute of Medicine reports for each nutrient. Or each nutrient report may be read on line at the Institute of Medicine website by typing dietary reference intakes in the search box. www.iom.edu

DIABETES UPDATE

People with pre-diabetes are at increased risk for type 2 diabetes, heart disease and stroke. The great news is prevention of diabetes is possible. The diabetes prevention clinical trials showed that 71 percent of the study participants with pre-diabetes over the age of 60 years old were able to prevent or delay diabetes. Simple lifestyle changes in nutrition and activity had the most results for prevention. Detailed information is available at the National Diabetes Education Program “*Small Steps Big Rewards*” website: <http://www.ndep.nih.gov>. This site has especially helpful information for facility staff and Assisted Living and Residential Health Care Residents.

Diabetes prevention is proven, possible, and powerful. Additional information is also available at the <http://www.diabetes.org/diabetes-prevention.jsp>

Diabetic Neuropathy

Diabetic neuropathy can affect any part of the nervous system. This nerve disorder should be suspected in all patients with type 2 diabetes and in patients who have had type 1 diabetes for more than five years. In some instances, patients with diabetic neuropathy have few complaints, but their physical examination reveals mild to moderately severe sensory loss. Idiopathic neuropathy has been found to precede the onset of type 2 diabetes or to occur as an early finding in the disease.

Neuropathy can affect nerves throughout the body, causing numbness and sometimes pain in the hands, arms, feet, or legs, and serious problems with the digestive tract, heart, and sex organs. Falls often occur before a diagnosis of type 2 diabetes is made. <http://www.aafp.org/aafp/20050601/2123.html>

Symptoms of Sensory Motor Neuropathy

Muscular symptom: muscle weakness (not fatigue), atrophy, balance problems, ataxic gait.
Sensory symptoms: pain, paresthesia, numbness, paralysis, cramping, nighttime falls, antalgic gait.

Treatment first involves bringing blood glucose levels within the normal range. Good blood glucose control may help prevent or delay the onset of further problems. Many new forms of insulin and oral medications are available to control blood glucose

Although goals for glucose control are individualized for each resident, The American Diabetes Association <http://www.diabetes.org/type-1-diabetes/blood-glucose-checks.jsp> defines good blood glucose control as:

A1C (average blood glucose for past 2 to 3 months) - <7.0%

Pre-postprandial plasma glucose – 90-130 mg/dl (5.0-7.2 mmol/l)

Postprandial plasma glucose - <180mg/dl (<10.0 mmol/l)

HEALTH OCCUPATIONS CREDENTIALING CORNER

NUTRITION ASSISTANT TRAINING PROGRAM

Health Occupations Credentialing oversees four training programs for unlicensed/uncertified workers in adult care homes: operator, social services designee, activities director and paid nutrition assistant. The nutrition assistant training program is to be implemented when the adult care home regulation changes are adopted.

The nutrition assistant training program is the result of a cooperative effort of the Kansas Department of Health and Environment and the following contributors and consultants: Judy Bagby, RN, LNHA; Kay Billinger, RD/LD; Kathy Bode, RN, MS; Sandra Dickison, MS, RD, LD; Diane Glynn, JD, RN; Kim Halbert, RN, BS, LACHA; Patricia Maben, RN, MN; Marilyn Munoz, CNA, CMA; Isla Richards, RN; Mike Simpson, SLP; Linda Sullivan, MS, RN, ARNP, LNHA; Vera VanBruggen, RN, BA, CDONA/LTC. The following organizations nominated these individuals to serve in this effort: Flint Hills Technical College, Kansas Adult Care Executives, Kansas Advocates for Better Care, Kansas Association of Homes and Services for the Aging, Kansas City Kansas Community College, Kansas Department on Aging, Kansas Health Care Association, Kansas Speech-Language Hearing Association, Kansas State Board of Nursing, and Kansas State Nurses Association.

Nutrition assistant training in Kansas:

- Minimum of 12 hours of training that includes a competency test. The course content includes roles and responsibilities of a nutrition assistant, working as a member of a team, creating a home environment in the facility, resident rights, residents with special needs, a safe dining experience (infection control, food safety and emergencies), fundamentals of good nutrition and documentation. The complete course outline is available from HOC and will be posted on the website www.kdhe.state.ks.us/hoc.
- Must be sponsored by an adult care home or a postsecondary school under the jurisdiction of the Kansas Board of Regents.
- Must be taught by a registered nurse who has a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care facility services, and has completed a course in teaching adults, or has experience in teaching adults, or supervising nurse aides.

The guidelines for sponsoring a course will be available from Health Occupations Credentialing after the regulations are adopted. Contact Dolores Staab at 785-296-6796 or

dstaab@kdhe.state.ks.us if you would like to sponsor a course. If you have questions about the training course, contact Dolores as listed above, or Martha Ryan at 785-296-0058 or mryan@kdhe.state.ks.us.

A “Frequently Asked Questions” document that may answer some of your questions about nutrition assistants will be posted on the HOC website after the regulations are adopted.

2005 NO DEFICIENCIES AND EXEMPLARY AWARDS

Facility	City	Type	Ex. Lett.	No Def.	Survey Date
Wilson Nursing Center	Wilson	SNF/NF		x	4/7/05
Golden Heights	Garnett	SNF/NF	x		4/27/05
Douglas Co. Senior Serv.	Lawrence	ADC		x	4/14/05
Andbe Home	Norton	NF		x	4/27/05
Chapman Valley Manor	Chapman	SNF/NF		x	5/26/05
Salina Presbyterian Manor	Salina	SNF/NF	x	x	5/26/05
Sedgwick Health Care	Sedgwick	SNF/NF	x		6/8/05
Bethel Home	Montezuma	NF		x	6/9/05
Leisure Homestead	St. John	NF		x	6/2/05
Bethany Home	Lindsborg	NF		x	6/23/05
Glenn Moore Meadows	Holton	HP		x	6/15/05
Alterra Sterling House	McPherson	ALF		x	6/29/05
Guest Home Estates VII	Erie	RHCF		x	6/13/05
The Sweet Life at Rose Hill	Shawnee	SNF		x	6/15/05

ENFORCEMENT ACTIONS

*Licensure Category	1st	2nd	3rd	4th
ANE Issues	8	3		
Disaster Preparedness	2	3		
General Sanitation and Safety	8	10		
Health Care Services	5	9		
Inadequate Administration	5	2		
Inadequate Admissions	1	2		
Inadequate Accounting of Funds	-	-		
Inadequate Documentation of Employee Records	-	1		
Inadequate Documentation of Resident Records	8	2		
Inadequate Drug Regimen Review	5	3		
Inadequate Inservice Education	1	-		
Inadequate Policies/Procedures Regarding Infection Control	-	-		
Inadequate Policies and Procedures for Special Care Unit	-	-		
Inadequate Range of Motion Services	-	1		
Inadequate Supervision	-	2		
Inadequate or Unqualified Staffing	8	1		
Inadequate or Inappropriate Dietary/Nutritional Services	3	3		
Inadequate or Inappropriate Hygiene and Skin Care	1	-		
Inappropriate Admissions	-	2		
Inappropriate or Unauthorized Use of Restraint	1	-		
Negotiated Service Agreement	14	8		
Physician Verbal Orders for Licensed Personnel	-	-		
Resident Functional Capacity Screen	3	7		
TB for Residents/Staff	3	2		
Unsafe Medication Administration or Storage	2	9		
Other	-	-		
Civil Penalties	4	6		
Correction Orders	22	16		
Bans on New Admissions	4	10		
FEDERAL REMEDIES	1st	2nd	3rd	4th
Civil Monetary Penalties Recommended		9		
Denial of Payment for New Admissions Imposed		19		
Terminations		1		
No Opportunity to Correct		23		

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