



# SUNFLOWER CONNECTION

**KANSAS DEPARTMENT ON AGING**  
**LICENSURE, CERTIFICATION AND EVALUATION COMMISSION**

**CONNECTING KDOA WITH LONG TERM CARE PROVIDERS**

Volume 3, Number 3

<http://www.agingkansas.org/kdoa/index.htm> July 2006

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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.

## ELECTRONIC SUBMISSION OF SEMI-ANNUAL REPORT

For the semi - annual report due July 10, 2006, facilities that have access to the internet need to complete the semi -annual report using a new web-based application accessible through the internet browser (Microsoft Internet Explorer).

Each facility should use the same password that was issued to them in December for the annual statistical report. Administrators and Operators should use the same e-signature code that was issued at that time.

Facility staff will need to complete the report information using this new application and upon completion submit the information electronically.

Beginning June 30, 2006, the application and instructions will be available on the KDOA website at: ([http://www.agingkansas.org/kdoa/lce/LTC\\_Reports.html](http://www.agingkansas.org/kdoa/lce/LTC_Reports.html)) [http://www.agingkansas.org/kdoa/lce/LTC\\_Reports.html](http://www.agingkansas.org/kdoa/lce/LTC_Reports.html)

Printable versions of the semi-annual report forms and systematic instructions are also at the above link. The printable version may be used to gather data before entering data in the electronic version.

KDOA Information Services Help Desk, the contact for questions related to the computer application, can be reached at (785) 296-4987.

Sandra Dickison, the contact person for questions related to the reports, can be reached at (785) 296-1245 or at [SandraDickison@aging.state.ks.us](mailto:SandraDickison@aging.state.ks.us)

KDOA is pleased both the semi-annual and annual resident statistics reports may be submitted electronically. Thank you for all your efforts to make this change happen.

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

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**CMS UPDATES**

**Revisions to Appendix PP – Guidance to Surveyors for LTC Facilities**  
**Effective Date: June 1, 2006**

<http://www.cms.hhs.gov/transmittals/downloads/R19SOMA.pdf>

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
R	Appendix PP/Index
R	Appendix PP/§483.15(f)/Tag 248/Activities
R	Appendix PP/§483.15(f)(2)/Tag 249/Activities Director
R	Appendix PP/Tag F276/Quarterly Review Assessment
N	Appendix PP/§483.25(n)/Influenza and Pneumococcal Immunizations
N	Appendix PP/§483.30(e)/Tag F356/Nurse Staffing Information
R	Appendix PP/§483.35(e)/Tag F367/Therapeutic Diets
N	Appendix PP/§483.35(h)/Paid Feeding Assistant
R	Appendix PP/§483.35(i)/Sanitary Conditions/Tags F370/F371/F372
R	Appendix PP/§483.75(o)/F520/Quality Assessment and Assurance

(R = Revised, N = New, D = Deleted)

**REVISIONS TO STATE OPERATIONS MANUAL**  
**APPENDIX P - SURVEY PROTOCOL FOR LONG TERM CARE FACILITIES - PART I**  
**(Rev., 06-09-06)**

[http://cms.hhs.gov/manuals/Downloads/som107ap\\_p\\_ltcf.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_p_ltcf.pdf)

The revisions include correction of typos and word omissions, directions in the off-site preparation to the survey team for selection of additional potential sample residents; and addition of information regarding the QA Committee, psychosocial outcomes; and determination of past non-compliance.

**SURVEY AND CERTIFICATION LETTERS**

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/>

Click on Policies and Memos to States and Regions; scroll down to the specific letter.

**New Psychosocial Outcome Severity Guide – Effective June 8, 2006**

March 10, 2006; Ref: 06-10

Archived Webcast. <http://www.cms.internetstreaming.com>

**Nursing Home and Medicare Part D**

May 11, 2006, Ref. 06-16

Clarification of Resident Rights and Provider Responsibilities

**CORRECTION – DECISION TREE FOR NOTIFICATION OF NEGLECT**

The Decision Tree for notifying KDOA/KDHE about actual or potential neglect printed in the April 2006 Sunflower Connection contained an error. Please refer to the corrected Decision Tree in this edition.

It is important for Medicare and Medicaid certified facilities to realize the CMS Survey and Certification Letter, Clarification of Nursing Home Reporting Requirements for Alleged Violations, 12/16/2004 Ref. 05-09, supersedes this tree for all Medicare and Medicaid Certified Facilities. The discussion section of the S&C letter includes definitions of neglect and injuries of unknown source and the requirement that a facility must report all alleged violations immediately (within 24-hours) to the State Agency.

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## **MDS COMMUNICATION**

### **UPCOMING MDS EDUCATION**

MDS 2.0, Care Plan, RAPS, and RUGS Education will be presented on July 20 and 21 via video teleconferencing to the KDHE District Offices at Dodge City, Hays, Wichita, Salina, Lawrence, Chanute and Topeka.

Registration Forms are available at [http://www.agingkansas.org/kdoa/lce/Education\\_Info/enrollment\\_form\\_kdoa.pdf](http://www.agingkansas.org/kdoa/lce/Education_Info/enrollment_form_kdoa.pdf)

### **WHO CAN COMPLETE THE MDS AND RAPS?**

A frequently asked question is which facility staff may complete the MDS and RAPS. The staff who may complete the MDS are Registered Nurses, Licensed Practical Nurses with additional education in assessment, Physical Therapists, Occupational Therapists, Speech Language Pathologists, Registered Dietitians, Licensed Social Workers, Social Worker Designees who have a degree in a human services field, Therapeutic Recreation Specialists, Activity Directors (Section N only), and Certified Dietary Managers (Section K 2-5 only). The staff who may complete the RAPS are Registered Nurses, Licensed Practical Nurses with additional education in assessment, Physical Therapists, Occupational Therapists, Speech Language Pathologists, Registered Dietitians, Licensed Social Workers, and Therapeutic Recreation Specialists.

While these specified licensed health care professionals and designated certified staff may conduct the process of completing the MDS and/or RAPS, it is important for them to communicate with the resident, their family or legal representative, the resident's physician, and all facility staff who work with the resident. All these individuals have valuable knowledge needed to complete an accurate and thorough assessment and the resulting individualized resident care plan.

### **RESOURCES FOR MDS COORDINATORS**

MDS 2.0 Manuals and Forms – RAI Manual and Updates.

[http://www.cms.hhs.gov/NursingHomeQualityInits/20\\_NHQIMDS20.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp)

QIES Home Page [Re-type or copy and paste this into the URL due to security alert, click on yes to proceed]. Contains MDCN information and other informative MDS information.

<https://www.qtso.com/index.php>

MDS Download from QIES Technical Support Office [Re-type or copy and paste this into the URL due to security alert, click on yes to proceed]. Contains information regarding MDS updates, RUGS information, QI/QM reports, facility user's guide, validation report messages and descriptions and other useful MDS information.

<https://www.qtso.com/mdsdownload.html>

RAI-MDS 2.0 homepage contains technical information related to the MDS 2.0 resident assessment instrument.

<http://www.cms.hhs.gov/MinimumDataSets20/>

MDS 2.0 Software and Specifications contains software and specifications related to the MDS 2.0 resident assessment instrument.

[http://www.cms.hhs.gov/mds20swnspecs/01\\_overview.asp](http://www.cms.hhs.gov/mds20swnspecs/01_overview.asp)

MDS 2.0 Web Based Training in Progress.

<http://www.MDStraining.org>

Archived Web casts

<http://cms.internetstreaming.com>

Improving MDS Accuracy - ADLs and Restorative Nursing, August 27, 2004.

Improving MDS Accuracy – Disease Diagnosis, Medications and Health Conditions, October 29, 2004.

D.A.V.E., June 20, 2003.

Archived videos are also available from the KDOA Video Library,

[http://www.agingkansas.org/kdoa/lce/av\\_resources.html](http://www.agingkansas.org/kdoa/lce/av_resources.html)





## **F329 – UNNECESSARY DRUGS IS THE MEDICATION UNNECESSARY?**

Although F329, CFR 483.25(l) is titled Unnecessary Drugs, the actual prescription of the medication may not always be unnecessary. A common contributing factor to the deficient practice is a lack of documentation by the interdisciplinary team supporting the initial or continued use of the medication as a necessary medication for the resident. Completion of the required documentation prompts facility staff to do the needed assessment, to develop and implement a care plan, and to evaluate the effectiveness of the plan of care related to the use of a medication for a resident.

Prior to a physician ordering a medication, especially antipsychotics, anti-anxiety, and hypnotics, it is important for the nursing and social services staff to write supporting documentation in the clinical record. The documentation should include the specific behaviors or symptoms a resident may display; possible environmental factors that may have caused or contributed to the resident's behavior or symptom; and what non-medication interventions facility staff have attempted and the effect of those interventions. When the physician orders a medication, the physician should provide medical justification for the medication including a diagnosis when possible. Since many medications have adverse effects for elderly people, the physician should also document the desired effect of the medication for the resident and why the desired effect of the medication outweighs the potential adverse effects of the medication.

Once the medication is ordered, the nursing staff and social service staff should continue to monitor the resident's environment for contributing factors and document the effectiveness of non-medication interventions used in conjunction with the medication therapy. It is important for nursing staff to have knowledge of the parameters for determining the medication's effectiveness and its potential for adverse effects. Facility staff need to document this

information in the care plan or another area of the clinical record. When the physician has prescribed a medication to manage a resident's specific behavior, facility staff, including certified or licensed nursing or social services staff, need to maintain a record of the resident's behavior in the progress notes or on a flow sheet. A monthly review of the behavior monitoring by licensed nursing or social services staff is helpful to determine if the physician should consider discontinuing medication or changing the dose of the medication. When a physician orders a medication to maintain a resident's physical health status within normal parameters, i.e. cardiovascular, licensed nursing staff need to record and review the resident's heart rate and/or orthostatic blood pressures as ordered by the physician or as recommended by the pharmaceutical guidelines.

When a physician discontinues a medication or changes the dose of a medication, it is important for nursing and social services staff to monitor the resident's response to the change. If the medication is for behavior management, it is important to document any reoccurrence of undesired behaviors in spite of the intervention of non-medication interventions. Licensed nursing staff need also to document the presence or absence of potential or actual adverse effects of a medication exhibited by the resident. If actual adverse effects are identified, the licensed nursing staff need to notify the physician to allow for an evaluation of the resident to determine if the risk (adverse effect) outweighs the benefit (positive effect) of the medication. If the physician chooses to continue the medication and at the same dose, the physician must document the medication's desired effect on the resident and how the continued effectiveness of the medication is more important for the resident than the presence of the adverse effects.

When the pharmacist does the monthly medication regime review, they need to review the clinical record to be certain that the needed documentation is in place for use of the medication, to provide needed staff education regarding medication effect, adverse effects, and monitoring, and to guide regulatory compliance for needed required dose reductions.

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### **F329 – UNNECESSARY DRUGS continued**

It takes the efforts of the entire interdisciplinary team to ensure a resident is receiving only necessary medications.

Additional information on this topic is available in the QIS Surveyor Training Manual, Section 10 Critical Elements for Psychoactive Drugs. The manual is available at [www.agingkansas.org](http://www.agingkansas.org) Licensure, Certification, and Evaluation Commission.

### **RESIDENT CENTERED KITCHENS**

Kansas facilities strive to be leaders in resident centered care. This issue of the Sunflower Connection focuses on The Cedars in McPherson. The Cedars is a Continuous Care Retirement Community (CCRC) including a nursing facility licensed for 117 residents. The Cedars is the first traditional nursing facility in Kansas to have individual houses for nursing facility residents. The Cedars has constructed four separate beautiful homes for 14 nursing facility residents in each house. The local community gave a “welcome new home” shower to each house. Shower gifts included service ware for the dining room.



The photos of one kitchen and dining room were taken prior to residents’ arrival. These rooms overlook a fenced patio with a moveable grill the residents will enjoy.

The 14 residents in each home will have an opportunity to be involved in the sight, smells and preparation of their food.

#### ***MORE resident choices.***

The facility’s central kitchen located in the original building .6 mile away does pre-preparation to reduce food preparation time for staff in houses for the noon and evening meals. For example, fillings and sliced tomatoes for sandwiches are sent in bulk; and sandwiches are made to order in the houses for residents. Residents have choice and there is no “soggy” bread that would occur with “made ahead” sandwiches. Breakfast is prepared in each house, so residents may choose their breakfast times.

The week’s menus are posted for residents. A resident may have their own copy if they wish. For residents with diabetes the menu has all foods with 15 grams of carbohydrate per serving written in red and star\*. A food written in red with 2 stars\*\* would indicate 30 grams of carbohydrate. This allows each resident choice at meals to follow their consistent carbohydrate meal plan by counting stars\*.

Each kitchen has 2 refrigerator/ freezer combinations. (The second, not visible in the photo, is on the wall on the right side of the photo). This allows extra food from meals to be stored for residents to choose later. Each house has a microwave to maintain quality when these foods are reheated. Plus there is storage of other foods to provide resident’s choice.

#### ***Ongoing focus on residents***

Original kitchen safety features included a keyed safety switch for the range, lockable cabinets, and a counter height lockable door (not visible in the photos). Attractive wrought iron has been added to

**RESIDENT CENTERED KITCHENS continued**  
this door after residents arrived since some residents climbed over the lower door.

Initially the houses were staffed with universal workers who provided resident care and prepared food. The Cedars staffs have since decided the residents would be better served if dietary staff were also in each house kitchen.

After working in the houses the Cedars staff decided another sink, next to the under-counter dishwasher, in addition to the hand-washing sink and 2-compartment preparation sink, would make work in the kitchens easier.

Sheri McCabe from The Cedars said, "I do hope lots of other folks look for an opportunity to adjust their dining services--even if they don't build new houses!"

***What residents say is the most important.***

What are residents' responses to the new homes and food service? The resident council notes say "food smells good and tastes great."

**TUBERCULIN UPDATE**

DeAnna McClenahan- Consultant, TB Control Program



The TB Control Program conducts trainings across the state to provide updated information about tuberculosis. During training sessions, problems have been identified, solutions formed and implementation to resolve the problems has occurred.

The Mantoux tuberculin skin test (TST) is the standard method of identifying persons infected with mycobacterium tuberculosis. Purified Protein Derivative (PPD) is the solution used in the administration of the TST. PPD has certain criteria that must be followed to ensure that it is being given properly. The following are common errors the TB

Control program has discovered in facilities that place TSTs on a regular basis.

***Storage and Handling of PPD***

1. PPD adheres to plastic - To minimize reduction in potency by absorption PPD should be drawn up and given as soon as possible after the syringe has been filled.

2. Controlled storage temperatures - PPD should be stored at temperatures between 36-46 degrees Fahrenheit. If the antigen is accidentally frozen, it should be discarded.

3. PPD is sensitive to light - PPD should be stored in the dark, and excessive exposure to light should be avoided. If the PPD is subjected to light for a long or undetermined amount of time, it should be discarded. Store PPD in the refrigerator in the box that it is packaged in, and do not leave on countertops.

4. PPD expires 30 days after the vial is punctured. A vial of PPD once punctured should be dated and discarded after 30 days. The manufacturer's expiration date only applies if the vial has not been opened.

***Planting the TST***

1. PPD is administered as an intradermal injection.

2. A wheel should be produced that measures 6-10 mm in diameter.

3. An alternative site for administration of the TST is the scapula.

***Reading the TST***

1. The TST should be read 48-72 hours after the PPD is injected.

The TST should be measured and documented appropriately. Measure only the induration and record the measurement in millimeters. If no induration is found, "0 mm" should be recorded, not "negative."

***Documentation of the TST***

1. Name of the individual being tested
2. Date of birth

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## **TUBERCULIN UPDATE continued**

3. Manufacturer of the PPD
4. Lot Number of the PPD
5. Manufacturer expiration date
6. Date PPD planted
7. Location that the PPD is planted (left forearm, right forearm)
8. Signature of person planting the PPD
9. Date PPD read
10. Measurement of the TST in millimeters
11. Note any adverse reactions
12. Signature of person reading the TST
13. If positive, note what is being done (i.e. TB Control Program notified; physician will prescribe 9 months of INH therapy)

### ***State Law to Report All Positive Skin Tests***

1. K.S.A. 65-118, 65-128, 65-6001-65-6007, K.A.R. 28-1-2, 28-1-4, and 28-1-18 requires individuals to report Latent Tuberculosis Infection. These may be phoned to the TB Control Program at 785-296-0739 or faxed to 785-291-3732.

The above referenced Statutes and Regulations also require that any suspect or confirmed case of Active Tuberculosis be reported within four hours by telephone to the TB Control Program. The

2. Epidemiology Hotline: 1-877-427-7317 may be used or 785-296-0739.

In the future, the TB Control Program is expecting to see some new guidance from the Centers for Disease Control (CDC) as it relates to Long Term Care Facilities. New TB Control recommendations place emphasis on each individual health care facility conducting risk assessments to determine the frequency of screening and testing for tuberculosis. For example if Facility A has not seen a case of TB for 20 years, the counties that Facility A provides services for have not seen a case of TB for 20 years, then Facility A will fall into the category of Low Risk. Low Risk facilities will only need to skin test upon hire or upon admission into that facility. They will not do annual skin testing. Hospitals across Kansas are incorporating these new recommendations into their hospital policies and procedures. The TB Control Program will be

reviewing the regulations that pertain specifically to Long Term Care Facilities and will suggest changes based upon these new recommendations. Until then, continue following the present interpretation of KAR 28-39-161 (b) (3), KAR 28-39-253 (b) (7), KAR 28-39-288 (b) (6), KAR 28-39-433 (b) (7), 42 CFR 483.460 (a) (3) (10) and 42 CFR 483.470 (a) (4).

The TB Control Program is available for:

1. Training
2. Providing medications at no cost for the treatment of Latent Tuberculosis Infection, and Active Tuberculosis
3. Providing PPD at a reasonable price- \$15.00 for a 50 test vial, \$8.00 for a 10 test vial with a shipping and handling fee of \$7.00. (These prices may fluctuate)
4. Answering questions related to tuberculosis
5. Helping conduct contact investigations

To contact TB Control Program Personnel:

Phil Griffin - Co-Director, HIV/STD/TB

785-296-8893

DeAnna McClenahan - Consultant, 785-296-8479

Ginny Dowell - Nurse Consultant, 785-296-0739

Linzi Meyer - Research Analyst, 785-296-2547

Sue Aschenbrenner - Office Specialist,

785-296-5589

Fax: 785-291-3732 [www.kdhe.state.ks.us/tb/](http://www.kdhe.state.ks.us/tb/)

## **DIETARY QUESTIONS & ANSWERS**



### **DIET HOLIDAY**

**Question:** How should a Diet Holiday be ordered?

**Answer:** Almost all food(s) in reasonable portions may be included in most therapeutic diets by substituting desired food for other foods on the planned menu. The facility should document the reason the foods the resident wishes cannot be provided through substitutions to the planned menu.

The facility must have specific physician orders for each resident when food holidays are observed. For example, resident may have a diet holiday one time per month. Increase insulin 6 units for each additional 15 grams of carbohydrate eaten.

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## USE OF LOCALLY GROWN FRUITS AND VEGETABLES



**Question:** CFR 483.35(h)(1), F 370, states, “Procure food from sources approved or considered satisfactory by Federal, State or local authorities.” Does this allow the purchase of locally grown fresh fruits and vegetables?

**Answer:** Yes. A facility may purchase and use uncut quality locally grown fruits and vegetables. Unless the fruits or vegetables are organically grown, the grower should provide a written statement that herbicides and pesticides have been used according to label directions.

The Kansas State Regulation Interpretation, Donated Foods, Number 93-25, states, “Donated food shall meet the following...e. homegrown fresh fruits and vegetables that smell and appear of good quality may be used. A facility shall be assured that the donated produce has met the pre-harvest interval between the last application of pesticide and the date of harvest.”

Locally grown produce can provide superior flavor and healthy variety at reasonable costs. The Kansas Food Policy Council, sponsored by the Kansas Rural Center, is investigating ways to get fresher, local produce into institutional food service situations. If funding becomes available, the Council hopes to target a few facilities in Kansas with supplemental dollars to buy fresh produce. In the meantime, facilities may want to visit their local farmer’s market and introduce themselves to some growers. The growers may be interested in providing the facility with tomatoes, sweet corn, lettuce and other salad items, as well as sweet potatoes and apples in the fall. Contact with the Food Policy Council can be made through Dan Nagengast, at [nagengast@earthlink.net](mailto:nagengast@earthlink.net) or 785-748-0959.



## ASK AL



## CONSTRUCTION, NEW AND REMODELING PROJECTS

**Question:** Does KDOA need to be notified of all facility construction, new and remodeling projects?

**Answer:** Prior to a facility beginning new construction or an addition, or remodeling that involves structural elements, the administrator or operator must send a letter of intent to Rita Bailey, Licensing Administrative Specialist, and receive approval of the project. Structural changes may include removing a weight-bearing wall. When any wall is removed, the architect needs to send a letter to Al Gutierrez, Environmental Specialist, stating whether the wall is weight bearing or not.

Remodeling projects that involve cosmetic changes such as painting and replacing carpet do not require notification and approval from KDOA. However, facilities are encouraged to notify Al about the project so the agency can respond appropriately if any complaints are received about paint or carpet glue odors in the facility.

## DRUG DESTRUCTION

Kansas State Board of Pharmacy  
March 2006 newsletter  
<http://www.kansas.gov/pharmacy/Newsletters/March2006.pdf>



“The Board is often asked the best way for patients to dispose of unused or expired medications. There is not an easy answer to this question. In the past, the advice was to throw the medication down the toilet, but this is no longer recommended because of the potential for environmental damage. At this time, the best option is to direct the customer to a local hazardous waste facility; however, some waste facilities do not take medicines so you should have an alternate option. If there is a Pharmacy Take-Back program in your area, you could refer the customer to them. The last option is to throw the

**DRUG DESTRUCTION continued**

drugs in the trash. If you advise them to throw the drugs in the garbage they should follow the following steps to lessen the potential for abuse and privacy issues and to improve safety.

1. Keep the medication in the original container with the child-proof lid attached.
2. Remove the patient’s name if it is present on the container.
3. Add a small amount of water to the solid drug or an absorbent material such as Kitty Litter®, sawdust, or flour to liquid drugs before recapping.
4. Adding a nontoxic spice such as cayenne pepper is another idea to make the drug unpalatable.
5. Double enclose the contained drugs in a bag or any other waste container, such as a brown paper bag, to prevent immediate identification of a drug container.
6. Place medicines in the trash as close to garbage pickup as possible.

benefits may be adversely impacted by their admission to the facility. The DOPNA has no impact on newly admitted residents who are private pay. Once the facility is back in substantial compliance, Medicare or Medicaid payment will begin for the residents who were admitted while the denial was in place. If a facility is found to be in substantial compliance with all cited deficiencies on the first revisit following a DOPNA, the denial is lifted retroactive to the correction date submitted on the plan of correction. If substantial compliance is not achieved by the revisit, the DOPNA continues.

A Ban on Admissions is a remedy under the state licensing law that is different from the federal DOPNA. Under a ban on admissions, the provider is not allowed to admit any new residents, regardless of payment source. This enforcement remedy is imposed on adult care homes that are licensed only and have no Medicare or Medicaid Certification.

**COMMISSIONER’S COMMENTS**

**DENIAL OF PAYMENT FOR NEW ADMISSIONS (DOPNA) VERSUS BAN ON ADMISSIONS**

Denial of Payment for New Admissions (DOPNA) is an enforcement action in which payment for newly admitted residents whose payment source would be Medicaid or Medicare is withheld. It is an enforcement remedy under federal certification regulations that must be imposed on long-term care nursing facility providers who are not found to be in substantial compliance within 3 months following any survey. A DOPNA is also imposed if a facility receives a "G" or higher deficiency on the current survey and the last recertification survey, or any intervening survey (i.e. double G+). The provider can choose to admit new residents whose payment source would be Medicaid or Medicare, but they will not receive payment for these residents’ stay until the facility is determined to be back in substantial compliance. The facility must inform the potential resident that Medicare and/or Medicaid will not pay for their services and furthermore, other Medicaid

**SCOPE OF PRACTICE FOR AN LPN IN ADULT CARE HOMES EXCERPT FROM THE KANSAS BOARD OF NURSING**

<http://www.ksbn.org/legal/faq.htm>

*Legal Frequently Asked Questions*

**Question:** What is the scope of practice for an LPN?

**Answer:** K.S.A. 1113(d)(2) sets three qualifiers for LPN practice:

- 1) an LPN must have a supervisor that is an RN, someone licensed to practice medicine and surgery (M.D. or D.O.) or a dentist;
- 2) an LPN must function in the area of supportive and/or restorative care; and
- 3) an LPN's activities must be based on acceptable educational preparation.

If these three criteria are met, an LPN may engage in care, nursing diagnosis, treatment, counsel and health teaching, supervision, administration, teaching of the nursing process and execution of the medical regimen.

These activities are most often limited by the LPN's educational preparation. Any post basic education obtained can be considered and should meet the industry standard.

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## LCE STAFF CHANGES

**Michelle Hickling** is the new Enforcement Coordinator. Michelle is a Registered Nurse. Prior to her most recent position as a Health Facility Surveyor with the NE District, Michelle was employed at KDOA in the Nursing Facility/Care Program and was instrumental in establishing special Medicaid rates for Ventilator Dependent Residents and developing helpful information for facilities to use to minimize trauma when relocating elderly residents.

**Ernie Beery** is a new Intake Specialist with the Complaint Program. Ernie is a Registered Nurse with several years of experience in acute care and home health. Ernie has been a Health Facility Surveyor with the NE District for the past two years. The addition of Ernie to the Complaint Program will allow for future expansion of the Hotline hours to 8 am to 5 pm.



### BEST PRACTICE GUIDELINES FOR ADULT CARE HOMES FALL MANAGEMENT FORMS

These forms can be accessed at  
<http://www.agingkansas.org>

- ◆ On the right-hand side, click “Aging Kansas Website.”
- ◆ On the left-hand side, click “Licensure, Certification & Evaluation.”
- ◆ Scroll down to “Quality Practice Workshop.”
- ◆ Click “Best Practice Guidelines for Adult Care Homes-Fall Management.”

## CHANGE OF ADMINISTRATOR, OPERATOR, OR DIRECTOR OF NURSING SERVICE

KAR 28-39-145a (g) Change of administrator, director of nursing, or operator. Each licensee of an adult care home shall notify the department immediately when there is a change in administrator, director of nursing, or operator. When a new administrator, director of nursing, or operator is employed, the licensee shall notify the department of the name, address, and Kansas license number of the new administrator or director of nursing. In the case of a new operator, the licensee shall provide evidence that the individual has completed the operator course as specified by the secretary.

When there is a change in employment of an administrator, operator, director of nursing service, the licensee of the facility must send a letter of notification to Rita Bailey, Licensing Administrative Specialist, KDOA, 503 South Kansas Avenue, Topeka, KS. 66603-3404. The letter needs to identify when the change will occur or occurred, the name of the person leaving employment, and the name of the person hired for the position. If there is an interim period, the facility must provide notification as to who will be temporarily filling the position. The facility does not need to submit the Notification of Change of Administrator or Operator form until an administrator or operator is hired permanently for the position. The submission of the form will serve as notification to the department that the facility has hired a permanent administrator or operator. The facility must send the department a letter when it has filled the director of nursing position permanently.



**ENFORCEMENT ACTIONS**

*Licensure Category	1st	2nd	3rd	4th
ANE Issues	6			
Disaster Preparedness	3			
General Sanitation and Safety	23			
Health Care Services	17			
Inadequate Administration	2			
Inadequate Admissions	6			
Inadequate Accounting of Funds	-			
Inadequate Documentation of Employee Records	-			
Inadequate Documentation of Resident Records	6			
Inadequate Drug Regimen Review	6			
Inadequate Inservice Education	-			
Inadequate Policies/Procedures Regarding Infection Control	3			
Inadequate Policies and Procedures for Special Care Unit	-			
Inadequate Range of Motion Services	-			
Inadequate Supervision	-			
Inadequate or Unqualified Staffing	17			
Inadequate or Inappropriate Dietary/Nutritional Services	4			
Inadequate or Inappropriate Hygiene and Skin Care	-			
Inappropriate Admissions	3			
Inappropriate or Unauthorized Use of Restraint	2			
Negotiated Service Agreement	14			
Physician Verbal Orders for Licensed Personnel	-			
Resident Functional Capacity Screen	12			
TB for Residents/Staff	-			
Unsafe Medication Administration or Storage	15			
Other				
Civil Penalties	2			
Correction Orders	26			
Bans on New Admissions	4			
<b>FEDERAL REMEDIES</b>	<b>1st</b>	<b>2nd</b>	<b>3rd</b>	<b>4th</b>
Civil Monetary Penalties Recommended	9			
**Denial of Payment for New Admissions Imposed	20			
Terminations	-			
No Opportunity to Correct	27			

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

**2006 DEFICIENCY FREE AND EXEMPLARY RECOGNITION**

<b>FACILITY</b>	<b>CITY</b>	<b>TYPE</b>	<b>AREA</b>	<b>EXEMPLARY</b>	<b>DEFICIENCY FREE</b>	<b>SURVEY DATE</b>
Independent Living	Atwood	BCH	SB/QR		<b>X</b>	1/10/06
Country Place Senior Living	Ellinwood	HP	SB/QR		<b>X</b>	1/24/06
Country Place Senior Living	Larned	HP	SB/QR		<b>X</b>	1/24/06
The Homestead of Topeka	Topeka	ALF	MH/RH		<b>X</b>	1/26/06
Cumbernauld Village	Winfield	NF	SC		<b>X</b>	1/26/06
Cumbernauld Village	Winfield	NF	SC	<b>X</b>		1/26/06
Windsong Home	Milford	HP	SB/QR		<b>X</b>	1/31/06
Beverly Health & Rehab	Lucas	SNF/NF	W	<b>X</b>	<b>X</b>	2/1/06
Edwardsville Manor	Edwardsville	NFMH	MHRH		<b>X</b>	2/9/06
Deer Park Senior Group Home	Meriden	HP	SB/QR		<b>X</b>	3/15/06
Life Care Center of Seneca	Seneca	SNF/NF	NE		<b>X</b>	3/15/06
Catholic Charities Adult Day	Wichita	ADC	SB/QR		<b>X</b>	3/16/06
Meadowlark Adult Care Home	Wichita	HP	SB/QR		<b>X</b>	3/30/06



**EXEMPLARY PERFORMANCE**

Cumberland Village of Winfield was recognized in January 2006 for its exemplary performance in implementing programs that promoted both quality of care and life for residents. The recognized achievements included the development of creative methods for meeting the nutritional needs and personal food preferences of residents and the development and implementation of creative and innovative activity programs that met the needs of the residents with varying abilities, interests, and levels of functioning.

Beverly Health and Rehabilitation of Lucas was recognized in March 2006 for its exemplary performance in implementing programs that promoted both quality of care and life for residents. The recognized achievements included implementation of a care management program to assist the residents to improve their continence status and the development and implementation of a creative and innovative activity program that met the needs of the residents who had varying abilities, interests, and levels of functioning.

LONG TERM CARE  
REGULATION INTERPRETATION  
LICENSURE, CERTIFICATION AND EVALUATION COMMISSION

KAR 28-39-162 (a)  
K.A.R. 28-39-254 (a) (b) (c)  
K.A.R. 28-39-254(g) (1) (E)  
K.A.R. 28-39-254(g) (3) (B)

**SUBJECT:** Shower accessibility for a Resident with Disabilities

**DATE:** 04-06

**NUMBER:** 06-02

**INTERPRETATION:** New construction, modification, and equipment in Adult Care Homes, e.g. nursing, assisted living, and residential health care facilities, must meet the Americans with Disabilities Act Accessibility Guidelines (ADAAG) Title III Chapter 6 Medical Facilities, Long Term Care Facilities. The ADAAG for Long Term Care Facilities require all public use and common use areas and at least 50% of the rooms, areas, and spaces be accessible to individuals with disabilities. This includes the showers in the residents' rooms, apartments, and individual living units. Fifty percent of the residents' rooms, apartments, and individual living units must have roll-in showers that measure 3 feet by 5 feet and have no greater than a ½ inch lip.

The remaining 50% balance of residents' rooms, apartments, and individual living units may have showers that do not specifically meet the ADAAG for accessibility but rather allow for meaningful access. The Adult Care Home regulations require all residents' apartments and individual living units in assisted living and residential health care facilities to have a toilet room which contains a toilet, lavatory, and a bath tub or shower accessible to a resident with disabilities, but do not specify ADAAG must be met for the remaining 50% balance.

Residential health care facilities previously licensed totally or partially as a nursing facility on or before July 1, 1995, must have private bathing facilities in at least 20% of the individual living units in each section. If a facility must remodel the building to achieve the 20% requirement, the private bathing facilities must include roll-in showers that measure 3 feet by 5 feet and have no greater than a ½ inch lip.

**DISCUSSION:** The state ADA Coordinator provided clarification as to the ADA classification of the Adult Care Homes, e.g. nursing, assisted living, residential health care, home plus, adult day care and boarding care facilities, licensed by LCE. The adult care homes are classified as Long Term Care Facilities under Title III of ADA Chapter 6 Medical Facilities. The state ADA Coordinator also clarified the showers in resident rooms, apartments, and individual living units are included in the rooms, areas, and spaces that must be accessible. In view of the population who lives in Adult Care Homes, the state ADA Coordinator further affirmed the agency's requirement that 50% of the residents' rooms, apartments, and individual living units to have roll-in showers that measure 3 feet by 5 feet and have no greater than a ½ inch lip. The people living in adult care

homes often have mobility issues that limit their ability to safely use a shower independently or with minimal assistance when having to step across a shower lip, or when the room floor and the shower floor are at different heights. Facilities and contractors must be aware not all shower compartments labeled as ADA approved meet ADAAG.

Adult Care Home regulations require all residents' apartments and individual living units in assisted living and residential health care facilities to have toilet rooms/bathrooms containing a toilet, lavatory, and bath tub or shower accessible to a resident with disabilities and facilities must meet this requirement for the remaining 50% balance. KDOA recommends all the residents' rooms, apartments, and individual living units have roll-in showers that measure 3 feet by 5 feet and have no greater than a ½ inch lip. However, the facility has the flexibility to determine how a resident with a disability will have meaningful access in the toilet room/bathrooms and in use of the associated fixtures, toilet, lavatory, and bathing facility. A disability is defined as an impairment that substantially limits one major life activity, including caring for oneself, walking, seeing, hearing, speaking, breathing, and working. Grab bars appropriately placed and a seating appliance in the shower or tub may assist in resident safety and accommodation of needs for the bathing/showering process.

If a resident living in a room, apartment, or living unit that does not have a roll-in shower with no greater than a ½ inch lip presents an ADA complaint regarding shower accessibility, the facility will be required to make the needed modification of lowering the height of the lip. The resident cannot be required to move to another apartment or be discharged to avoid this accommodation. The facility is responsible overall to ensure the needs of the residents residing in the rooms, apartments or living units are accommodated and that the resident is not dependent on staff assistance due to the toilet and shower or bathtub not meeting their level of disability.

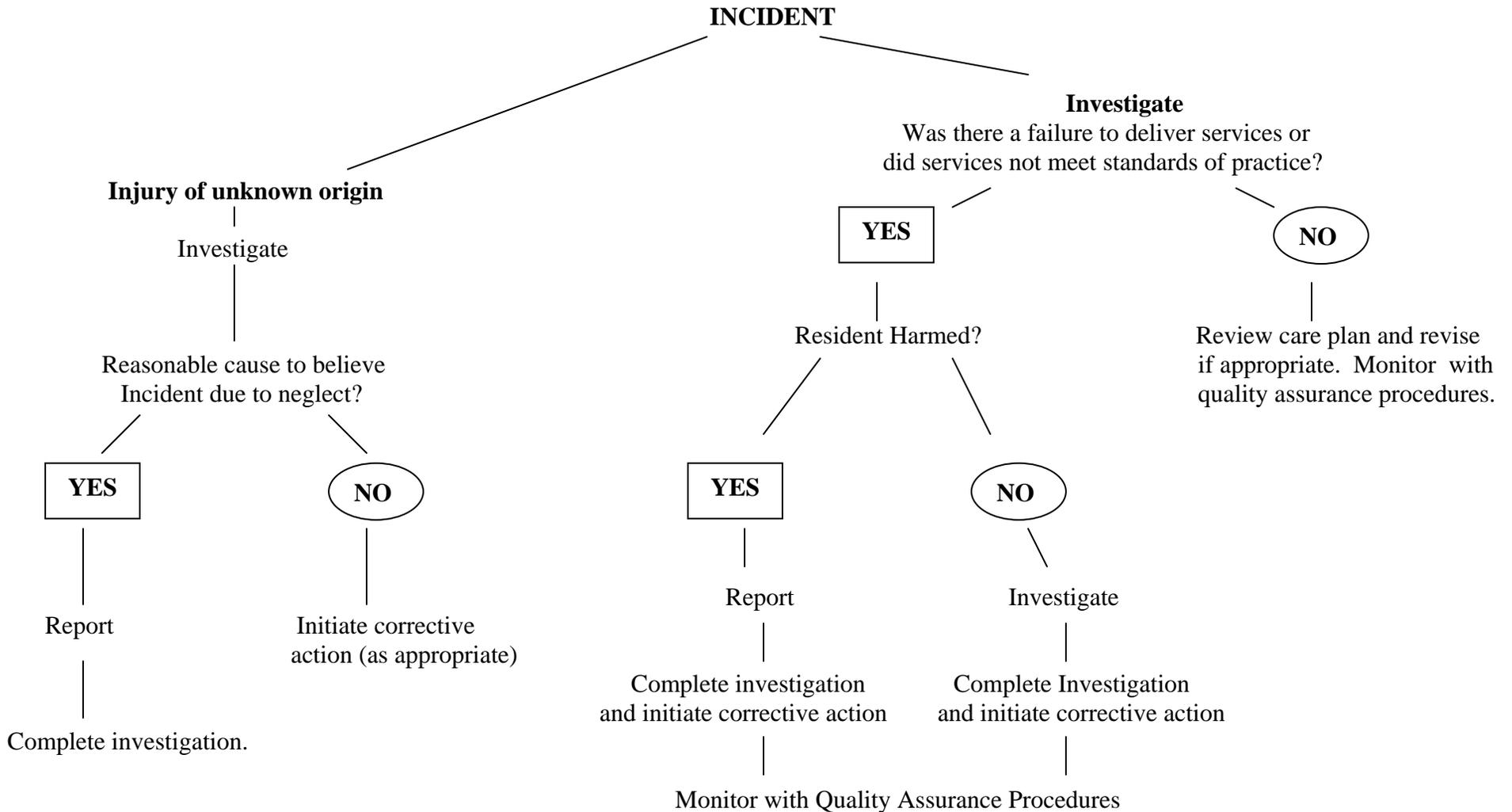
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Vera VanBruggen, RN, BA  
Long Term Care Director

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Martin Kennedy, Commissioner  
Licensure, Certification and Evaluation

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



Survey and Certification Letter, Clarification of Nursing Home Reporting Requirements for Alleged Violations, 12/16/2004 Ref. 05-09, supersedes this tree for all Medicare and Medicaid Certified Facilities. <http://www.cms.hhs.gov/SurveyCertificationGenInfo/>