

KANSAS DEPARTMENT ON AGING
LICENSURE, CERTIFICATION AND EVALUATION COMMISSION
SUNFLOWER CONNECTION
CONNECTING KDOA WITH LONG TERM CARE PROVIDERS
Volume 3, Number 2 <http://www.agingkansas.org/kdoa/index.htm> April 2006

In This Issue...

**MEDICAID PROVIDED SERVICES
AND SUPPLIES**

**SAFEGUARDING CLINICAL RECORD
INFORMATION**

**RESIDENT RIGHTS
VISITATION AND ACCESS TO
CLINICAL RECORD**

CERTIFIED MEDICATION AIDES

**DISPOSITION OF CONTROLLED
DRUGS**

NEGLECT DECISION TREE

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.



Promoting Excellent Alternatives in Kansas

CALL FOR 2006 PEAK APPLICATIONS

*Celebrate your leadership by promoting your success!
Share how residents' quality of life has been enhanced!
Take this opportunity to recognize staff for their hard work!*

PEAK Applications are now available on KDOA's website at

**www.agingkansas.org/kdoa/programs/peak.htm
or contact one of the following KDOA staff for more information:**

- Bill McDaniel (785) 296-0700**
BillMcDaniel@aging.state.ks.us
- Dave Halferty (785) 296-8620**
DaveHalferty@aging.state.ks.us
- Patsy Samson (785) 296-0378**
PatsySamson@aging.state.ks.us

Deadline for applications is Friday, May 12, 2006!

The Sunflower Connection published by The
Kansas Department on Aging

Kathleen Sebelius, Governor
Kathy Greenlee, Acting Secretary

**Licensure, Certification and Evaluation
Commission**

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

COMMISSIONER'S MESSAGE

This edition of the Sunflower Connection is the first since I assumed my new role as Commissioner of Licensure, Certification and Evaluation on January 15. The past 9 weeks have been an intense time of learning and growing for me, as I'm sure you can imagine. While my past experience gave me a general understanding of nursing facility regulation, I am continually reminded and impressed with the large body of knowledge you bring to work with you every day.

Before her retirement, but later in her career, my mother was a nursing home administrator of a county-owned facility in the small town where she grew up. She knew her residents because they were her neighbors, relatives and her parents' friends. She shared deep bonds with them and the delivery of quality care was a matter of personal commitment.

My mother was an active member of her professional association and regularly attended continuing training opportunities. From our conversations I know this commitment was simply an extension of her dedication to her residents.

Since assuming my new role, I have seen this dedication to service repeated again and again on the part of Kansas nursing home administrators and staff members. KDOA staff members also share your commitment. The Sunflower Connection is one way KDOA supports quality nursing home care.

We are committed to continuing and expanding our efforts. Thank you for your hard work and please contact me if you have questions or suggestions about moving Kansas nursing home care forward. My email address is martinkennedy@aging.state.ks.us.

Sincerely,
Martin Kennedy, Commissioner

SURVEY AND CERTIFICATION LETTERS WEBCASTS

Link to Letters

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/>
Click on Policies and Memos to States and Regions; Scroll down to the specific letter.

Link to Webcasts

<http://www.cms.internetstreaming.com/> There is no registration fee but a password must be established in advance to view.

Battery Powered Smoke Detector Installation

April 14, 2005; Ref: 05-26

Letter Summary – Non-sprinkled facilities must install battery powered smoke detectors in resident rooms and common areas such as dining, activity, and other areas where residents gather. Facilities will be surveyed for compliance with this requirement beginning May 24, 2006.

Revised Guidance for Activities – F248 and F249

March 10, 2006; Ref: 06-09

Letter Summary – Advanced copy of revised guidance effective June 1, 2006, for surveying F248 and F249

Webcast – Live April 7, 2006. Recorded for viewing after April 7. Nursing Home Journal Volume III: Surveying the Activities Requirements – Introduction of New Activities Guidelines

New Psychosocial Outcome Severity Guide

March 10, 2006; Ref: 06-10

Letter Summary – Advance copy of new guidance for psychosocial outcome severity guide effective June 1, 2006.

Webcast – Recorded from live webcast on March 24, 2006

Revised Guidance for Quality Assurance and Assessment – F520

March 10, 2006; Ref: 06-11

Letter Summary – Advance copy of revised guidance effective June 1, 2006, for surveying QAA. F520 and F521 condensed into F520.

Fire Marshal

LSC 2006 – SPRINKLERS



Question: Is there an update on when sprinklers in nursing homes will be mandated, either by CMS regulation or by an adoption of 2006 NFPA 101? Should facilities that are preparing budget information for the next year budget for sprinklers?

Answer: There is no specific time that we know of for a regulation change adopting the 2006 edition of the LSC. It has to go through the regulatory process with a notice of proposed rulemaking and a comment period. Then it will take CMS time to finalize the rule - this should give facilities adequate notice in which to plan budgets. CMS encourages all facilities to become sprinklered at the earliest date to provide the greatest possible fire protection for beneficiaries.

MEDICAID PROVIDED SERVICES AND SUPPLIES

CFR 483.10(c)(8) - F162 speaks to the regulation that facilities cannot charge Medicaid eligible residents for items and services paid for by Medicaid. A general listing of the items and services is provided in the regulation. A more detailed list of covered services and supplies is found in Medicaid Regulations KAR 30-10-15a Reimbursement. Payment for Services. The link to the regulation is <http://www.kslegislature.org/legsrv-kars/index.do> and type in Search for Specific Regulation, 30-10-15a. The service listed in KAR 30-10-15a(b)(1)(KK) is non-emergency transportation. Non-emergency transportation includes transportation to and from clinic appointments and dialysis treatments.

MDS COMMUNICATION



MDC Coordinators: Stay informed about KDOA MDS workshops, manual updates, questions and

answers by sending your email address to carylgill@aging.state.ks.us.

Education: Basic MDS 2.0 – Interactive Televideo Workshop is scheduled for April 13 and 14. Tentative dates of future interactive televideo workshops are August 3 and 4 and November 2 and 3. Pre-registrations are not being accepted at this time for the August and November workshops. Watch for posting on <http://www.aging.state.ks.us/> website, Licensure, Certification, and Evaluation Commission

Manual Update: January 2006. <http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20Update200601.pdf>

Resource: MDS Follow Up Assessment Scheduling Calendar 2006 and other helpful MDS and QM/QI information can be found at <http://www.qtso.com/mdsdownload.html>

Question: A resident was admitted to the facility with Medicare as the payment source. Only a 5-Day PPS MDS was completed before the resident returned to the hospital. The admission assessment was not started. What form needs to be completed when the resident leaves the facility? What assessment should be done when the resident returns to the facility on Medicare?

Answer: *When the resident leaves* a Discharge Tracking Form should be completed. See RAI Manual: 2-23-24 Discharge – Prior to Completion of Initial Assessment (AA8a=8) is indicated when a resident is admitted to the facility and the admission assessment is not completed before the resident is discharged. *When the resident returns on Medicare:* RAI Manual 2-25 – Reentry Tracking Form is not required upon return. A8a1. RAI Manual 2-3 – Admission Assessment – Comprehensive Assessment. The admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission if the resident has just returned after being discharged prior to the completion of the initial assessment. A8b.5 RAI Manual 2-31 – Medicare Readmission/ Return Assessment (A8b.5) – Medicare assessment that is completed when a resident whose stay was being reimbursed by

Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital.

Question: After a hard copy of the MDS is printed, what date should staff use when they sign at AA9?

Answer: RAI Manual 3-212. Refers to signing the RB2 date but the directive is applicable for the AA9 date also. Coding: “If for some reason, the MDS cannot be signed on the date it is completed, it is appropriate to use the date that it is signed. It is recommended the staff document the reason for the discrepancy in the clinical record. Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.”

CDM ROLE IN COMPLETION OF RAI

Question: How may a Certified Dietary Manager be involved in the RAI (Resident Assessment Instrument) process?

Answer: Section K – Oral/Nutritional Status 3-149 states “the RAI must be conducted or coordinated with appropriate participation of health professionals... facilities have the flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility’s responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.”

The Dietitians Practice Act, Statute 65-5912 allows dietary managers/dietetic services supervisors to perform information gathering and other tasks under the “general direction” of a licensed dietitian. Therefore, when a dietary manager performs portions of the MDS Section K2-5 Oral/Nutritional Status, a dietitian must provide guidance and training to ensure that the dietary manager can perform this function competently. Evidence that a dietitian has determined that the dietary manager is capable of performing portions of the Section K2-5 must be documented in the dietary manager’s personnel file.

It is very important that residents who need the expertise of a dietitian in assessing their nutritional needs receive that service. Facilities must have effective systems in place to notify the dietitian of residents with nutritional problems. The dietitian can set parameters by which the dietary manager or licensed nurse notifies the dietitian of potential or actual nutritional problems. The dietitian must provide appropriate ongoing nutritional services to residents, not only when actual or potential problems are identified during the MDS assessment period.

Only a licensed nurse, dietitian, or speech language pathologist may complete Section K1. Oral Problems and Section L. Oral/Dental Status. Identification of actual or potential problems with swallowing and chewing is critical in preventing nutritional problems in residents.

A certified dietary manager may not complete Resident Assessment Protocol (RAP) 12 Nutritional Status. The RAP process is an assessment that must be completed by a Registered Nurse, a licensed nurse with additional education in assessments, or a dietitian. It cannot be delegated to a certified dietary manager.

FOODS ON PLANNED MENU



Question: Must every resident be served every food item on the planned menu?

Answer: Based on their individualized nutritional assessment and care plan, a resident need not be served every food item on the planned menu. The facility must have a system to identify what food(s) and at which meal(s) the specific resident does not need to receive the planned menu item(s).

SAFEGUARDING CLINICAL RECORD INFORMATION



In accordance with CFR 483.75(I) (3), “the facility must safeguard clinical record information against

loss, destruction, or unauthorized use.” The regulations for Nursing, Assisted Living and Residential Health Care, Home Plus, and Adult Day Care Facilities listed respectively at KAR 28-39-163(m), 250, 434, and 285 also address this requirement. Facilities may find the Long Term Care Health Information Practice and Documentation Guidelines developed by the American Health Information Management Association helpful. The link is <http://www.ahima.org/infocenter/guidelines/lts/>

MYCOBACTERIUM TUBERCULOSIS GUIDELINES

In December 2005, the Centers for Disease Control and Prevention (CDC) released Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis. These guidelines replace the 1994 guidelines. The guidelines define health care workers as all paid and unpaid persons working in health-care settings (employees of the facility as well as students and volunteers).

Key recommendations included in the 2005 guidelines are as follow:

1. The risk assessment process (Appendix B-located on pages 129-134) include the assessment of additional aspects of infection control. It is recommended that it is completed once and then updated (annually if possible) at each facility.
2. The term “tuberculin skin tests” (TSTs) is used instead of purified protein derivative (PPD).
3. The frequency of TB screening for health care workers (HCW) has been decreased in various settings, and the criteria for determination of screening frequency have changed.
4. The scope of settings in which the guidelines apply has been broadened to include laboratories, additional outpatient, and nontraditional facility-based settings.
5. These recommendations usually apply to an entire health-care setting rather than areas within a setting.

6. New terms, airborne infection precautions (airborne precautions) and airborne infection isolation room (AII room), are introduced.

The link to the guidelines is

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>

INFLUENZA VACCINATION



In February 2006, the CDC released recommendations concerning influenza vaccination of health-care personnel in the United States. The link to the guidelines is <http://www.cdc.gov/mmwr/pdf/rr/rr5502.pdf>

BED RAIL ENTRAPMENT

FDA Med Watch

On March 10, 2006, the Food and Drug Administration issued a guidance designed to reduce the occurrence of hospital bed entrapments that occur when part of a patient's body becomes caught between parts of the bed, such as in the space between the mattress and the side rail. This can cause strangulation and death.

Entrapments have occurred in a variety of patient care settings, including hospitals, nursing homes, and private homes. The guidance identifies special issues associated with hospital bed systems, provides design recommendations for manufacturers of new hospital beds and provides suggestions for health care facilities on ways to assess existing beds for potential entrapment risks. The guideline is <http://www.fda.gov/medwatch/safety/2006/safety06.htm#bed>

RESIDENT RIGHTS VISITATION AND ACCESS TO CLINICAL RECORD



It is important for facilities to promote positive relationships with their residents and their families. More families are visiting their parent or grandparent on a daily basis. They want to be actively involved in

their family member's life in the facility and the decision-making surrounding it. If the nursing home is truly the resident's home, staff should not display behaviors of "whispering around the corner", "suddenly disappearing," or responding rudely to requests by the family on behalf of the resident. CFR 483.10(j) Access and Visitation Rights, interpretative guidelines state "Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. However, the facility may try to change the location of visits to assist care giving or protect the privacy of other residents, if these visitation rights infringe upon the rights of other residents in the facility. For example, a resident's family visits in the late evening, which prevents the resident's roommate from sleeping. Non-family visitors must also be granted "immediate access" to the resident. The facility may place reasonable restrictions upon the exercise of this right such as reasonable visitation hours to facilitate care giving for the resident or to protect the privacy of other residents, such as requiring that visits not take place in the resident's room if the roommate is asleep or receiving care." KAR 28-39-147(l) also speaks to the resident's right to have visitors.

Promotion of positive relationships also requires facilities to be polite and avoid defensive behaviors when a family member who has the legal right requests to review or make copies of the resident's clinical record. CFR 483.10(b)(2) states, The resident or his or her legal representative has the right-- (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. The regulations for Nursing, Assisted Living and Residential Health Care, Home Plus, and Adult Day Care Facilities listed respectively at KAR 28-39-163(m), 250, 434, and 285 address the resident's or

legal representative's rights regarding the clinical records.

Families who feel both their presence and input into their family member's life is welcomed by the facility are less likely to contact the ombudsman and/or complaint hotline.

QUALITY OF LIFE FOR PERSONS WITH ALZHEIMER'S DISEASE

Three areas make a significant difference in quality of life for persons with Alzheimer's disease.

- 1) Inadequate consumption or inappropriate food and fluid choices can contribute directly to a decline in a resident's health and well-being.

Food and fluid consumption goals

- Provide good screening and preventive systems for nutritional care.
- Assure proper nutrition and hydration, given resident preferences and life circumstances.
- Promote mealtimes as pleasant and enjoyable activities where staff have an opportunity to observe and interact with residents.

- 2) Pain is under-recognized and under-treated among residents with dementia.

Pain management goals

- Ease stress associated with pain.
- Treat pain as the "fifth vital sign."
- Tailor pain management to each resident.

- 3) Activities can help residents maintain their functional abilities and can enhance quality of life.

Social engagement goals

- Offer many opportunities each day for providing a context with personal meaning, a sense of community, choices and fun.
- Do *with* – not *to*, or *for*, the resident.
- Respect resident preferences, even if the resident prefers solitude.
- More information about the new program supported by 24 organizations is found at the Alzheimer's Association website.

<http://www.alz.org/Downloads/DementiaCarePracticeRecommendations.pdf>

TRAUMATIC BRAIN INJURY

Valerie Merrow, BBA, BGS, Care Senior Manager
In cooperation with Michael Deegan, BA, Traumatic
Brain Injury Program Manager



Older Persons and Traumatic Brain Injury

March is Traumatic Brain Injury (TBI) Awareness month. A TBI touches all levels of society and can impact all areas of a person's life. Statistics show that TBI poses a significant risk to seniors in that: men and women over the age of 70 experience the second highest frequency of occurrence of TBI; individuals who are 75 years of age and older have the highest rates of TBI-related hospitalizations and deaths; and falls cause the majority of head injuries among older adults, and more than 1/3 of adults age 65 and older fall each year.

Traumatic Brain Injury is an injury to the brain caused by the head being struck, penetrated, or shaken. If an incident is not witnessed but changes in health and behavior are noted, such as difficulties completing daily activities such as routine chores, dressing, or bathing, a medical exam should still be conducted, particularly if bruising is observed around the head/facial area.

Complications can be delayed, the result being that symptoms are often not associated with the injury. This is especially true with seniors whose physical or mental health have declined and their changes in behavior are seen as a sign of aging, and something to be "managed." Signs of dementia, such as difficulty with thinking, reasoning, and memory, can be confused with a brain injury which, unlike dementia, is treatable and might be reversible.

Signs of an injury to the head

- | | |
|-----------------------------------|----------------|
| Loss of consciousness | Confusion |
| Poor coordination | Headache |
| Irrational or aggressive behavior | Slurred Speech |
| Difficulty walking | Amnesia |
| Dizziness | Drowsiness |

Numbness or paralysis in any part Nausea/vomiting
Seizures of the body

Treatment

Treatment for brain injury depends on the type of injury, its severity, and its location. Medical care might be followed by some form of rehabilitation, including physical, occupational, or speech therapy. If the injury results in long-term cognitive and other difficulties, strategies can be developed to assist the individual to compensate for any change in abilities and, thus, maintain the greatest possible level of independence. Some of these strategies include in-home supports, home modifications, and transportation services.

Other Resources

Your **local TBI Service Access Agency** can be found at:
<http://www.srskansas.org/hcp/css/HeadInjury.htm>, then click on **Home Community Based TBI Medicaid Waiver Services** and click on **TBI Program Access Agencies**.

The **Brain Injury Association** (of Kansas and Greater Kansas City): **816.842.8607**.
Michael F. Deegan, the state's Traumatic Brain Injury Program Manager, can be reached at: **785.296.5568** or (MFD@srskansas.org)

Some Fall Prevention Tips: remove throw rugs from kitchen; keep stairs, steps and living areas free from clutter and make sure they are well lit; avoid wearing only stockings and get non-skid footwear; and use a slip-resistant rug next to the shower/tub as well as using grab bars and a raised toilet seat for stability. For more information on falls prevention and T.B.I. go to: www.cdc.gov

CERTIFIED MEDICATION AIDES



Health Occupations Credentialing regularly receives inquiries from medication aides who need to take the approved 10-hour continuing education course because their certification is due to expire. The medication aides may not understand that they can keep their certificate valid by completing the course **at any time** during the two year certification period.

We suggest that the aide look for a potential course at least six to 12 months ahead of the expiration date.

The expiration date of the certificate appears on the confirmation letter on the Kansas Nurse Aide Registry. That may be accessed at www.ksnurseaidregistry.org. The expiration date also appears on the aide's pocket certificate card.

The continuing education programs are sponsored by community colleges, vocational technical schools, adult care homes and associations. You may contact the sponsor to learn about approved upcoming 10-hour continuing education courses. You may also access the list of continuing education courses approved by the certifying agency, the Kansas Department of Health and Environment, Health Occupations Credentialing (HOC) on HOC's website, www.kdheks.gov/hoc (choose Health Care Personnel Resources, CMA Resources, CMA Update Courses), or call HOC (785-296-6796) for continuing education course information.

It is important that the aide plan ahead so that a course is available before the certificate expires. If the aide successfully completes the continuing education course within the preferred timeframe, a new certificate will be mailed to him/her about two weeks before the expiration date of his/her current certificate.

If the certificate expires, the aide may reinstate by taking an approved continuing education course within three years of the expiration date. The new certificate will be valid for two years from the date it

is issued. To maintain a valid certificate, the aide must complete, at any time during those two years, a program of 10 hours of continuing education approved by HOC.

If the certificate has been expired for more than three years, the aide is required to retake the 75-hour medication aide course.

Because the continuing education course is often completed long before the new certificate is issued, it is important that the aide inform HOC of name and address changes as they occur. To report a change of address, the aide may call (785) 296-0060 or (785) 296-1250. For a name change, the aide must submit an HOC form (Request for new card or change name or address change). The form is available on the website, or the aide may request it by calling either of the above listed numbers. The aide will be required to submit documentation of the name

DISPOSITION OF CONTROLLED DRUGS



The regulations for Assisted Living/Residential Health Care Facilities (KAR-28-39-247(f)(5)), Home Plus (KAR 28-39-436(f)(5)) and Adult Day Care (KAR-39-282(f)(5)) state, "Each facility shall ensure that there are records maintained of receipt and disposition of all controlled substances managed by the facility so that there can be an accurate reconciliation." The Board of Pharmacy was contacted for guidance on the destruction of controlled substances when a controlled drug is discontinued or the resident who has received a controlled drug dies or is discharged. The recommendation is two licensed care professionals should witness the destruction of a controlled drug and sign a form indicating destruction of the drug. The appropriate licensed care professionals may be two licensed nurses or a licensed nurse and a pharmacist.

ENFORCEMENT ACTIONS

*Licensure Category	1st	2nd	3rd	4th
ANE Issues	8	3	4	6
Disaster Preparedness	2	3	-	1
General Sanitation and Safety	8	10	17	3
Health Care Services	5	9	8	11
Inadequate Administration	5	2	4	6
Inadequate Admissions	1	2	4	6
Inadequate Accounting of Funds	-	-	-	-
Inadequate Documentation of Employee Records	-	1	-	-
Inadequate Documentation of Resident Records	8	2	7	6
Inadequate Drug Regimen Review	5	3	4	6
Inadequate Inservice Education	1	-	-	2
Inadequate Policies/Procedures Regarding Infection Control	-	-	-	8
Inadequate Policies and Procedures for Special Care Unit	-	-	-	-
Inadequate Range of Motion Services	-	1	-	-
Inadequate Supervision	-	2	-	-
Inadequate or Unqualified Staffing	8	1	7	9
Inadequate or Inappropriate Dietary/Nutritional Services	3	3	6	6
Inadequate or Inappropriate Hygiene and Skin Care	1	-	1	1
Inappropriate Admissions	-	2	2	-
Inappropriate or Unauthorized Use of Restraint	1	-	-	1
Negotiated Service Agreement	14	8	14	-
Physician Verbal Orders for Licensed Personnel	-	-	-	-
Resident Functional Capacity Screen	3	7	7	10
TB for Residents/Staff	3	2	3	-
Unsafe Medication Administration or Storage	2	9	5	9
Other	-	-	-	-
Civil Penalties	4	6	3	3
Correction Orders	22	16	24	15
Bans on New Admissions	4	10	10	4
FEDERAL REMEDIES	1st	2nd	3rd	4th
Civil Monetary Penalties Recommended	13	9	13	17
**Denial of Payment for New Admissions Imposed	29	19	43	22
Terminations	-	1	-	-
No Opportunity to Correct	17	23	33	23

***A correction order on civil penalty may consist of multiple issues summarized**
**** Total figures for previous quarters are updated as this remedy becomes effective.**

Deficiency Free and Exemplary Recognition

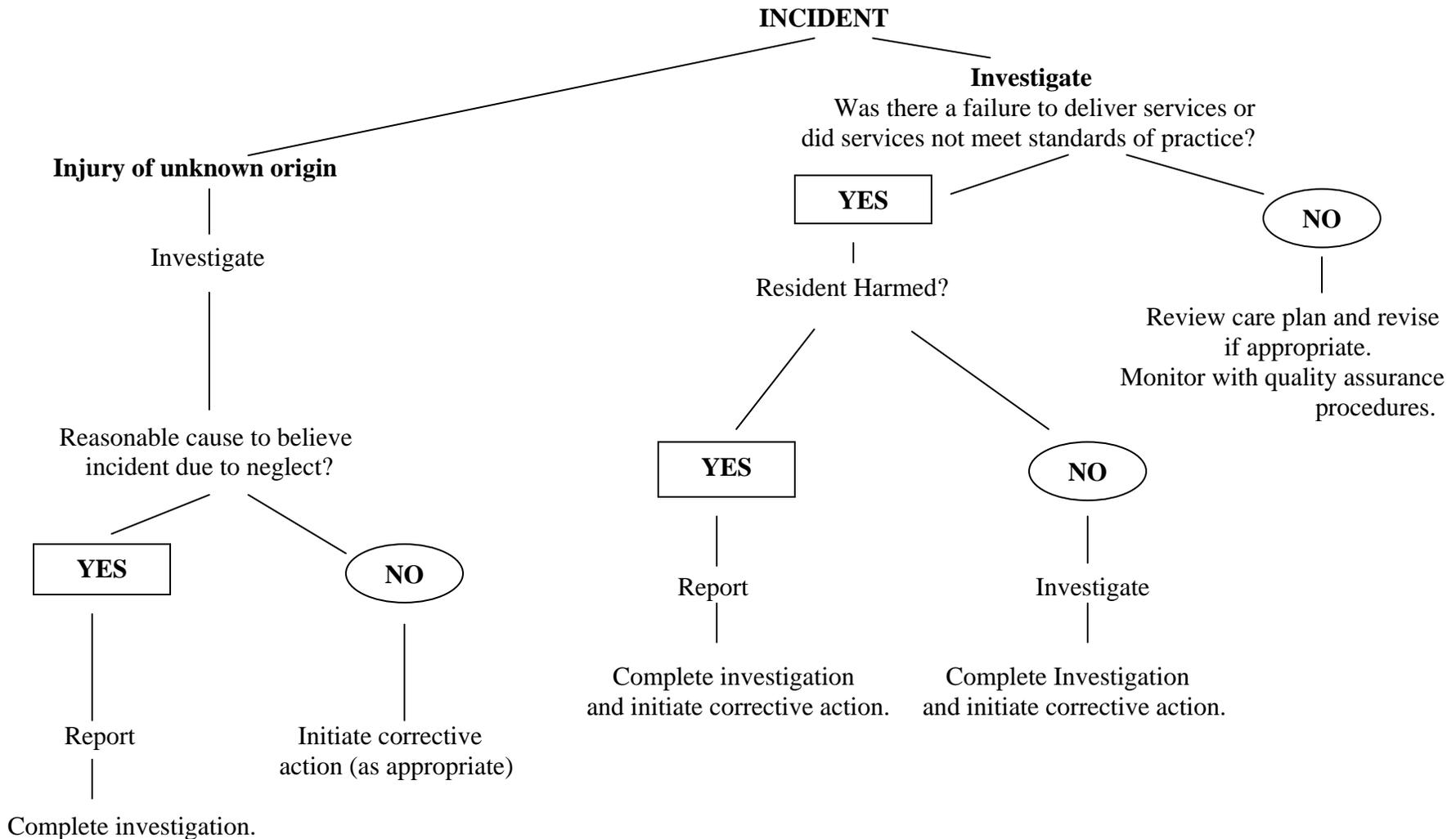
FACILITY	CITY	TYPE	AREA	EXEMPLARY	DEFICIENCY FREE	SURVEY DATE
Meadowlark III	Wichita	BCH	MH/RH		X	10/10/05
Guest Home Estates of Pittsburg	Pittsburg	RHCF	MH/RH		X	10/12/05
Sandstone Heights	Little River	NF	NC		X	10/20/05
Glenwood House	Wellington	BCH	MH/RH		X	10/24/05
Friendly Acres III	Wellington	BCH	MH/RH		X	10/25/05
The Arbor Home	Wichita	BCH	MH/RH		X	10/26/05
Parkside Homes	Hillsboro	SNF/NF	NC		X	10/27/05
Vintage Park at Baldwin City	Baldwin	ALF	MH/RH		X	11/17/05
Waterfront Inn Assisted Living	Living	ALF	MH/RH		X	11/21/05
Moore Adult Care Home	Topeka	BCH	MH/RH		X	11/22/05
J&T Community Residence	Topeka	BCH	MH/RH		X	11/23/05
Conene's Private Adult Care Home	McPherson	BCH	MH/RH		X	11/23/05
Midwest Homeplace South	Leavenworth	BCH	MH/RH		X	11/29/05
Midwest Homeplace West	Leavenworth	BCH	MH/RH		X	11/29/05
Loving Care of McPherson	McPherson	BCH	MH/RH		X	11/30/05
Keen Boarding Care Home	Clay Center	BCH	MH/RH		X	12/6/05
Beaver Creek Home Plus	Milan	BCH	MH/RH		X	12/8/05
Chanute Care Center	Chanute	SNF/NF	SE	X		12/12/05
Comfort Care Home 641	Wichita	BCH	MH/RH		X	12/13/05
Dooley Center	Atchison	SNF/NF	NE		X	12/21/05
Keepsake Care Home (Bryan St)	Wichita	BCH	MH/RH		X	12/22/05
Special People, Inc.	Abilene	BCH	MH/RH		X	12/28/05
Comfort Care Home 441	Wichita	BCH	MH/RH		X	12/29/05
The Gran Villas	Neodesha	ALF	MH/RH		X	12/29/05

EXEMPLARY PERFORMANCE



Chanute Healthcare Center was recognized in January, 2006, for its exemplary performance in implementing programs that promoted their resident's quality of life. The recognized achievement outcomes were developing and implementing creative and innovative activity and social programs which meet the needs of residents with varying abilities, interests and levels of functioning and developing and maintaining the physical environment of the facility in a manner that assured the residents' highest degree of function, autonomy, sanitation, cleanliness, and aesthetic appeal.

Decision Tree For Notifying KDOA/KDHE About Actual or Potential Neglect
This is NOT a Decision Tree for Notification of Actual or Potential Abuse.



URINARY INCONTINENCE

Joint training on Urinary Incontinence, Catheter Use, and Urinary Tract Infections was held for both providers and surveyors in January 2006. It is important for all those attending to realize the presentation by the health care practitioners, Dr. Catherine DeBeau and Judy Algrim, ARNP, was to provide clinical knowledge on the topic. It is the responsibility of those attending, providers and surveyors, to use their discretion in applying the information in caring for residents with urinary incontinence and in surveying residents with urinary incontinence. The specific Regulation CFR 483.25 (d)1(1) and (2) or F tag 315 and the corresponding Interpretative Guidelines that provide guidance as to how compliance can be achieved can be downloaded at <http://www.cms.hhs.gov/> and in the Search Box – place Appendix PP.

KAHSA received questions from several providers following the presentation and requested a response from LCE staff.

Assessment Questions:

1. What is an adequate assessment for elders with dementia?
2. What type of assessment are our nurses expected to conduct?
3. Does a 3 day PVR (post void residual) have to be completed on every incontinent resident upon admission? How frequently thereafter?

CFR 483.25(d)(2) states “A resident who is incontinent of bladder receives appropriate treatment to prevent urinary tract infections and to restore as much normal bladder function as possible. The intent of the regulation is to ensure each resident is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible.”

A resident with dementia is not excluded from the regulation. The facility conducts as complete an assessment as needed to identify the factors causing or contributing to a resident’s urinary incontinence and to develop a plan of care to manage it. The Resident Assessment Protocol (RAP) for Urinary Incontinence and Indwelling Catheter, in effect

since the mid 1990s, which guides a more thorough assessment of the problem, includes many of the same factors as listed in the Interpretative Guidelines for F315 and gives guidance as to the order to review the possible factors causing the urinary incontinence. The RAP also states that a resident with no memory recall and extensively dependent in self-transfer does not need to be catheterized to obtain a clean catch urine to check for a UTI and may not benefit from extensive testing such as a stress test and post void residuals. The following Assessment information is taken directly from the Assessment Section of the Interpretative Guidelines.

Assessment

Factors contributing to urinary incontinence sometimes may be resolved after a careful examination and review of history. In addition, for a resident who is incontinent of urine, determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident’s quality of life and functional status. **A resident should be evaluated at admission and whenever there is a change in cognition, physical ability, or urinary tract function.** This evaluation is to include identification of individuals with reversible and irreversible (e.g., bladder tumors and spinal cord disease) causes of incontinence. If the resident has urinary incontinence that has already been investigated, documented, and determined to be irreversible or not significantly improvable, additional studies may be of limited value, unless there has been advancement in available treatments. Documentation of assessment information may be found throughout the medical record, such as in an admission assessment, hospital records, history and physical, and the Resident Assessment Instrument (RAI). The location of RAI assessment information is identified on the Resident Assessment Protocol (RAP) summary form. It is important that staff, when completing the comprehensive assessment, consider the following:

- Prior history of urinary incontinence, including onset, duration and characteristics, precipitants of urinary incontinence, associated symptoms (e.g.,

dysuria, polyuria, hesitancy) and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI;

- Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days;
- Medication review, particularly those that might affect continence, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedative/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention);
- Patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output;
- Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake);
- Pelvic and rectal examination to identify physical features that may directly affect urinary incontinence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, distended bladder, or bladder spasms;
- Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence, such as impaired cognitive function or dementia, impaired mobility, decreased manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, decreased vision, pain with movement;
- Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination;
- Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders (e.g., Multiple Sclerosis,

Parkinson's Disease or tumors that could affect the urinary tract or its function);

- Identification of and/or potential of developing complications such as skin irritation or breakdown;
- Tests or studies indicated to identify the type(s) of urinary incontinence (e.g., **post-void residual(s)** for residents who have, or are at risk of, urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs; and
- Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, availability of urinals, use of bed rails or restraints, or fear of falling).

Physician questions:

The intent of F501 Medical Director states: "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 are related to the provision of services by physicians and other licensed health care practitioners."

1. What does a provider do in the case of a physician who does not want to undertake a thorough diagnostic effort? If the facility believes the resident needs a thorough diagnostic effort to determine the factors causing or contributing to a resident's urinary incontinence and the physician refuses – they need to enlist the assistance of their medical director.

2. Is it sufficient if the physician has documented the type of incontinence a resident has, even if we do not have access to all of the tests that may or may not have been performed to lead to the diagnosis? The physician needs to follow his standard of practice for diagnosing. We do not require the clinical record to have test results to support diagnoses for any disease processes. If you have problems with the diagnosis, you need to request the services of the Medical Director.

Plan of Care Questions

1. Are there any circumstances in which a resident can be on the traditional every two hours

when awake and before and after meals toileting schedule?

The Interpretative Guidelines state: “**Habit Training/Scheduled Voiding**” is a behavioral technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident’s voiding habits. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges. Habit training includes timed voiding with the interval based on the resident’s usual voiding schedule or pattern. Scheduled voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.”

The program which you call the traditional toileting program of toileting a resident every two hours when awake and before and after meals schedule would be appropriate when a resident has no memory recall, requires extensive or total assistance with transfers, shows no consistent voiding pattern supported by a documented voiding pattern study, use of the traditional toileting schedule does manage the resident’s incontinence problem (the resident is not observed wet), promotes the resident’s well being, and prevents skin breakdown or rashes. It is very important that the finding of no consistent voiding pattern is correct and not the result of staff inconsistency in checking the resident and offering toileting assistance.

2. What if the resident has no discernable toileting frequency pattern?

Refer to the above answer. And the RAI manual which states that a resident who has no memory recall and requires at least extensive assistance with transfers may be considered for the use of pads, i.e. check and change.

The Interpretative Guidelines **Absorbent Products, Toileting Devices, and External Collection Devices** state “Absorbent incontinence products include perineal pads or panty liners for slight leakage, undergarments and protective underwear for moderate to heavy leakage, guards and drip collection pouches for men, and products (called adult briefs) for moderate or heavy loss. Absorbent products can be a useful, rational way to manage

incontinence; however, every absorbent product has a saturation point. Factors contributing to the selection of the type of product to be used should include the severity of incontinence, gender, fit, and ease of use.

Advantages of using absorbent products to manage urinary incontinence include the ability to contain urine (some may wick the urine away from the skin), provide protection for clothing, and preserve the resident’s dignity and comfort.

NOTE: Although many residents have used absorbent products prior to admission to the nursing home and the use of absorbent products may be appropriate, absorbent products should not be used as the primary long term approach to continence management until the resident has been appropriately evaluated and other alternative approaches have been considered.

The potential disadvantages of absorbent products are the impact on the resident’s dignity, cost, the association with skin breakdown and irritation, and the amount of time needed to check and change them

It is important that residents using various toileting devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident’s voiding pattern, accepted standards of practice, and the manufacturer’s recommendations.”

3. Does the resident’s care plan have to include precise times to toilet?

The Interpretative Guidelines state in the Investigative Protocol 3. Record Review. Care Plan. “Review the care plan to determine if the plan is based upon the goals, needs and strengths specific to the resident and reflects the comprehensive assessment. Determine if the plan:

- Identifies interventions specific enough to guide the provision of services and treatment (e.g., toilet within an hour prior to each meal and within 30 minutes after meals, or check for episodes of incontinence within 30 minutes after each meal or specific times based upon the assessment of voiding patterns)”

Other

1. How should the MDS be coded if a resident does not meet the criteria for a symptomatic urinary tract infection (UTI) but the physician places the resident on antibiotic therapy and gives a diagnosis of UTI?

Do not code the resident on the MDS as having a UTI at Section I.2.j. The manual states to include chronic and acute symptomatic infections the resident has experienced in the last 30 days. You will want to place a note in the clinical record explaining the reason for not coding the resident as having a UTI on the MDS. You may also want to bring the situation to the attention of the medical director. See regulation F501 in Physician questions.

The Interpretative Guidelines state under **Indications to Treat a UTI** “Because many residents have chronic bacteriuria, the research-based literature suggests treating only symptomatic UTIs. Symptomatic UTIs are based on the following criteria:

- Residents without a catheter should have at least three of the following:
 - Fever (increase in temperature of >2 degrees F (1.1 degrees C) or rectal temperature >99.5 degrees F (37.5 degrees C) or single measurement of temperature >100 degrees F (37.8 degrees C));
 - New or increased burning pain on urination, frequency or urgency;
 - New flank or suprapubic pain or tenderness;
 - Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or
 - Worsening of mental or functional status (e.g., confusion, decreased appetite, unexplained falls, incontinence of recent onset, lethargy, decreased activity).
- Residents with a catheter should have at least two of the following signs and symptoms:
 - Fever or chills;
 - New flank pain or suprapubic pain or tenderness;
 - Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or

as reported by the laboratory (new pyuria or microscopic hematuria); and/or

- Worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present.

2. If we demonstrate that we have a plan and are making a good faith effort and progress towards getting in compliance on F315, will surveyors cite us?

The actual regulatory requirement has not changed. The interpretative guidelines became effective on June 28, 2005. The interpretative guidelines are to provide additional assistance as to how the regulation can be met.

Based on the resident’s comprehensive assessment, the facility must ensure that -

§483.25(d) (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary; and

§483.25(d) (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

*CMS presented a webcast in October 2004 entitled Urinary Incontinence, Volume II. Facilities have expressed it is helpful. The webcast can still be viewed under “Archived Webcasts” at <http://cms.internetstreaming.com/>

