

KANSAS DEPARTMENT ON AGING
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SUNFLOWER CONNECTION

CONNECTING KDOA WITH LONG TERM CARE PROVIDERS

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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.

**WORKFORCE ENHANCEMENT GRANT – NO COST
EDUCATION FOR DIRECT CARE STAFF**

For the past two years KDOA has offered the Workforce Enhancement Grant to incorporated entities, i.e. facilities, organizations, community colleges, and businesses, which provided educational programs at no cost for unlicensed staff in long term care nursing facilities and long term units of hospitals. As of August 30, 2006, there have been over 2,800 attendees at the educational programs.

The grant will be offered again this year. The final date for grant applications is October 31, 2006. The criteria for which individuals may attend the educational presentations at no cost has been expanded to include one licensed staff person for every two unlicensed staff persons employed by the same nursing facility or long term care unit of a hospital.

Facilities are encouraged to take advantage of this grant to promote education of both their staff and staff of other facilities. One facility applied for the grant to take its in-service programs to other facilities. Other facilities have contacted entities requesting they provide specific topics helpful for their unlicensed staff. Many positive responses have been received from individuals attending the programs. Facilities need to be aware the entities are reimbursed only for individuals who actually attend the programs, thus every effort needs to be made for staff that are registered for the programs to attend them.

KDOA recognizes the importance of ongoing education of direct care staff to promote the quality of life and care of the people living in nursing facilities and strongly encourages all facilities to take advantage of the educational programs made available by the Workforce Enhancement Grant.

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Licensure, Certification and Evaluation
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COMMISSIONER'S COMMENTS

Martin Kennedy

This edition of the Sunflower Connection is the third since I became Commissioner. It's been an eventful 8 months "on the job" in which I've enjoyed many opportunities to get to know nursing home administrators and staff around the state, as well as visit our KDOA surveyors in each of the regions of the state.

I've spent a considerable amount of time traveling with Acting Secretary Greenlee. We've had the opportunity to share our observations about the survey process and the operations of Kansas nursing homes. As you may know, the Acting Secretary has stated her support of resident centered care (aka "culture change") in Kansas. We have shared a vision that finds ways to use the survey process to not only assure regulatory compliance, but also advance the quality of care in nursing homes and quality of life for Kansas nursing home residents.

We're committed to making the survey process a positive force in promoting resident centered care. Vera VanBruggen and I spent time in Washington state in August, evaluating that state's quality assurance program to determine whether their approach, which mandates quality assurance visits by nurses to each facility on a quarterly basis, could provide a model for a similar program in Kansas. In addition, we're evaluating our upcoming joint provider training programs and in-service curriculum to make sure we're addressing concerns identified as promoting resident centered care.

Acting Secretary Greenlee intends that KDOA will play a leadership role in helping the process move forward. This will be a long term effort over the next several years, but the agency can't be successful on its own. Our Kansas nursing homes will improve and move forward because of the work of administrators and staff. Change will only happen because of the commitment, dedication and energy of individuals working at every level in each facility. We at KDOA will work to assure that our survey and regulatory systems don't get in your way, but only you can make the changes in your facility that your residents need and deserve.

POLICIES AND PROCEDURES REQUIRED FOR INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION

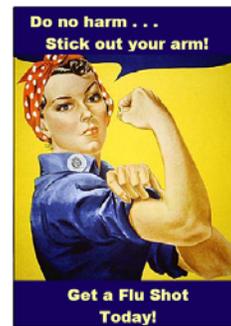
CMS issued CFR 483.25(n) Influenza and Pneumococcal Immunizations 6/1/06 and it became effective immediately. The regulation requires a facility to develop policies and procedures that include resident and legal representative education of the immunizations, offering of the immunizations, and documentation of the immunizations. The regulations can be downloaded at <http://www.cms.hhs.gov/>. In the Search Box, type Appendix PP.

CMS resources available to assist in the process include a webcast and printed material.

The web cast "Nursing Home Immunizations" presented in September 2005, can still be viewed at <http://cms.internetstreaming.com/courses/> under Archived Web casts. Educational and resource material is available at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp. information about Medicare's adult immunization benefits, billing Medicare for vaccinations, and other helpful information, is available at: http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp

In the fall of 2005, KFMC sent all the facilities an Immunization Tool Kit. The tool kit can be accessed at www.medqic.org. Select "Nursing Homes" across the top, and then in the center of the screen under "QIC Picks," choose "Immunization Toolkit".

IMMUNIZATIONS TOOLKIT



QUALITY PARTNERS
OF RHODE ISLAND

WHAT IS A COMPREHENSIVE ASSESSMENT?

CFR 483.20 Resident Assessment states, “**The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity.**” F272, the requirement for the completion of the Minimum Data Set (MDS) assessment and the Resident Assessment Protocols (RAPs), is part of this regulation. While the completion of the MDS serves many purposes, its most important purpose is beginning the process of a comprehensive assessment of the resident to assist in the development of an individualized care plan. A facility’s failure to complete a comprehensive assessment has long been the root problem of many deficient practices. The facility’s failure to complete a comprehensive assessment is often included in the citation of a care outcome tag. With the revised interpretative guidelines for urinary incontinence, pressure ulcers, and activities, the need for a comprehensive assessment has received more emphasis and the lack of a comprehensive assessment is being cited separately.

The process of a Comprehensive Assessment includes completion of the MDS, “working” the RAP, and writing a RAP summary. The MDS assessment is considered a preliminary screen of the resident. The coding of different items on the MDS triggers common problem areas for the nursing home population. The problem areas are to be thoroughly assessed by “working the RAPS.” The RAPs are listed in Appendix C of the Resident Assessment Instrument. Additional assessment guidance that expands on the RAPS is provided in the revised interpretative guidelines of the specific tags.

Each RAP is divided into 4 sections. Section One, Problem, provides information on how the problem area is seen in the nursing home population. Section 2, Triggers, identifies the items on the MDS that triggered the problem area. Section 3, Guidelines, provides in-depth information to use in assessing the resident. It lists possible causative factors, questions to encourage critical thinking about the problem and the need to gather additional information, recommendations for consultations, and potential care plan interventions.

Section 4, RAPS Key, identifies additional MDS items to consider in the assessment process. The revised interpretative guideline assessments should also be included in the RAPS process.

Over the years, software has been developed to assist in the MDS and RAPS process. However, most software or the manner in which it is used only identifies the data listed on the MDS. It does not produce a Comprehensive Assessment of the resident; neither does the adding of care plan interventions to the form result in a comprehensive assessment.

The Resident Assessment Protocol Summary should include key findings identified in the comprehensive assessment process that will allow an individualized care plan to be written for the resident. The summary can be written in a narrative form or specific information or forms in the clinical record can be referenced by name, date, and time. The summary should include:

- The NATURE or DESCRIPTION OF THE PROBLEM as it is seen in the resident.
 - How is it affecting the resident’s daily functioning?
 - What is the cause of the problem?
- The COMPLICATION(S) the resident is experiencing related to the problem.
- The RISK FACTOR(S) the resident has associated with the problem.
 - How the complications or risk factors affect the resident’s decline or lack of improvement.
- The resident’s STRENGTH OR UNIQUE FACTORS that will help the resident in managing the problem.
 - How those factors have minimized resident’s decline or promoted resident’s improvement.
- REFERRALS OR FURTHER EVALUATIONS to appropriate health professionals that have been made and additional ones that will be beneficial.
- An evaluation of past and current care plan interventions may be included but it is not appropriate to just list the interventions.

In summary, to meet the requirements of F272, a facility must complete a comprehensive assessment of a resident’s needs by completion of the MDS, a thorough assessment using the RAPS and assessment section of the revised interpretative guidelines, and a documentation of the process in the RAPS Summary.

NURSING HOMES RESPONSIBLE TO PROVIDE ROUTINE AND EMERGENCY MEDICATION



Survey and Certification Letter 06-16 dated May 11, 2006, included the nursing homes' responsibilities to provide drugs to residents in relation to Medicare Part D. The letter and attachment can be accessed at the following link: <http://www.cms.hhs.gov/SurveyCertificationGenInfo/>. Click on Policies and Memos to States and Regions; scroll down to the specific letter. The letter reinforced that nursing homes are still responsible to maintain compliance with F483.60 Pharmacy Services (F425) states, "The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement as described in 483.75(h) of this part." Also included is a portion of the interpretative guidelines for F425 which states, "A drug ... must be provided in a timely manner. If failure to provide a prescribed drug in a timely manner causes the resident discomfort or endangers his or her health and safety, then this requirement is not met."

In striving to remain in compliance, nursing homes need to be aware of potential delays for obtaining the resident's medications and know how to avoid them. The nursing home is responsible for supplying the medications unless it has made previous arrangements with a person who is private pay or a pharmacy who will cover the cost.

One potential delay is preauthorization, which may be required for some drugs on the plan's formulary. Preauthorization must be obtained from the plan before the prescription is written. In many cases this just takes a phone call, and preauthorization is granted over the phone. However, some situations may require a form to be faxed, so time should be allowed for this. Once preauthorization is granted, the plan should notify the pharmacy so that the prescription can be filled. This process should take no longer than 24 hours.

Another potential delay involves the Exceptions Process. If a resident needs a medication that's not on the plan's formulary, the resident (or nursing

home staff acting on the resident's behalf) can ask for an Exception to have the medication covered. A standard Exception review should be completed within 72 hours, and an expedited review should be completed within 24 hours. The plan is not required to provide a temporary supply of the medication during this review process. If the Exception is granted, the cost of the prescription will be covered by the drug plan. If the Exception is denied, the cost of the prescription will be the responsibility of the nursing home or resident. If Medicaid pays for the resident stay, the facility needs to check with the resident's Social and Rehabilitation Services (SRS) Medicaid Eligibility Worker to determine who will pay for the medication. Medicaid residents cannot be charged for prescription drugs. If there is no other source of payment for the prescription drug, the nursing home provider must pay for it as part of the content of service. To learn more about Medicaid reimbursement, contact Dave Halferty at (785) 296-8620.

If a resident is switching drug plans and is on a medication that was covered by the old plan but is not covered by the new plan, the resident needs to request an Exception to have the drug covered by the new plan. In this case, the new plan will provide a one-time temporary fill of the medication while the Exception request is being reviewed. The temporary fill is only available when the Exception request is the result of a plan switch.

To ensure residents receive prompt services from other health care providers, nursing homes should include the name of the resident's plan and contact number whenever a resident goes to any appointment or setting, i.e. clinic, emergency room, hospital, at which they may receive a new prescription. It would also be helpful for the nursing home to send a current copy of the plan's formulary. The formulary will let the physician know if any medications are subject to pre-authorization or quantity limits.

Additional information about these processes and other Medicare Part D questions may be obtained by contacting Medicare at 1-800-MEDICARE (1-800-633-4227) or by contacting Senior Health Insurance Counseling for Kansas (SHICK) at 1-800-860-5260.

ASSESSMENT CANNOT BE DELEGATED TO CERTIFIED STAFF



CFR 483.75(b) Compliance with Federal, State, and Local Laws and Professional Standards (F492) states, “The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility”. CFR 483.20(k)(3) (F281) states, “The services provided or arranged by the facility must --- (i) Meet professional standards of quality ...” The intent of the regulation states “this regulation is to assure that services need to be provided to meet professional standards of quality ... and by the appropriate qualified staff (e.g. licensed, certified)”.

Surveyors are finding frequently that facilities are having CMAs complete “nursing tasks” that require an assessment for the task to be completed properly. One example was CMAs using the auscultation method for checking placement of a feeding tube. Another example was CMAs changing dressings to pressure ulcers nearly daily and the nurse only assessed the ulcer weekly.

According to the Kansas Nurse Practice Act 65-1113 (d) Practice of Nursing, (1)(d), The practice of professional nursing as performed by a registered professional nurse for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and amendments thereto, means the process in which **substantial specialized knowledge** derived from the biological, physical, and behavioral sciences is applied to: the care, diagnosis, treatment, counsel and health teaching of persons who are experiencing changes in the normal health processes or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity; administration, supervision or teaching of the process as defined in this section; and the execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry. The ability to perform assessments requires a substantial

specialized knowledge base as identified in the nurse practice act. Neither CMA nor CNA curriculum or practicum contains this substantial specialized knowledge and this substantial specialized knowledge cannot be delegated to them.

CFR 483.75(b) Compliance with Federal, State, and Local Laws and Professional Standards (F492) states, “The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility”. CFR 483.20(k)(3) states, The services provided or arranged by the facility must --- (i) Meet professional standards of quality ... The intent of the regulations states that the services need to be provided to meet professional standards of quality and by the appropriate qualified staff (e.g. licensed, certified).

CHECKING PLACEMENT OF A GASTROSTOMY TUBE

Certificated medication aides (CMAs) may only check placement of a gastrostomy tube by aspiration of gastric contents. According to The Lippincott Manual of Nursing Practice, Seventh Edition, the following procedure should be followed for checking placement:

Aspirate gastric contents. If the “residual gastric contents exceed 100 cubic centimeters for intermittent tube feedings or greater than 1.5 times the hourly rate for continuous tube feeding, hold feeding and notify health care provider.” CMAs should notify the licensed nurse.

The pH of the gastric contents should be measured using pH strips.

If the gastric contents are within normal limits and placement has been confirmed, the content should be returned to the stomach.

If there is a question about placement, the CMA should notify the licensed nurse.

Facilities should develop policies and procedures regarding enteral feeding via gastrostomy as well as delegation of the task to unlicensed nursing staff. Regulation Interpretation 93-16 provides guidelines for the delegation of nursing tasks to medication aides and nurse aides. It is available at www.aging.state.ks.us.

MDS COMMUNICATION UPCOMING MDS EDUCATION

MDS 2.0, RAPS, Care Plan, and RUGS Education will be presented on November 2 and 3, 2006, via video teleconferencing to the KDHE District Offices at Dodge City, Hays, Wichita, Salina, Lawrence, Chanute and Topeka. The Topeka site allows for direct contact with the presenters. The workshop provides basic information on completion of the MDS, RAPS, and Care Plan for new MDS Coordinators and other individuals who complete the information. Registration Forms are available at http://www.agingkansas.org/kdoa/lce/Education_Info/enrollment_form_kdoa.pdf

Therapy Restarted After another Medicare Required Assessment (OMRA) Completed

Question: A resident whose payer is Medicare Part A was receiving both skilled nursing services and therapy. I completed their 5 Day MDS and 14 Day MDS. The resident's therapy was discontinued, so I completed an OMRA. A day after the OMRA was completed; the resident began to receive therapy again. What type of Assessment may I do to receive credit for the restarting of therapy? **Answer:** No Prospective Payment System (PPS) assessment can be done to increase the rate for the restarting of therapy. If the resident has had a significant change in status after the OMRA was completed, a second OMRA would need to be done. RAI Manual, 2-39, Combining Assessments explains how to code a Significant Change MDS for a resident on Medicare Part A when the assessment does not take place in the time period of specified Medicare Assessment. RAI Manual 2-8, 9 provides Guidelines for Determining a Significant Change. If the resident would have been restarted on therapy prior to the required time period for completion of an OMRA (2-29), an OMRA would not be completed or transmitted. The PPS schedule would continue as usual.

Hospital Return Question: A resident was admitted to the hospital. What type of OBRA assessment must I complete when they return?

Answer: RAI Manual 2-15, Assessments Upon Readmission/Return, paragraph 2 states, "If a resident returns to a facility following a temporary absence for hospitalization or therapeutic leave, it is considered a readmission. Facilities should evaluate the resident upon readmission to determine if a significant change

in the resident's status has occurred. In these situations, follow the procedure for Significant Change in Status assessment. If it is determined that a resident has not experienced a Significant Change in Status, the next OBRA assessment is completed within 92 days of the completion of the last OBRA assessment prior to the resident leaving the facility." RAI Manual 2-25 explains the process for the completion of the tracking sheets.

SCSA when a Resident is Receiving Therapy

Question: When a resident is receiving therapy and continues to improve on each PPS assessment, at what time must an OBRA Significant Change Assessment be completed? **Answer:** RAI Manual 2-10, Guidelines When a Change in Resident Status Is Not Significant, states in bullet 4, "Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized." When a resident is showing steady improvement while receiving direct skilled therapy it is appropriate to wait to do a Significant Change in Status assessment until the resident is discharged from direct skilled therapy.

PERIPHERAL AND CENTRAL VENOUS DEVICES

The National Guideline Clearinghouse (NGC) contains a database of evidence-based clinical practice guidelines and related documents. NGC is an initiative of the Agency for Healthcare Research and Quality and the U.S. Department of Health and Human Services. Its mission is to provide health care professionals a mechanism for obtaining information on clinical practice guidelines.

Included in the data base are guidelines related to vascular access devices. The access device guidelines: recommendation for Nursing Practice and Education can be found at http://www.guidelines.gov/summary/pdf.aspx?doc_id=8338&stat=1&string. The other guideline, Care and Maintenance to Reduce Vascular Access Complications, can be found at http://www.guideline.gov/summary/summary.aspx?doc_id=7260&nbr=004322&string=vascular+AND+access+AND+devices. The entire database of guidelines is available at <http://www.guideline.gov/about/about.aspx>.

“WHAT’S PASRR AND WHAT DO I NEED TO DO WHEN ADMITTING SOMEONE TO MY FACILITY?”

By Valerie Merrow, KDOA CARE Team

The Preadmission Screening and Resident Review (PASRR) is required to ensure individuals with mental illness (MI) and/or mental retardation/developmental disability (MR/DD) needs are appropriate for nursing facility placement.

PASRR is a federal mandate and all states have a process. The process in Kansas is called Client Assessment, Referral and Evaluation (CARE) assessment. It is likely other states do not call their process a CARE assessment, but they do have proof of PASRR. They also have different forms as the proof of PASRR. Examples of these forms for bordering states can be found at: www.aging.state.ks.us. Select KDOA program information, select CARE and scroll down until you see the state you want to view. Regardless of where the PASRR is completed, the documentation must state that Nursing Facility (NF) placement is appropriate before an individual is admitted to the NF. If the PASRR does not state that NF care is appropriate, the person cannot be admitted to the facility.

The current valid proof of PASRR documentation in Kansas is the CARE certificate. If the CARE certificate indicates a Level II evaluation is needed, the Letter of Determination becomes the proof of PASRR and it must state that NF placement is appropriate in order for the individual to be admitted to a NF. Questions about whether a proof of PASRR from Kansas or another state is valid should be directed to your area agency on aging (AAA) CARE Coordinator, or the Kansas Department on Aging, CARE Program.

The CARE Level I assessment is valid for 365 days unless the individual has a significant change in condition or if they came to the nursing facility (NF) and then went home for a period of time and now want to return. If the individual goes to a NF within the 365 days of the assessment date and remains in the NF-hospital system (i.e. goes to hospital for pneumonia and returns to NF), then the Level I assessment is valid indefinitely.

Please go to <http://www.aging.state.ks.us> and select **KDOA program information**, select **CARE** and select

CARE Newsletter – Summer 2005. On page 2 of the 2005 Summer Newsletter is an article titled, “**Review of the PASRR process and provisional admissions to nursing facilities in Kansas**” that will provide further instruction on what to do for these admissions.

Questions about the CARE program can be directed to the Kansas Department on Aging at 785-296-4986, or your local AAA.

UNNECESSARY DRUGS, PHARMACY SERVICES

CMS has issued revised guidance for long term care surveyors regarding Unnecessary Drugs, Pharmacy Services, Drug Regimen Review, and Labeling and Storages of Drugs and Biologicals. F329, F330, and F331 were merged into F329. F425, F426, and F427(1) were merged into F425. F428, F429, F430 were merged into F428. F427(2)(3), F431, and F432 were merged into F431. The guidance will become effective on December 18, 2006. A link to the advance copy is <http://www.cms.hhs.gov/SurveyCertificationGenInfo/>. Go to **Policy & Memos to States and Regions**. Scroll Down to Details for Issuance of Revised Surveyor Guidance for Unnecessary Medications (F329) and entire Pharmacy section. Memo #06-29. Posting Date 09/15/2006.

A live satellite web cast on the revised guidance of F329, unnecessary drugs and revised guidance for pharmacy services will be on December 15, 2006 at 1:00 PM EDT. The web cast is available on <http://www.cms.internetstreaming.com/> at Live and Upcoming Broadcasts. These can be viewed via computer. There is no registration fee but a password must be established prior to the webcast. This can be done through the above link also.



PERSON DIRECTED CARE, RESIDENT CENTERED CARE, CULTURE CHANGE

The journey has many different names. If you are wondering how to begin or how to keep traveling down the road to improve the quality of life and care and the environment for the people who live and work in your facility, there are many resources available. Through a grant from KDOA, K-State University Center on Aging has produced educational modules to assist facilities. The modules are available at no cost to Kansas facilities. Samples of the modules and contact information to receive a CD of the modules are available at <http://www.k-state.edu/peak/>. Kansas Foundation for Medical Care, the state Quality Improvement Organization, is also in the process of providing each facility at no cost with a Tool Kit, "Person Directed Care Leadership Series Educational Video Series and Facilitator Guide 2006."

KDOA also provided grant monies towards a Tool Kit entitled "Household Matters: A Good Life "Round the Clock" by Steve Shields. It is available for purchase through Kansas Health Care Association www.khca.org and KAHSa www.kahsa.org Proceeds from the sale of the tool kits will go to further culture change in Kansas.



If you would like to become directly involved in learning about and promoting the journey across the state, the Kansas Culture Change Coalition (KCCC) may interest you. Feel free to contact Judy Bagby, the KCCC facilitator, for additional information at jbagby@medicalodges.com.

OPEN BREAKFAST – 14 HOURS



Question. Our facility has open dining time at breakfast. We have a resident who often sleeps late and as a

result frequently more than 14 hours has lapsed between his meals. Is this a problem? **Answer.** F368 §483.35(f) Frequency of Meals states, "(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. (2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below. (3) The facility must offer snacks at bedtime daily. (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served".

The intent states "this regulation is to assure that the resident receives his/her meals at times most accepted by the community and that there are not extensive time lapses between meals. This assures that the resident receives adequate and frequent meals."

As long as breakfast is available in the facility within the 14 hour window and the resident was offered a bedtime snack, the intent of the regulation is met. The resident's care plan should include the resident's breakfast time preferences and how their daily nutritional needs will be met in response to a late breakfast. This resident may prefer a larger breakfast and a morning, afternoon, or evening snack. When implementing an open breakfast, it is also important to assess each resident to ensure those who have any health problems that require specific meal times, i.e. diabetes, do receive their meals appropriately.

RESIDENT CENTERED KITCHENS

Residents and staff at Parkside Homes in Hillsboro, Kansas, are now saying, “The kitchen is the hub of everything.” Parkside Homes is the second Continuous Care Retirement Community in Kansas to construct 2 beautiful homes for 12 nursing facility residents in each house. Parkside Homes is unique because it also remodeled an area in its existing nursing facility into a neighborhood. The photos in this article were taken before residents moved to the two new homes.

Even the outside of the homes is designed to focus on quality resident centered care. The sidewalks are constructed with electric wiring to heat them in winter. This will provide safety for residents to be outside on the lovely fenced patios and safe travel for staff and food deliveries during cold weather

MORE resident choices

Residents selected all the glasses, dishes, and service ware patterns.

Staff obtained a wide variety and numbered choices in each category. After seeing and holding items, residents selected their choice in each category. After voting ended, staff was surprised how nearly unanimous the residents’ choices were.

Breakfast is cooked to order by Homemakers in each house. The time breakfast begins is determined by the residents and currently all three have different beginning times, i.e. 7:30, 7:45 and 8:00 am. The time breakfast begins will continually change as resident’s preferences change. Between meals, treats from fresh baked cookies to fresh cut watermelon are prepared in each house.

Each house has a cool to the touch Keurig Single Serve Beverage Machine. This beverage machine uses single “pods” to brew each resident’s choice from a wide flavor selection of coffee, tea and other beverages.

For the dinner and supper meals, most of the preparation is done in the main kitchen. The facility’s main kitchen is 50 to 100 yards from the two new homes.

Residents are so involved in their food and meals, not only can they see, smell, and enjoy the

food, but some tell staff exactly how large a portion they want to eat as their meal is prepared.

Ongoing focus on residents

Since residents have arrived, changes have been ongoing. Staff shared, “We thought we had planned for every scenario.” However, there is continual change. It may be a simple change, i.e. moving menus from the refrigerator to the center counter island so residents may read the menu easier, or large changes, including staffing changes. In one household, to keep up quality it was not efficient for one staff member to be responsible for both housekeeping and meals. Dietary staff has taken over meal preparation and service in this household. A message to share is “train, retrain, and train again.”

Equipment information

The facility selected a dish machine with a 70 minute cycle. In order for the dishes to be ready for the next meal, staff follows a set time to start the first “load” of dishes even if this means the dish machine is not full. At times, some dishes are also transported to the main kitchen for washing.

The facility has purchased several brands of water resistant thermometers to ensure the dish machine reaches 160 degrees Fahrenheit. So far those brands have broken in a short time. If you choose a long cycle dish machine, you may want to check with Parkside Homes for specific information to avoid purchasing a thermometer that will not meet your needs.

What do residents say?

When asked about the food service, a resident said, “The food is marvelous”.



MAY A CMA GIVE PRN MEDICATIONS?

(The following response was provided with assistance from Martha Ryan at HOC)

CMA's work under nurse supervision and are allowed to do the tasks that are taught in the state curriculum in addition to tasks that a nurse might choose to delegate in accordance with the Nurse Practice Act KSA 65-1165, KSA 65-1113 (d), and KSA 65-1124. Regulation Interpretation 93-16 provides additional interpretation on the delegation of Nursing Tasks to Medication Aides and Nurse Aides. It is recommended the facility have a policy regarding the tasks a CMA may perform in the facility.



Excerpts from the CMA Curriculum that are applicable to the question "May a CMA give PRN medications" are as follows:

1. The first quote (page 23-6) is from a heading "Medication orders should: Identify the dosage--including the amount of the drug and the strength, when and how often, if the order is for a limited number of doses or to be used as a PRN whenever necessary) basis."

2. The second (page 23-7), "PRN--to be given whenever necessary. Ordering practitioners may write a PRN order for a medication or treatment. The order must contain specific parameters for implementing the order. The order must include the name of the drug, the dosage and specific reasons for administration. An example would be: "Tylenol #3 every six hours for pain at incision site". If the resident requests medication for a headache, the Tylenol #3 should not be administered as the site of the pain is not covered by the order. Medication aides may not administer PRN medication which requires an assessment. For example, a medication aide could not administer a PRN drug order for Ativan PRN for agitation. Standard of practice is for a nurse to assess the resident and decide the best method for reducing the resident's agitation. The medication aide would need to call a nurse for instructions".

3. A third (page 23-12) is in the material on the "5 Rights:" Under right dose, Medication aides must never calculate the correct dosage of a medication. If the dosage requires calculation, contact a licensed nurse. The dosage information on the MAR should provide specific information related to the dose to be administered..."

4. A fourth (page 24-4) is in the material on specific situations, PRN and STAT medications which says, "Chart on the MAR according to facility procedure. Record the reason the medication was administered including pertinent observations of the resident prior to and after administration of the medication in interdisciplinary notes. Always report PRN and STAT medication administered to the oncoming staff in the shift change report".

5. A fifth (page 25-6) under Use caution with PRN medications says, "Make sure you chart PRN medications immediately. If you don't, someone else could give another dose. Follow up with charting about resident's response to medication".

If a facility chooses to allow a CMA to administer PRN medications, the conditions as stated in the curriculum must be met. Facilities also need to be aware it is a licensed nurse, not the facility, that delegates this and other nursing tasks. Prudent nurses will want to be certain they are following the Nurse Practice Act and CMA Curriculum in the delegation of allowing a CMA to administer PRN medications. The nurse will also want to be certain CMA reports whenever they administer any type of PRN medication to a resident.

MEDICAL NUTRITION THERAPY

Medical nutrition therapy is available as a Medicare-covered preventive service for Medicare beneficiaries with diabetes OR renal disease (subject to certain eligibility and other limitations).

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Although chronic diseases are among the most common and costly health problems, they are also some of the most preventable. Medicare has expanded the preventive

services it pays for. Subject to certain eligibility and other limitations the following preventive services and screenings are provided:

- Cardiovascular Disease Screening
- Cancer Screenings: Breast (Mammography), Cervical and Vaginal (Pap Test and Pelvic Exam), Colorectal , and Prostate
- Diabetes Screening
- Diabetes Supplies
- Diabetes Self-Management Training
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Bone Mass Measurements
- Adult Immunizations: Influenza (Flu), Pneumococcal Polysaccharide Vaccine (PPV), Hepatitis B Virus (HBV)
- Glaucoma Screening
- Smoking and Tobacco-Use Cessation Counseling Services

How Can You Help? The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare are aware that Medicare provides coverage for preventive services that could save their lives.

For More Information, CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for preventive services covered by Medicare. The Preventive Services Educational Products Web Page http://www.cms.hhs.gov/MLNProducts/35_Preventive_Services.asp provides information for each preventive service covered by Medicare. Click on <http://www.cms.hhs.gov/>, select “Medicare” and scroll down to “Prevention.” For products to share with your Medicare residents, visit <http://www.medicare.gov/> on the Web.

ALFS, RHCFS, HOME PLUS FACILITIES

QUESTIONS AND ANSWERS

1. Question: Must the functional capacity screen accurately reflect a resident’s status?

Answer: Yes. KAR 28-39-243 (c) Designated staff at each facility shall ensure that the screening to determine each resident’s functional capacity is accurately reflected on that resident’s screening form.

2. Question: Must a facility use the KDOA Functional Capacity Screening form to do the FCS?

Answer: No. KAR 26-39-243 (a) ... A facility administrator or operator may integrate the department’s screening form into a form developed by the facility, which shall include each element and definition specified by the department.

3. Question: May the person doing the functional capacity screen write additional notes on the form to clarify coding decisions? **Answer:** Yes. The screening form is a legal document. Any documentation added to the form after the screen was completed must be dated and signed. Any information added to the form by a person other than the screener who signed and dated the form must be dated and signed by that person.

4. Question: A nurse prefills insulin syringes to correspond to sliding scale accuchecks. A CMA or resident does the resident’s accucheck and based on the results, the CMA selects the correct prefilled insulin syringe and hands it to the resident to inject themselves. Is this an appropriate task for a CMA?

Answer: No. The CMA may do the accucheck for the resident, but the resident must be able to select the correct insulin syringe for self-injection. The CMA Curriculum in Unit 23, “Always follow the 5 Rights of Medication Administration,” identifies the components involved in the administration of medication. In the above scenario the CMA is assuming all the components. Number 3 of the 5 Right dose states, “Medication aides must never calculate the correct dosage of a medication. If the dosage requires calculation, contact a licensed nurse. The dosage information on the MAR should provide specific information related to the dose to be administered...” By selecting the correct syringe to match the accuchecks, the CMA is calculating the

correct dose. The CMA is also completing an assessment that the accuchecks results do accurately reflect the resident's status. CMAs cannot do assessments.

5. Question: Does an LPN need an RN supervisor in an adult care home? **Answer:** Yes. Although an LPN may take orders from a physician or dentist in their duties as a nurse in an adult care home, the physician or dentist is not the LPN's supervisor.

KSA 1113(d) (2) states, "The practice of nursing as a licensed practical nurse means the performance for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and any amendments thereto, of tasks and responsibilities defined in part (1) of this subsection (d) which tasks and responsibilities are based on acceptable educational preparation within the framework of supportive and restorative care under the direction of a registered professional nurse, a person licensed to practice medicine and surgery or a person licensed to practice dentistry."

An LPN must have an RN supervisor unless they are employed in a physician's office or dental clinic where the physician or dentist is the nurse's direct supervisor.

RESOURCES FOR ENVIRONMENTAL SUSTAINABILITY



Hospitals for a Healthy Environment (H2E) is creating a national movement for environmental sustainability in health care. It was jointly founded by the American Hospital Association, the U.S. Environmental Protection Agency, Health Care Without Harm and the American Nurses Association. H2E provides a wealth of practical tools and resources. Although the tools are directed toward hospitals, the material is also practical for all health care facilities. H2E's website is located at: <http://www.h2e-online.org/about/index.htm>



Alzheimer's Association
Heart of America Chapter Presents
The 6th Annual

Defining Hope

The Best Friends Approach to Alzheimer's Care-
Creating Quality Programs for People with Dementia

Wednesday, November 1, 2006
9:00 a.m. – 2:45 p.m.

Kansas Museum of History
6425 SW 6th Avenue
Topeka, Kansas 66615-1099

Keynote Speaker: David A. Troxel, MPH
(Co-author of the internationally recognized book
"Best Friends Approach to Alzheimer's Care")

\$40.00 includes conference and lunch
\$50.00 includes conference, 4.5 CEUs/ Certificate of
Attendance and lunch
Registration deadline is October 24, 2006

Contact 785-234-2523 or email
karen.johnson@alz.org for registration information.

ENFORCEMENT ACTIONS

*Licensure Category	1st	2nd	3rd	4th
ANE Issues	6	19		
Disaster Preparedness	3	2		
General Sanitation and Safety	23	10		
Health Care Services	17	16		
Inadequate Administration	2	2		
Inadequate Admissions	6	4		
Inadequate Accounting of Funds	0	0		
Inadequate Documentation of Employee Records	0	1		
Inadequate Documentation of Resident Records	6	10		
Inadequate Drug Regimen Review	6	4		
Inadequate Inservice Education	0	2		
Inadequate Policies/Procedures Regarding Infection Control	3	2		
Inadequate Policies and Procedures for Special Care Unit	0	0		
Inadequate Range of Motion Services	0	0		
Inadequate Supervision	0	2		
Inadequate or Unqualified Staffing	17	15		
Inadequate or Inappropriate Dietary/Nutritional Services	4	2		
Inadequate or Inappropriate Hygiene and Skin Care	0	3		
Inappropriate Admissions	3	1		
Inappropriate or Unauthorized Use of Restraint	2	1		
Negotiated Service Agreement	14	10		
Physician Verbal Orders for Licensed Personnel	0	0		
Resident Functional Capacity Screen	12	7		
TB for Residents/Staff	0	3		
Unsafe Medication Administration or Storage	15	15		
Other	-	-	-	-
Civil Penalties	2	7		
Correction Orders	26	28		
Bans on New Admissions	4	11		
FEDERAL REMEDIES	1st	2nd	3rd	4th
Civil Monetary Penalties Recommended		18		
**Denial of Payment for New Admissions Imposed	23	22		
Terminations		-		
No Opportunity to Correct		30		

* 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 NO DEFICIENCY AND EXEMPLARY AWARDS

FACILITY	CITY	TYPE	AREA	EXEMPLARY LETTER	NO DEF.	SURVEY DATE
The Camillia at Park West Plaza	Wichita	HP	SB/QR		X	04/06/2006
C&R Boarding Care Home	Topeka	ADC	SB/QR		X	04/12/2006
Midland Adult Day Care	Topeka	ADC	SB/QR		X	04/12/2006
Golden Heights Living Center	Garnett	SNF/NF	SE	X		04/13/2006
Topeka Adult Care Center	Topeka	ADC	SB/QR		X	04/13/2006
Brighton Gardens of Prairie Village	Prairie Village	NF	LW		X	04/18/2006
Guest Home Estates VII	Garnett	RHCF	SB/QR		X	04/19/2006
Life Care Center of Burlington	Burlington	SNF/NF	SE	X		04/27/2006
Comfort Care Home #6504	Wichita	HP	SB/QR		X	05/09/2006
Autumn Adult Day Care	Topeka	ADC	SB/QR		X	06/05/2006
Guest Home I	Caney	RHCF	MH/RH		X	06/07/2006
Redbud Plaza	Onaga	ALF	MH/RH		X	06/06/2006
Glenn Moore Meadows	Holton	HP	SB/QR		X	06/19/2006
The Lutheran Home – WaKeeney	WaKeeney	NF	W		X	06/29/2006

CONGRATULATIONS

to the
2006 PEAK AWARD-WINNING HOMES!

- *Bethany Home, Lindsborg
- *Dooley Center, Atchison
- *Hillsboro Community Medical Center
- *Medicalodge of Eureka
- *Minneola District Hospital LTCU
- *Newton Presbyterian Manor
- *Pleasant View Home, Inman

CONGRATULATIONS

to the
2006 EXEMPLARY AWARD-WINNING HOMES!

- *Golden Heights Living Center
- *Life Care Center of Burlington

CONGRATULATIONS

to the
2006 NO DEFICIENCY AWARD-WINNING HOMES!

- * The Camillia at Park West Plaza
- * C&R Boarding Care Home
- * Midland Adult Day Care
- **Topeka Adult Care Center
- * Brighton Gardens of Prairie Village
- * Guest Home Estates VII
- * Comfort Care Home #6504
- *Autumn Adult Day Care
- *Guest Home I
- *Redbud Plaza
- *Glenn Moore Meadows
- *The Lutheran Home – WaKeeney