



# LTC Newsletter



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Division of Long Term Care Publication

January 2007

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## NEW DEPUTY HEALTH COMMISSIONER



The Indiana State Department of Health announced the appointment of Mary L. Hill as the Deputy State Health Commissioner, effective November 13, 2006. Hill currently serves as the Director of Ethics Integration for St. Vincent Health, which operates health care facilities and services throughout central Indiana.

“Mary’s energy and background make her a perfect choice to help us achieve our prime objectives,” said State Health Commissioner Judith A. Monroe, M.D. “She has a strong personal commitment

to good health that will make her a great leader for the INShape Indiana initiative, and we are excited to have her as part of our team.”

“Her experience as a nurse and with the insurance industry will help the State Health Department to better integrate medical care with public health and to continue to develop public health policies and initiatives that are data-driven,” said Dr. Monroe. “Mary’s expertise in the area of ethics will also make her an asset for our public health preparedness efforts.”

“I’m looking forward to working with Dr. Monroe and the dedicated team at the State Department of Health,” said Hill. “Since entering the nursing profession more than twenty years ago, I have been committed to public health and health care. My appointment as Deputy Health Commissioner enables me to continue working to improve the health of Indiana.”

Since 1996, Hill has been an attorney with the law firm of Hall Render Killian Heath and Lyman where she practiced in the areas of health law, employment law and litigation. Hill also teaches in the St. Vincent medical residency programs, and has served as adjunct faculty at the I.U. Schools of Nursing and Law.

“Mary shares my commitment to working with Governor Daniels to make a positive difference in the health of Hoosiers,” said Dr. Monroe. “We appreciate her willingness to leave the private sector and to serve the state when called.”

Hill received a B.S. in Nursing, summa cum laude, from the University of Cincinnati in 1984 and a J.D., summa cum laude, from the I.U. School of Law, Indianapolis in 1995.

Prior to becoming an attorney, Mary worked as a psychiatric nurse at Wishard Health Services; Vice President of Medical Delivery for Sagamore Health Network; Director of Nursing at Brierwood Hospital in Greer, South Carolina; and as a geriatric psych nurse at a state hospital in Cincinnati, Ohio.

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## Medicare Fraud Alert

Comprehensive eye examinations by an optometrist are covered by Medicare when they are performed in relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury. However, routine eye examinations are not. It has been determined that, in three states, some optometrists have billed for routine eye examinations as comprehensive eye examinations. This practice has occurred primarily in nursing homes and at home. These optometrists often work out of their automobiles, soliciting Medicare beneficiaries via door-to-door canvassing often under false pretenses. Some optometrists have visited nursing facilities and provided routine eye examinations to all of the residents and submitting CPT codes 92004, 92012, and 92014 to circumvent the Medicare system.

### ICFMR Automatic Cancellation Date Letters

Earlier this year the Division of Long Term Care ("Division") updated the procedure for notifying ICFMR providers of an Automatic Cancellation Date. Instead of one letter notifying the provider of both the survey information and the automatic cancellation date, there will now be two letters. The first letter will notify the provider of the survey results and set a plan of correction date. Upon receipt of an acceptable plan of correction, the Division will set the automatic cancellation date. The second letter will then be sent by the Division notifying the provider of the automatic cancellation date. Compliance must be achieved before the automatic cancellation date or certification will be cancelled. If an automatic cancellation date is set based upon the results of the health survey, then that automatic cancellation date applies to the life safety code survey as well. If you have any questions please contact Miriam Buffington at 317/233-7613.



## Cell Phone Photographs

The Indiana State Department of Health, Division of Long Term Care

("Division") has been made aware of several incidences of long term care facility staff taking pictures of residents and displaying them to the public. This is a violation of resident rights and is to be strongly discouraged. Please monitor your staff for this type of behavior. If you have any questions regarding this situation please contact Suzanne Hornstein at 317-233-7289.

## New MDS Coordinator

Gina Berkshire has joined the Indiana State Department of Health as the new MDS Coordinator. She is looking forward to working with and growing in knowledge along with the providers in Indiana. Gina is an Indiana native and graduated from Ball State with a BS in nursing in 1978. She worked for Ball Memorial Hospital in Muncie for 28 years in the following units; med/surg, in-patient surgery and out-patient surgery with OR and Preop experience. She is a former "first lady" of Muncie, her ex-husband was Mayor for one term. Gina has a German Wirehaired Pointer and enjoys reading, knitting, antiquing, scrapbooking and shopping. Gina can be reached at 317/233-4719.

## Administrators Reference Guide

Effective September 1, 2006 the Administrator's Reference Guide can be found on-line at: [http://www.in.gov/isdh/regsvcs/ltc/admin\\_guide/index.htm](http://www.in.gov/isdh/regsvcs/ltc/admin_guide/index.htm). There will no longer be a hard copy of the guide. If there are any questions or comments regarding the content found within the Administrator's Reference Guide please contact the Program Director-Provider Services at 317-233-7794.

## QMA Renewal

The Qualified Medication Aide (QMA) is responsible for completing the in-service education requirements, maintaining documentation of in-service education, and submitting or ensuring the submission of the qualified medication aide record of annual in-service education form and appropriate fee. Annual in-service education must relate to medication and/or medication administration. If a QMA performs medication administration via a G-tube/J-tube, hemocult testing, finger stick blood glucose testing, annual in-service must be done yearly.

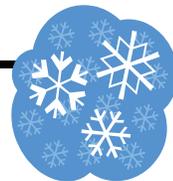
The in-services must be completed by February 28, 2007 and submitted to the Indiana State Department of Health by March 31, 2007. The form and instructions can be downloaded from the ISDH website at: [www.in.gov/isdh](http://www.in.gov/isdh).



## Annual Reporting Requirement

The Indiana Administrative Code (410 IAC 16.2-3.1-13 (o)) requires that each nursing facility submit an annual statistical report to the Indiana State Department of Health. The Annual Statistical Questionnaire for the year 2006 will be distributed in March. Each nursing facility is expected to submit the statistical report within sixty (60) days of its receipt.

There were substantial changes made to the format of the Annual Statistical Questionnaire for the 2005 version. No additional changes will be made to the 2006 Annual Statistical Questionnaire. If there are any questions please contact the Program Director-Provider Services in the Division of Long Term Care at 317-233-7794.



# 2006 Year In Review

Looking at the data from 2006 reveals that 10 new long-term care facilities opened in Indiana last year, of which 7 are certified comprehensive care and 3 are licensed residential care. Conversely, 4 long-term care facilities were closed in 2006.

Survey data for long-term care facilities shows that Division surveyors conducted 12 initial certification surveys, 470 annual recertification for certified facilities, 6 relicensure surveys for Non-certified Comprehensive Care facilities in 2006. In addition, surveyors conducted 1,510 complaint investigation surveys. Of the 470 recertification surveys 41 were deficiency-free and 429 required follow-up visits. As a result, surveyors completed a total of 1,408 follow-up surveys for the year. The grand total number of surveys conducted in long-term care facilities in 2006 was 3,399. Immediate jeopardy was found in 76 of these surveys, and 78 surveys had findings of substandard quality of care.

In 2006, 7 new Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) opened and 2 were closed. ICF-MR surveyors conducted, in addition to the 9 initial certification and state licensure surveys, 540 recertification and relicensure surveys and 175 complaint investigation surveys. 931 follow-up surveys were conducted in ICF-MR, bringing the total number of surveys to 1,655. Immediate jeopardy was found during 22 ICF-MR surveys in 2006. Please see the table below to compare these numbers to 2005.

LTC	2005	2006
New Facilities	27	10
Closures	5	4
Changes of Ownership	29	29
Initial Surveys	7	12
Recertification Surveys	485	470
Complaint Investigations	1,514	1,510
Revisits	1,255	1,408
Total Surveys	3,266	3,399
Deficiency-Free Recertification Surveys	51	41
Surveys with IJ	56	76
Surveys with SQC	79	78

ICF-MR	2005	2006
New Facilities	6	7
Closures	2	2
Changes of Ownership	1	8
Initial Surveys	6	9
Recertification Surveys	522	540
Complaint Investigations	88	175
Revisits	874	931
Total Surveys	1,490	1,655
Surveys with IJ	18	22

Top 10 Life Safety Code Deficiencies 2006	
LTC	ICF-MR
1. K0046	1. KS053
2. K0143	2. KS051
3. K0045	3. K0152
4. K0056	4. K0130
5. K0062	5. KS147
6. K0144	6. KS046
7. K0050	7. KS018
8. K0018	8. KS056
9. K0038	9. KS032
10. K0025	10. KS017

IDR Stats	2005	2006
Total Tags	287	309
No Changes	201	224
Scope/Severity Change	6	13
Deletion of Tag	16	31
Removal of Examples or Wording Changes	36	18
Withdrawn IDR Requests	28	23



New Year's resolutions are filled with lofty aspirations of weight loss, increased fitness levels, and healthier diets. However, these resolutions are often – and easily – broken.

What's the key to finding a fitness plan that can keep you healthy and independent all year long? Choosing activities you can do regularly, even every day, with friends, family or by yourself. Fitness can even provide an opportunity to learn new things and have fun, like taking golf lessons or learning to ballroom dance. It doesn't matter what activity you choose as long as it gets you moving!

The key to achieving your fitness goal is to do at least 30 minutes of regular physical activity, most days of the week. If that sounds like a lot, think again. There are plenty of activities you already do that contribute to your daily goal of 30 minutes. Cleaning the house, gardening, even grocery shopping can rev up your heart rate and breathing if you do them at a brisk pace. You won't even feel like you're exercising.

Consider these activities for your daily exercise:

- Clean the house
- Mop, sweep or vacuum the floor
- Garden
- Go grocery shopping
- Climb stairs
- Mow or rake the lawn
- Walk the dog
- Wash the car



By engaging in regular physical activity, you'll discover many of the benefits, including:

- Having more energy
- Strengthening your bones
- Lowering your blood pressure
- Improved flexibility and mobility
- Having stronger toned muscles
- Discovering enjoyable new activities

To start the New Year off right, sign up for the 10 in 10 Challenge at [www.INShape.IN.gov](http://www.INShape.IN.gov) and lose 10 pounds in 10 weeks with INShape Indiana.

Source: <http://www.aarp.org/learntech/wellbeing/Articles/a2003-04-23-keepactivesession1.html>



## *Norovirus:* **'Tis the Season**

'Tis the season for snow, holidays, and noroviruses. Since November, this noro season has started off with a bang in outbreaks, particularly in long term care (LTC) facilities. Although commonly called “stomach flu”, it is important to not confuse *Norovirus* infection with influenza, a respiratory illness characterized by fever, sore throat, cough, and muscle aches. The seasonality of both *Norovirus* infection and influenza overlap, but the transmission routes and prevention methods are very different.

Noroviruses are shed primarily in stool and are very easily transmitted by the fecal-oral route, such as consuming contaminated food or beverages or having close contact with someone who is ill. The predominant symptoms of *Norovirus* infection are nausea, diarrhea, and vomiting. Some people may experience a low-grade fever, chills, headache, muscle aches, and fatigue. This virus has a quick incubation period, ranging from 12-96 hours and averaging 24-48 hours. While there is no treatment available for *Norovirus* infection besides some good couch time and fluid replacement, ill persons will recover on their own within 1-2 days.

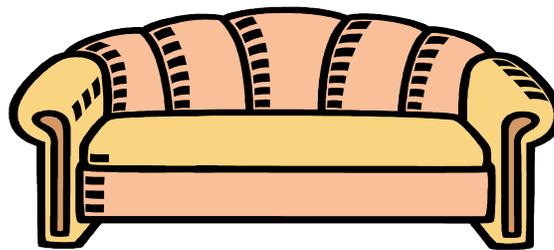
- Prevention is the key to limiting the spread of infection, since there is no effective treatment and people can be contagious up to two weeks after recovery.
- Encourage good hand hygiene
- Thoroughly wash contact surfaces and contaminated areas with a 1:10 dilution of bleach water
- Exclude anyone who is symptomatic with diarrhea and/or vomiting from high risk settings:
- Long term care facilities
- Health care workers
- Day care facilities
- Food handling
- Schools



By Lynae Granzow, BS  
Enteric Epidemiologist

## **Outbreaks**

Your local health department may respond onsite to assess outbreaks, including kitchen assessment and recommendations to assist in control of the outbreak. If you should have questions please contact Debbie Beers, 317/233-7067.



## **Life Safety Code Rule Update: Upholstered Furniture**

All new upholstered furniture within both Long Term Care and ICF-MR facilities should be tested in accordance with the provisions of 10.3.2 and 10.3.3 to ensure that they are resistant to cigarette ignition or smoldering.

Life Safety Code 10.3.2(1) states that the components of the upholstered furniture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall meet the requirements for Class I when tested in accordance with NFPA 260, Standard Methods of Tests and Classification System for Cigarette Ignition Resistance of Components of Upholstered Furniture.

Life Safety Code 10.3.3 states that upholstered furniture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall have limited rates of heat release when tested in accordance with NFPA 266, Standard Method of Test for Fire Characteristics of Upholstered Furniture Exposed to Flaming Ignition Source, or ASTM E 1537, Standard Method for Fire Testing of Real Scale Upholstered Furniture Items as follows: The peak rate of heat release for the single upholstered furniture item shall not exceed 250 KW.

The total energy released by the single upholstered furniture item during the first five minutes of the test shall not exceed 40 MJ.

This deficient practice could affect all the clients, staff and visitors. The exception to this is upholstered furniture belonging to the resident in sleeping rooms, provided that a smoke alarm is installed in such rooms. Battery-powered single-station smoke alarms are permitted (32.7.5.2, 33.7.7.2). If you have any questions regarding this matter, please do not hesitate to contact Rick Powers at 317-233-7471.

## Placement of Consultants in Long Term Care Facilities

The Division of Long Term Care administers the Civil Money Penalty Fund Consultant Program for the placement of consultants in certified long-term care facilities. The program is designed to assist facilities in achieving Medicare/Medicaid compliance, and the Civil Money Penalty Fund pays for the consulting program. The Division currently utilizes the services of professionals in the following long-term care professional areas: Health Facility Administrators, Registered Nurses, Registered Dietitians, Licensed Social Workers, Activity Personnel, and Qualified Mental Retardation Professionals.

Consultants in conjunction with facility staff are responsible for developing a work plan to address facility specific issues and to provide professional consultation services to assist in the implementation of the work plan.

The Division is proud to announce that the facilities which have utilized the Civil Money Penalty Program have benefited and have achieved compliance.

To learn more about the program, contact Michael Dean, CMP Coordinator, Long Term Care Division at 317.233.7784 or by email, [midean@isdh.in.gov](mailto:midean@isdh.in.gov).

## Residents of Nursing Homes that are Known Sex Offenders

In an effort to ensure the safety of all our residents and to promote appropriate planning for a resident with a history of abuse requiring listing on the Sex Offender Registry, a work-group (consisting of members of the State Associations, ISDH, the Ombudsman Program, United Senior Action and Areas on Aging) have been meeting to address proactive steps that can be taken by a facility.

There is no specific language in State or Federal Regulation that requires that facilities utilize the Sex Offender Registry to screen potential residents, the interpretive guidance of F224 states the following:

“Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility’s identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.”

A recommendation was made by the aforementioned work-group that facilities are made aware of the availability of the Indiana Sex Offender Registry. You may log on this site as follows:

Go to the following web-site: <http://www.insor.org>. Please read acknowledgement and click on the “I verify box” then click on acknowledge  
Click on search (top left corner)  
At this point you can choose to search by:  
Address, City, Zip Code, Offender Search (by the individual’s name, date of birth, etc.)  
Click on search registry

It is not mandated that this become a part of the pre-admission screening process, however, it is an optional manner by which the facility may attempt to safeguard other residents and ensure that the facility can meet the individual needs of the prospective resident. Please be reminded that should a resident be admitted with a history of past behaviors of concern, the facility shall be responsible to ensure that an appropriate plan of care is in place and implemented consistently by the staff. The facility should also conduct ongoing re-assessment of the plan of care to ensure the efficacy of said interventions.



## Top 10 Deficiencies 2006

### LTC

1. F0324 Accidents
2. F0281 Resident Assessment
3. F0309 Quality of Care
4. F0157 Notification of Rights and Services
5. F0514 Administration
6. F0314 Pressure Sores
7. F0371 Sanitary Conditions-Food Prep & Service
8. F0253 Housekeeping/Maintenance
9. F0279 Comprehensive Care Plans
10. F0315 Urinary Incontinence

### ICF-MR

1. W0149 Staff Treatment of Clients
2. W0104 Governing Body
3. W0249 Program Implementation
4. W0153 Staff Treatment of Clients
5. W0227 Individual Program Plan
6. W0436 Space and Equipment
7. W0331 Nursing Services
8. W125 Protection of Clients Rights
9. W0440 Evacuation Drills
10. W0154 Staff Treatment of Clients

## Fire Protection Information Request

The Indiana State Department of Health, Division of Long Term Care ("Division") is updating its fire protection information. Each licensed facility with comprehensive care beds in the State of Indiana is asked to submit information on the status of smoke alarms within the facility. This information will be stored in the Division's Quality Assurance and Management Information System (QAMIS) and will be made available to the public on the Indiana State Department of Health's web-site.

If your facility has not completed the survey, please complete the attached fire protection information survey on pages 14 - 15 and return to the Indiana State Department of Health as soon as possible. If there are any questions about the survey, please contact Sue Hornstein, Division Director at 317-233-7289.

## Transfer or Discharge Forms Update

Effective January 1, 2007 the Indiana State Department of Health, Division of Long Term Care ("Division") has updated the following transfer or discharge forms:

- Notice of Transfer or Discharge (State Form 49669)
- Notice of Transfer or Discharge-Request for Hearing (State Form 49831)

The updated versions of these forms can be found in this newsletter on pages 10-13. It is recommended that facilities begin using these forms immediately. If you have any questions regarding the change please contact the Program Director-Provider Services at 317-233-7794.



## CNA's with Verified Findings

The Indiana Health Care Providers Web-Site contains a continuously updated listing of the CNA's with verified findings. These people are prohibited from working as an aide, CNA, QMA or HHA in any licensed health care entity. The current list can be found on pages 18-23. Updates will be published quarterly in each newsletter. The website of CNA's with verified findings is updated monthly and can be checked at: <http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>. If there are any questions regarding the list please contact Darlene Jones at 317-233-7351.

## MDS/OASIS Error Summary Report

The MDS/OASIS Technical Services will be sending out a copy of the "Error Summary Report by State", to each MDS and OASIS facility in the first part of 2007. This report lists the state averages of the most frequent warning errors that occurred on all accepted submissions for the 2006 year. The report displays the list of error number and the percentage of assessments with each error.

A similar report entitled "Error Summary Reports" by Facility is available for individual facilities and agencies in the CASPER Report System. This report lists all the most frequent warning errors that occurred on all accepted submissions for each facility/agency. It is recommended that Facility/Agency administrators pull their individual agencies/facility reports and compare results with the state averages.

Access to the CASPER Report System is through the CMS State Website. For OASIS Facilities use the "Online Reports (OBQI, OBQM, and HHA Reports)" link from the "Welcome to the CMS OASIS System" page and for MDS Agencies use the "CASPER Reporting (Online Reports)" link for the "Welcome to the CMS MDS System". If you have any questions about accessing these reports or any other MDS/OASIS Technical questions, you may contact MDS/OASIS Technical Services at 317-233-7206 or by e-mail at [MDS-OASIS@isdh.in.gov](mailto:MDS-OASIS@isdh.in.gov).

## Informal Dispute Resolution (IDR)

Effective January 1, informal dispute resolution (IDR) letters will have a new look. Although CMS does not require IDR decisions to be explained, several providers have expressed a desire to know more about the decisions that have been made. So for each tag reviewed, a short paragraph or summary will be included to indicate the rationale for the decision made.



## Indiana State Department of Health

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**Indiana State Department Of Health  
Division of Long Term Care**



**TELEPHONE GUIDE**

*Arranged alphabetically by subject*  
**All are Area Code 317**

<b>SUBJECT</b>	<b>CONTACT PERSON</b>	<b>EXTENSION</b>
Administrator/DON, Facility Name/Address Changes	Seth Brooke	233-7794
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Seth Brooke	233-7794
CNA Registry	Automated	233-7612
CNA Investigations	Zetra Allen	233-7772
CNA/QMA Training	Nancy Adams	233-7480
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Enforcement & Remedies	Miriam Buffington	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
Incidents/Unusual Occurrences	Fax	233-7494
	Voicemail	233-5359
	Other	233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Seth Brooke	233-7794
License Renewal	Seth Brooke	233-7794
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Seth Brooke	233-7794
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Gina Berkshire	233-4719
MDS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Reporting	Seth Brooke	233-7541
Rules & Regulations Questions	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Transfer/Discharge of Residents	Seth Brooke	233-7479
Unlicensed Homes/Facilities	Linda Chase	233-7095
Waivers (Rule/Room Size Variance/ Nursing Services Variance)	Seth Brooke	233-7794
Web Site Information	Sarah Roe	233-7904
<b>AREA SUPERVISORS</b>		
Area 1	Judi Navarro	233-7617
Area 2	Brenda Meredith	233-7321
Area 3	Brenda Buroker	233-7080
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Chris Greeney	233-7894
ICF/MR South	Steve Corya	233-7561

## Web Sites of Note

Certified Nurse Aide Registry

<http://www.in.gov/ai/appfiles/isdh-cna/>

CNAs with Verified Findings

<http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>

MDS Bulletins

<http://www.in.gov/isdh/regsvcs/acc/oasis/>

MDS Web Site

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

Nurse Aide Training Guide

<http://www.in.gov/isdh/regsvcs/ltc/naguide/index.htm>

Nurse Aide Training Sites

<http://www.in.gov/isdh/regsvcs/ltc/natdir/index.htm>

Consumer Guide to Nursing Homes

<http://www.in.gov/isdh/regsvcs/ltc/profile/index.htm>

Nursing Home Compare (CMS)

<http://www.medicare.gov/nhcompare/home.asp>

Report Cards

<http://www.in.gov/isdh/regsvcs/ltc/repcard/index.htm>

Access Indiana

<http://www.in.gov/>

Indiana Secretary of State

<http://www.in.gov/sos/>

Family and Social Services Administration- Aging:

<http://www.in.gov/fssa/elderly/>

Family and Social Services Administration- Healthcare

<http://www.in.gov/fssa/programs/healthcare/>

Indiana Medicaid

<http://www.indianamedicaid.com/ihcp/index.asp>

Indiana State Police

<http://www.in.gov/isp/>

Indiana State Department of Health Web Page

<http://www.in.gov/isdh/>

Health Care Regulatory Services Commission

<http://www.in.gov/isdh/regsvcs/>

Laws, Rules, and Regulations

<http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm>

State Operations Manual

<http://www.cms.hhs.gov/manuals/IOM/list.asp>

Centers for Medicaid and Medicare Services (CMS)

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

US Government Printing Office

<http://www.gpo.gov/>

ICF/MR Facility Directory

<http://www.in.gov/isdh/regsvcs/ltc/icfmrdir/index.htm>

Long Term Care Facilities Directory

<http://www.in.gov/isdh/regsvcs/ltc/directory/>

Non-Cert. Comp. Care Facility Dir.

<http://www.in.gov/isdh/regsvcs/ltc/nccdir/index.htm>

Residential Care Facilities Directory

<http://www.in.gov/isdh/regsvcs/ltc/resdir/index.htm>

Retail Food Establishment Sanitation

<http://www.in.gov/isdh/regsvcs/foodprot/retail.htm>

AdminaStar Federal

<http://www.adminastar.com>

TB Skin Testing Course

[http://www.in.gov/isdh/programs/tb/tb\\_train.htm](http://www.in.gov/isdh/programs/tb/tb_train.htm)

How to read a survey

<http://www.in.gov/isdh/regsvcs/ltc/readsurvey/index.htm>

Questions About Healthcare

<http://www.in.gov/isdh/regsvcs/ltc/questions/index.htm>

Reporting a Complaint

<http://www.in.gov/isdh/regsvcs/ltc/complaints/index.htm>

State Forms Online PDF Catalog

<http://www.state.in.us/icpr/webfile/formsdiv/index.html>

LTC Newsletters

<http://www.in.gov/isdh/regsvcs/acc/newsletter/index.htm>

**NOTICE OF TRANSFER OR DISCHARGE**

State Form 49669 (R4 / 11-06)

Indiana State Department of Health-Division of Long Term Care

<b>Resident Name</b>		<b>Date Issued (Month, Day, Year)</b>	
<b>Facility Name</b> ( <i>Facility resident is being discharged from</i> )			
<b>Facility Street Address (Number and Street)</b>		<b>Facility City</b>	<b>Facility ZIP Code</b>
<b>Transfer or Discharge Effective Date (Month, Day, Year)</b>			
<b>Resident is being transferred to:</b>			
<input type="checkbox"/> Another Nursing Facility ( <i>Please Specify Facility Name</i> ) <input type="checkbox"/> Another Health Facility ( <i>Please Specify Facility Name</i> ) <input type="checkbox"/> A private residence ( <i>including home</i> ) <input type="checkbox"/> Other ( <i>Please specify</i> )			
<b>Transfer or Discharge to Address (Number and Street)</b>		<b>Transfer/Discharge to City, State, ZIP Code</b>	
<b>Reason for Transfer or Discharge</b> ( <i>must select one of the reasons below</i> )			
<input type="checkbox"/> The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.			
<input type="checkbox"/> The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing facility.			
<input type="checkbox"/> The safety of the individuals in the facility is endangered.			
<input type="checkbox"/> The health of the individuals in the facility would otherwise be endangered.			
<input type="checkbox"/> The resident has failed, after reasonable and appropriate notice, to pay or payment has not been made under Medicare/Medicaid for a stay in a nursing facility.			
<input type="checkbox"/> The facility ceases to operate.			
<b>APPEAL RIGHTS</b>			
<p><b>You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana State Department of Health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge, unless the facility is authorized to transfer you as an emergency transfer under 410 IAC 16.2-3.1-12(a)8. If you wish to appeal this transfer or discharge please fill out the attached State Form 49831 and return to the address below. If you have any questions, call the Indiana State Department of Health at 317-233-7794 between the hours of 8:15 am and 4:45 pm.</b></p> <p style="text-align: center;"><b>To appeal this transfer or discharge, use the attached State Form 49831 and mail it to:</b></p> <p style="text-align: center;"><b>Indiana State Department of Health Division of Long Term Care 2 North Meridian St. Section 4-B Indianapolis, IN 46204</b></p>			

**A facility must permit each resident to remain in the facility and may not transfer or discharge the resident unless:**

- The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing facility.
- The safety of the individuals in the facility is endangered.
- The health of the individuals in the facility would otherwise be endangered.
- The resident has failed, after reasonable and appropriate notice, to pay or payment has not been made under Medicare/Medicaid for a stay in a nursing facility.
- The facility ceases to operate.

**A resident also has the following rights regarding a discharge:**

- The right to discuss with the administrator the facility's decision.
- Reasonable assistance from the nursing home in carrying out the transfer/discharge plan, including helping resident contact other facilities and transferring records when resident leaves.
- A discharge planning conference with the nursing home.

**The Ombudsman is a State Office that serves as an advocate for nursing home residents.  
The State long term care Ombudsman's address and telephone number is:**

State Ombudsman  
Family and Social Services Administration  
Division of Disability, Aging and Rehabilitative Services  
Bureau of Aging and In-Home Services  
P.O. Box 7083, 402 W. Washington St.  
IGC South, Room. W454  
Indianapolis, IN 46207-7083  
317/232-7134 or Toll free 1-800-622-4484

**Your Local Ombudsman:**

Name

Telephone number

Address (Number and Street, City, State, and Zip Code)

The Protection and Advocacy organization provides assistance if needed for residents who are mentally ill or developmentally disabled. Their address and telephone number is:

Indiana Protection and Advocacy Services  
4701 North Keystone Avenue, Suite 222  
Indianapolis, IN 46205  
Voice 1-800/622-4845 or 317/722-5555  
TTY 1-800/838-1131; Fax 317/722-5564



## NOTICE OF TRANSFER OR DISCHARGE REQUEST FOR HEARING

State Form 49831 (R4/12-06)

Indiana State Department of Health-Division of Long Term Care

Use this form to notify the Indiana State Department of Health that you wish to appeal your transfer/discharge. If you want to appeal the transfer or discharge, you must send it to the Department of Health **within 10 days** of your receiving the notice of transfer or discharge from the facility to:

Director, Transfer/Discharge Program  
Indiana State Department of Health  
2 North Meridian Street – Section 4-B  
Indianapolis, Indiana 46204

I hereby request a hearing on the decision to transfer or discharge me from a nursing facility.

Resident Name	Date (Month, Day, Year)
---------------	-------------------------

Resident's Representative Name

Representative Address (Number and Street)	Representative Telephone Number
--	---------------------------------

Facility Name (Facility resident is being discharged from)

Facility Street Address (Number and Street)	Facility City	Facility ZIP Code
---	---------------	-------------------

Facility Telephone Number (      )

### **Reason for Transfer or Discharge (as listed on the "Notice of Transfer or Charge" form)**

The transfer is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.

The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing facility.

The safety of the individuals in the facility is endangered.

The health of the individuals in the facility would otherwise be endangered.

The resident has failed, after reasonable and appropriate notice, to pay or payment has not been made under Medicare/Medicaid for a stay in a nursing facility.

The facility ceases to operate.

## **Nursing Facility Bed Hold Policy**

The bed-hold policy under the Family and Social Services Administration, Office of Medicaid Policy and Planning (405 IAC 5-31-8):

Reservation of nursing facility beds. Although it is not mandatory for facilities to reserve beds, Medicaid will reimburse for reserved beds for Medicaid recipients at one-half the per diem rate provide that the criteria set out in 405 IAC 5-31-8 is met.

### **Hospitalization:**

✦ Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the nursing facility

The total length of time allowed for payment of a reserved bed for a single hospital stay is 15 days

### **Therapeutic leaves of absence:**

✦ A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the recipient's plan of care

The total length of time allotted for therapeutic leave in any calendar year is 30 days. The leave days need not be consecutive

**Medicaid will not reimburse a nursing facility for reserving beds for Medicaid recipients when the nursing facility has an occupancy rate of less than ninety (90) percent.**

Although prior authorization by the office is not required to reserve a bed, a physician's order for the hospitalization or therapeutic leave must be on file in the nursing facility.

Facility bed hold policy:

Facility Bed Hold Policy Contact:

December 4, 2006

4B-07

Re: Fire Protection Information

The Indiana State Department of Health, Division of Long Term Care ("Division") is updating its fire protection information. Each licensed facility with comprehensive care beds in the State of Indiana is asked to submit information on the status of smoke alarms and sprinkler information within the facility. This information will be stored in the Division's Quality Assurance and Management Information System (QAMIS) and will be made available to the public on the Indiana State Department of Health's web-site.

**Please complete the fire protection information survey on the reverse side of this letter and return to the Indiana State Department of Health by January 1, 2007.** If there are any questions about the survey, please contact Sue Hornstein, Division Director at 317-233-7289.

Sincerely,

Sue Hornstein, Director  
Division of Long Term Care  
Indiana State Department of Health

FACILITY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

NUMBER OF COMPREHENSIVE CARE RESIDENT ROOMS \_\_\_\_\_

NUMBER OF COMPREHENSIVE CARE RESIDENT ROOMS WITH BATTERY OPERATED SINGLE STATION SMOKE ALARMS \_\_\_\_\_

NUMBER OF COMPREHENSIVE CARE RESIDENT ROOMS WITH SYSTEM BASED SMOKE ALARMS \_\_\_\_\_

NUMBER OF COMMON AREAS IN COMPREHENSIVE CARE AREA \_\_\_\_\_

NUMBER OF COMMON AREAS IN COMPREHENSIVE CARE AREA WITH SINGLE STATION SMOKE ALARMS \_\_\_\_\_

NUMBER OF COMMON AREAS WITH SYSTEM BASED SMOKE ALARMS \_\_\_\_\_

***Common Areas are: Dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.***

## Life Safety Update Penetration of Fire Barriers

**Question:** Are utility penetrations permitted in fire barriers in new and existing nursing homes and assisted living facilities?

**Answer: Yes.** Recently, some providers were informed that utility penetrations of fire barriers were not permitted in accordance with the 2000 NFPA Life Safety Code (LSC). This is not correct:: protected penetrations are permitted.

The particular situations that seem to be at issue are when a 2-hour rated fire barrier has been or is being installed to separate a new addition to an existing building or the separation of different and connected occupancies such as a nursing home from an assisting living facility.

The 2000 LSC states at 18/19.1.1.4.2, Communicating openings in dividing fire barriers required by 18/19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing doors. (See also Section 8.2). Section 8.2 discusses Construction and Compartmentation and further defines under what conditions utility openings in a fire barrier can exist and how they are protected. Section 8.2 permits utility penetrations of fire barrier walls as long as the penetrations are properly protected. This usually means fire stopping for pipe and conduit penetration and fire dampers for air handling duct penetrations.

Sections 8.2.3.2.4.1 of the 2000 LSC states “Openings in fire barriers for air-handling ductwork or air movement shall be protected in accordance with Section 9.2.1. Section 9.2.1 generally states that air handing systems shall be installed in accordance with NFPA 90A, *Standard for the Installation of Air Conditioning and Ventilation Systems*.”

Section 8.2.3.2.4.2 states “Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:”. The section then goes on to indicate the approved methods to protect the penetrations.

Please note that the wording in Sections 8.2.3.2.4.1 and 8.2.3.2.4.2 clearly indicate that penetrations of fire barriers are permitted or else the sections would just indicate that penetrations are not permitted. As always, local requirements may differ, but he above does reflect CMS requirements.

# MDS Coordinators, Take Note!



Check out the new Minimum Data Set Training Website:

[www.mdstraining.org](http://www.mdstraining.org)

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## CORRECTION

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

12-22-06

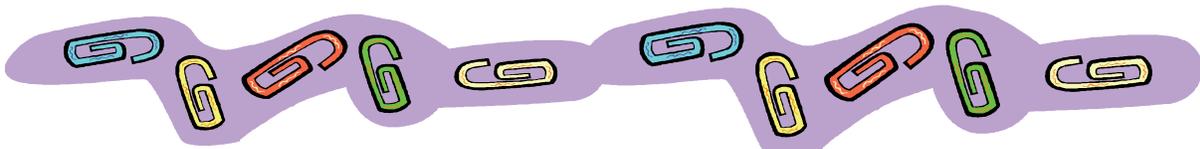
**Notification Regarding: Revised - Long Term Care Facility  
Resident Assessment Instrument (RAI)  
User's Manual for MDS Version 2.0**

It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that several commercial publishers have printed RAI Users Manuals for MDS Version 2.0 with misinformation regarding: Section G, Chapter 3, page 83. The official, correct and most up to date CMS version of Chapter 3 is the "Revised-June 2005" version. The incorrect version of Chapter 3 appears to have been printed using the "DRAFT" revisions dated MAY 2005. "DRAFT" revisions dated MAY 2005 were announced by CMS in April 2005, then *withdrawn*, updated, and released as "REVISED-JUNE 2005".

CMS's official, updated, on-line version of the RAI User's Manual for MDS 2.0, and related forms, are available at:

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

Please note CMS has removed the file named "Draft-May 2005" from "Previous Updates" located under "Downloads" at this website. This file had been intended as a draft document only and not intended for publication or training uses. Please remove this document from RAI User's Manuals and any training materials that may have been developed using information from this document. We regret any confusion and inconvenience to publishers, providers and other users of this information. Thank you.



## CNA's with verified findings as of 12/28/2006

Updates can be found at <http://www.in.gov/isdh/regsvcs/lc/cnafind/index.htm>.

ABEL, BETH A	BEEPOT, MARY C	BURNETT, MELISSA K
ABRAM, WILLIAM	BEERY, DEBRA L	BURNS, HELEN
ABSTON, ANGELA M	BEGLEY, THELMA C	BURRELL, MARGARET L
ACKER, EVELYN	BELCHER, WILLIAM D	BURRUS, KENNETH
ADAMS, JETTON	BENEMATTI, SCOTT	BUSH, DENICE
ADAMS, LYNN A	BENNETT, HELEN L	BUTLER, DONNA
ADAMS, MAURCITA W	BENNETT, LISA G	BUTLER, TONI R
ADAMS, SHERRY	BENSON, EDDIE	BUTLER JR, ROBERT L
AGNEW, LYNETTA C	BESTER, Gerdine	BYRD, DONNA E
ALBRECHT, DEBRA K	BIGLEY, VONNIE	BYRUM, JUDY J
ALDERFER, STEVEN M	BISHOP, JULIE A	CADE, TIANA L
ALFRED, ROBBIN	BJORNSTAD, GINGER L	CAIN, CHARLOTTE M
ALLEN, LYDIA J	BOGNER, PATRICIA	CAIN, JANICE
ALLEN, SHARIONE	BOHNERT, KRISTINA	CAIN JR, JAMES A
ALLEN, TREVA J	BOLDEN, DEMETRIUS	CALDWELL, LANOAH M
ALLISON, GENE M	BOLLER, MELISSA S	CAMPBELL, BRUCE R
ANDERSON, LOIS B	BOOE, LARRY E	CAMPBELL, CONSTANCE
ANDERSON, SARAH J	BOONE, DEBBIE A	CAMPBELL, EULA A
ANDERSON, YOLANDA A	BOOTHE, ROY C	CAMPBELL, TIFFANY J
ANDREWS, BETH E	BORJAS, JESSICA	CANNON, DEBORAH E
ANKROM, JOHN	BOTARF, CARA L	CANTER, CARRIE R
ARIHOOD, SARA E	BOWENS, JA VON R	CANTRELL, KATHY
ARNETT, FELICIA	BOWERS, CAROL A	CARLISLE, MARION E
ARNOLD, JUNE	BOWERS, CHERYL R	CARNLEY, MELINDA
ARNOLD, MICHAEL	BOWLING, JANUS	CARRUTHERS, TAMARA
ASBURY, HOPE	BOXELL, CHRISTOPHER D	CARTER, HELEN B
ASHBY, QUINTIL J	BOYD, KHAWANDA K	CARTWRIGHT, HELEN L
AURILUS, RISSA	BOYLL, BEVERLY -	CASE, DAVID C
BABB, KIMBERLY A	BRADSHAW, RODNEY J	CASE, ROSEMARY V
BACON, VERONDA M	BRADY-KRANTZ, AMY A	CASH, SHARON L
BAILEY, SHERRY Y	BRIDGEMAN, AMY L	CASWELL, CHAYDA C
BAIRD, JAMES E	BRIDGES, PRISCILLA	CEDRAS, PAMELA G
BAKER, ANGELA	BRISTOW, JENNIFER	CHAMNESS, CANDY
BAKER, JONATHAN	BROCKHAUS, VIRGINIA -	CHANDLER, KIMBERLY
BAKER, SHAMBERLEY	BROOKS, STEPHANIE L	CHANDLER, KRISTA
BAKER, SHERRY	BROOKS, STEPHANIE	CHAPMAN, EARLINE G
BALL, CHRISTOPHER	BROUGHTON, DOROTHY	CHAPMAN, ERIKKA
BALL, LORETTA	BROWN, JEAN M	CHARLESTON, VALERIE R
BANKS, CONERAL -	BROWN, NINA L	CHASE, DEBBIE L
BANKS, TAMMY R	BROWN, ROBIN R	CHATTIN, REBECCA J
BANYON, DEBORAH L	BROWN JR, FRED L	CHEEK, DIANA L
BARKALOW, LAURA	BROWNIE, PATRICIA A	CHILTON, TINA L
BARNER, DARLENE F	BRYANT, BARBARA A	CLABAUGH, DEBRA J
BARNES, KELLY S	BRYANT, NEFERTITI V	CLARK, ERNESTINE
BARR, JESSICA	BRYCE, SHARON N	CLARK, KIMBERLY
BARRINGTON, ANITA	BUCHANAN, JR, WALTER	CLARK, KYMYATA T
BASKIN, DELICIA A	BUDA, PHYLLIS	CLARK, SABRINA R
BAUGH, BILLIE J	BULLOCK, YVONNE	CLEVENGER, TARA
BAUSMAN, ANGELA	BURKE, NANCY R	CLONTS, DARNITA
BEARD, KEVIN W	BURKE, PATRICE C	COBBS, RENITA Y
BEARD, RENEE M	BURKS, MONA M	CODY, LESLIE L

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COFFEE, VALERIE	DAY, COURTNEY A	FISH, DONNA
COFFENBERRY, EMMA J	DEAN, MAGDALENE	FLATER, SHARON K
COLE, PEGGY A	DELONG, KATHY M	FLEENER, VANESSA
COLEMAN, KADIYATU W	DENTON, DELORES M	FLEMING, DANA C
COLLIER, LONNIE	DICKERSON, MYLES A	FLICKINGER, TRACY L
COLLINS, TERESA	DILDINE, ROBERT W	FOLEY, SHARON J
COLVIN, HENRY	DILWORTH, ANGELA	FOSTER, THERESA J
COLVIN, MARY A	DOSS, ALICIA E	FOUNTAIN, MONICA
COMER, FAUNA E	DOWNES, MARY L	FOUST, JOSEPHINE L
CONNER, ANGELA	DRAKE, DAVID R	FRANKLIN, JACQUELYN R
CONNER, YOLANDA I	DRUMMER, DANIELLE	FREDERICK, SHERRY L
CONWAY, BONITA G	DUFFY, SOPHIA	FRISQUE, ASHLEY
COOK, CHERYL	DUNN, AMBER	FUSON, CINDY
COOK, CORY E	DUNTON, HUMBERTO	GAMMONS, JEFF
COPPOCK, KATHY	DYER, LILLIAN	GANN, JULIA K
CORD, KRISTY A	DYKES, GARY	GANT, CHARISE E
CORY, DOLLIE	EAKLE, LEORA C	GARDNER, BRENDA F
COSTELLO, TERRI L	EARLYWINE, CARRIE	GARRETT, ALLYNE
COUCH, CAROLYN	EASTON, SHARON E	GARTRELL, CRISTINA R
COULTER, BETSY J	EASTRIDGE, LORIA E	GASAMA, MARGARET
COUTS, GENISE T	ECHTERLING, DARREN R	GEE, TERRI L
COX, NANCY -	EDMONDS, LISA M	GEISE, JUANITA
COX, TAWNDA S	EDMONDSON, MAKEDA J	GENTRY, TAMIKA L
CRAFT, MISTY D	EDMONDSON, MOLLY S	GHOLSON, MARSHA A
CRAIG, ANITA	EDWARDS, CHERYL L	GIBAT, JANET M
CRAIG, RUTH M	EIRK, ANN	GIBSON, ROSE M
CRAWFORD, ANGELA D	EISELE, VIVIAN	GIBSON, TYNEKA
CRAWFORD, CYNTHIA L	ELKINS, CASANDRA	GILBERT, MELINDA G
CREWS, PAULINA S	ELLIOTT, SARAH D	GILLESPIE, TRACY A
CRICK, AMANDA	ELLIS, GLENETTA I	GILMORE, THERESA D
CRIDER, KENNETH W	ELLIS, SUZANNE	GLEASON, TIMOTHY L
CRIDGE, WILLIE J	ELPERS, APRIL M	GODBERRY, DAVID
CRONIN, REBECCA J	ELSEA, RACHEL K	GODWIN, DAVID C
CROSS, KRISTY J	EMMONS, ROBERT	GOHEEN, DONNA P
CUFFEL, PRAMOTE L	ENGLEMAN, BETTY M	GOINS, MILES B
CULPEPPER, YVONNE R	ENYEART, CASEY S	GOLISH, CATHY
CUMMINGS, KEVEN	ESHELMAN, KAREN	GORMAN, MC COUDRA
CUMMINGS, VALERIE J	EVANS, ALISHA	GRAFF, ADLEN A
CUMMINS, KATHY	EVANS, TAMIKA A	GRAHAM, ANNA J
CUNNINGHAM, DANA	EVANS, WHITNEY L	GRANT, DWAYNE E
CURLIN, BARBARA A	EWUMI, EMMANUEL A	GREEN, KENNETH
CURTIS, JACQUELINE	FAITH, NANCY M	GREEN, MARILYN K
CUSHINBERRY, SANDRA L	FARKOS, MARJORIE	GREENE, LILLIE D
DAVIDSON, EDITH	FARRIS, AMANDA R	GREHAN, HEATHER M
DAVIS, DEDRIA L	FAULK, GABRIELLE L	GRIMES, SHARRON R
DAVIS, MAXINE -	FAULKENBERG, MELISSA A	GRIMES, WESTON
DAVIS, PAMELA D	FAVER, CASEY L	GROSS, MADALENE A
DAVIS, SHAWN W	FENNESSE, TAYNISHA	GRUBBS, VICKY
DAVIS, TABATHA A	FIDLER, STEVEN D	GUY, PAMELA J
DAVIS, VAUGHN L	FIELDS, BELINDA	GUZMAN, ISAAC
DAWS, CARLA S	FINDLEY, DOROTHY F	HACKMAN, MELINDA

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HAGERTY, RHONDA  
HALL, LOUIS M  
HALL, WILLA D  
HALLIBURTON, SHARON B  
HAMBY, JANICE A  
HAMILTON, AMANDA L  
HAMILTON, DONNA  
HAMPTON, CAROLYN W  
HAND, KRISTIN  
HANKINS, PEGGY D  
HANSFORD, SANDRA K  
HARDIMAN, GAIL L  
HARDY, CYNTHIA  
HARMON, VALERIE J  
HARMS, KRISTIE N  
HARNESS, MICHELLE  
HARRIS, ANGIE  
HARRIS, JUANITA -  
HARRIS, NIKITA  
HARRIS, TINA S  
HARROLD, MICHAEL E  
HARTING, RAE ANNA L  
HARTMAN, BARBARA A  
HARVEY, DORIS J  
HARWELL, RICHARD  
HATFIELD, MARY  
HATTON, DIONTREIA  
HAWKINS, FANNIE  
HAWKINS, HELEN P  
HAWKINS, LENA M  
HAYES, JERRY P  
HAYNES, MARTHA J  
HAYNES, RANDALL W  
HEBB, SONJA  
HENDERSON, LANONDRIA  
HENDERSON, SHERRY L  
HENNING, DAVE L  
HENSLEY, NORMAN T  
HIATT, CONCEPCION M  
HICKS, MIKOLA R  
HIGHSMITH, KATHY  
HILL, PATRICIA  
HILL, REGINALD  
HILLIARD, DANIELA T  
HILLMAN, ANGELA K  
HINTON, DONNA E  
HOBBS, ROSE A  
HOFFMAN, THOMAS L  
HOLBERT, KELLY L  
HOLDERMAN, VICKIE L  
HOLECHKO, NELL A

HOLLEY, MARIE A  
HOLLIS, SHARNELL  
HOLLOWAY, ERICA  
HOLMGREN, DIANA L  
HOMMEL, SHANNON R  
HONORABLE, RACHELLE  
HOOD, LAURA -  
HOOTEN, MICHAEL  
HORN, SANDRA A  
HOSKINS, ELLISA I  
HOSTETLER, SHANNA  
HOTTMAN, SANDRA L  
HOTZ, KAREN L  
HOUP, MARY E  
HOUSER, BARBARA  
HOWARD, CHARLOTTE A  
HOWELL, PHYLLIS S  
HUBBARD, DUWAYNE  
HUDICK, SANDRA L  
HUDSON, CATINNA  
HUDSON, LULU  
HUGHES, CYNTHIA K  
HUGHES, DEBORAH K  
HUGHES, LACY J  
HUGHES, MICHELLE  
HUNKER, DEAN  
HUTCHENS, HEATHER J  
HUTCHINS, CAROL  
HUTCHISON, TANYA  
INDERSTRODT, JAMES R  
INMAN, SHIRLEY A  
IRVINE, NATHAN A  
ISBELL, JENNIFER G  
JAMISON, DENISE  
JEWELL, NYLA J  
JINADU, OKE I  
JOHNSON, HELEN G  
JOHNSON, JAUNITA M  
JOHNSON, JOHN  
JOHNSON, LARRY D  
JOHNSON, LISA  
JOHNSON, MARK  
JOHNSON, MARY A  
JOHNSON, MURICE L  
JOHNSON, ORILL G  
JOHNSON, TISHA  
JONES, ARMETTA J  
JONES, BENEDETTA C  
JONES, BRIAN W  
JONES, DALE A  
JONES, ELIZABETH A

JONES, GABRIELLE  
JONES, LANA K  
JONES, MARY F  
JONES, MICHAEL P  
JONES, VANESSA  
JORDAN, ANTONIA F  
JORDAN, KELLY  
JORDAN, SHARON E  
JOSEPH, PAMELA M  
KANKEL, GREGORY A  
KARCH, MELISSA J  
KAUFMAN, SKYE  
KAWZINSKI, JUDY  
KEESLING, JUANITA  
KELLY, JENEE' M  
KENNY, DAVID S  
KERSCHBAUM, AMBER  
KERSEY, VANGELEEN  
KESSNER, BRENNAN D  
KEY, ANDREW W  
KEYES, SANDRA  
KHUKIE, JAMBO  
KILGORE, PAUL  
KING, ANTHONY P  
KING, MELISSA A  
KING, SHIRLEY A  
KINSER, DARLENA L  
KIRK, JANICE M  
KNIGHT, ANGELA Y  
KNIGHT, CHUCK  
KOEKKE, KENNETH A  
KOERS, ANNIE  
KOORSEN, TERESA L  
KREISHER, HANNAH M  
KRUK, NANCY J  
KUJAWA, AMANDA  
KUSTER, JAMES E  
LAISURE, SHIRLEY  
LAMB, JANE A  
LANDON, DOROTHY  
LANDWER, KATHLEEN  
LANE, CINDY  
LANGER, SUSAN  
LAPCZYNSKI, JUANITA K  
LASTER, ANGELA L  
LAWLER, MARGUERITE E  
LAWSON, STEPHANIE A  
LE MANSKI, VALERIE M  
LEE, DELONNA F  
LEE, EDNA L  
LEON, DAVID

## CNA's with verified findings as of 12/28/2006

Updates can be found at <http://www.in.gov/isdh/regsvcs/lc/cnafind/index.htm>.

LESHER, JOY  
LESLIE, ANGELA K  
LETNER, CATERINE  
LEWIS, CRAIG A  
LEWIS, RITA K  
LIPE, TIMOTHY R  
LIPSEY, LISA V  
LOCKRIDGE, MICHAEL W  
LONBERGER, DEVONNA M  
LOPEZ, SYLVIA  
LOTT, JOHNNIE B  
LOUDEN, CARRIE L  
LOUDEN, HESTER A  
LOWERY, CANDY  
LOWTHER, JAMES R  
LOYD, GWENDOLYN J  
LUNDSFORD, KAREN E  
LUNN, MELISSA V  
LUNSFORD, JEREMY  
LYONS, SAN D  
MACON, CONSTANCE L  
MADDEN, ANGELA D  
MAGEE, PAULA J  
MAGEE, YVONNE A  
MALONE, TAMMY K  
MANNA, CYNTHIA M  
MARCRUM, DONALD C  
MARTIN, BRONDA U  
MARTIN, DONALD T  
MARTIN, MARCUS E  
MARTIN, RHONDA  
MARTIN, SWANSETTA  
MASON, FRIEDA L  
MASON, MARY L  
MASON, MELISSA K  
MASUNAS, KATHLEEN J  
MATANO, RUTHIE L  
MATHIS, TROY L  
MATNEY, DONNETTE J  
MATTHIE, MICHELLE  
MAXWELL, JAMESE  
MAY, ROSIE -  
MC CLAIN, VERONICA  
MC CORDUCK, NORA I  
MC INTOSH, BONNIE S  
MC KENZIE, PAMELA A  
MC NEILL, STACEY L  
MCBARNES, KEVIN P  
MCBRIDE, BRADLEY D  
MCCLOSKEY, JOHN S  
MCCRAY, VERMELL L  
MCGOWEN, CAROL M  
MCGRUDER, NENA  
MCINTYRE, KATHY R  
MCMILLER, GREGORY L  
MCMILLIN, BEVERLY J  
MCROBERTS, MELODY G  
MEADS, STACEY  
MEDINA, KAREN S  
MELCHI, PATRICIA M  
MEREDITH, CYNTHIA M  
MIDDLETON, CHERYL  
MIDDLETON, ROBERT K  
MILLER, ANGELA M  
MILLER, CARRIE  
MILLER, DAWN M  
MILLER, MINNIE L  
MILLER, SHAWN E  
MIMS, DORIS L  
MINION, DELORES (LOIS) M  
MINKOSKY, BLANCHE  
MINNIS, RACHEL M  
MITCHELL, LEROY M  
MONCRIEF, PAMELA A  
MONTGOMERY JR, CHARLES  
MOORE, CHERYL Y  
MOORE, LISA  
MOORE JR, EVERETT F  
MORRIS, CARLENE E  
MORRIS, STACEY D  
MORTIMER, VICKI L  
MORTON, TRACEY S  
MOSER, CAMELLA E  
MOSS, MATTHEW T  
MOYER, SANDRA  
MTHAWANJI, RINA  
MUMFORD, MEDINA N  
MURPHEY, SHEILA -  
MURRAY, PATRICIA M  
MYER, BRIDGET E  
MYERS, ELISHA  
NANCE, BERNITA J  
NANTZ, JENNIFER  
NASH, RITA M  
NEAL, BARBARA  
NEAL, TOINETTE Y  
NELSON, RUBY J  
NELSON, SHAWNE  
NEWLIN, JUDY J  
NEWPORT -BUSSING, JEANETTA S  
NOENS, EMILY  
NOWLAN, BARBARA J  
OLINGER, KATIE H  
ORCUTT, DANIELLE M  
OSBORNE (ADKINS), LISA K  
OWALABI, ISAAC O  
OWENS, DANNY  
OWENS, PAMELA K  
PACE, NAQUITA  
PADGETT, JAMES R  
PARKER, AMBER N  
PARKER, SANDRA A  
PASSLEY, DARLENE  
PATEL, MEENA S  
PATRICK, STEPHANIE L  
PATTERSON, JOY  
PATTERSON, MELISSA  
PAYNE, KATHARINE -  
PAYNE (KELLER), RACHEL L  
PEARSON, SAMUEL -  
PEASE, LAURA K  
PENNELL, JR., JAMES G  
PENNINGTON, HAROLD M  
PEREZ, FREDDIE  
PEREZ, RHONDA  
PERRINE, KARA L  
PETERSON, JERMAINE L  
PETERSON, NATALIE  
PETTIT, ANGELA (ANGIE) -  
PFEIFFER, GEORGIA K  
PHILIPS, LEROY E  
PHILLIPS, CONNIE J  
PHILLIPS, PATRICIA A  
PHILPOT, KAREN  
PIONKE, SUSAN M  
PITTS, KATHERINE  
POWELL, EDWARD C  
PRITCHARD, CHRISTINA J  
PRYOR, GERALDINE -  
PURNELL, PATRICIA J  
QUERTERMOUS, CALVIN  
RAINEY, AMY  
RALSTON, DANIEL  
RAMEY JOHNSON, COLLEEN S  
RAMIREZ, CORRIE M  
RANDALL, DENISE  
RANKIN, WENDY K  
RANKINS, TAVARES  
READNOUR, ARDETH T  
REDDING, RENEE A  
REED, JUANITA M  
REED, KATHY S  
REED, PERCIOUS

## CNA's with verified findings as of 12/28/2006

Updates can be found at <http://www.in.gov/isdh/regsvcs/lc/cnafind/index.htm>.

REED, SCHLUNDA -	SELF, BETTY	SOUTH, ELAINE M
REED, TAMARA	SELLERS, PAMELA	SPENCER, JERONE T
REEVES, JULIA M	SERMERSHEIM, GUADALUPE	SPRINGER, SHEILA Y
REGAN, DAWN M	SESKE, TONIA	STACY, SHARON N
REINHARDT, MARY K	SEXTON, ANGELA D	STARKEY, FLORENCE -
REVELL, STEPHEN W	SEXTON, SHARON S	STARNES, LORENE L
REYNOLDS, ERIC J	SHAFFER, LORI D	STEAVESON, WILIAM
RHINERSON, DELLA	SHARLOW, SUSAN J	STEPHEN, HELEN M
RICE, BRANDY M	SHAW, CARLA J	STEPHENS, APRIL
RICHARDSON, PAMELA R	SHAW, HEATHER S	STERN, REBECCA -
RICHARDSON, PENNY S	SHAW, ISAAC R	STEVENSON, GARY
RICHCREEK, KATHLEEN	SHELTON, ALICIA L	STEVENSON, SANDRA S
RICHMOND, ROSE	SHEPHERD, LONNA L	STRICKLAND, BRITTNEY L
RIDDLE, RHONDA P	SHOAEI, SANDRA J	STRICKLANDT, VELMA M
RIGSBY, HEATHER M	SHOEMAKER, TIMOTHY E	STRONG, TESSA G
ROBERTS, CYNTHIA E	SHOWEN, TAMARA L	SUMMERS, DONNA M
ROBERTS, MARGARET	SHROUT, BESSIE E	SUTTON, CHRIS
ROBERTSON, KIMBERLY	SHULTZ, GLORIA G	SWANEGAN, DONNA I
ROBERTSON, ROBBIN L	SIDEBOTTOM, SEAIRRA S	SWARTZ, BRACIE
ROBINSON, GLORIA	SIGLER, CYRILYN	SWEENEY, BILL J
ROBINSON, MARY LOU	SILK, CRYSTOL	SWEET, GREGG H
ROBINSON, MICHELLE	SIMPSON, KAREN	TABRON, ZAKKIYYA
ROBINSON, SCHEREE L	SINGLETON, JILL L	TATA, MEZZIA A
ROGERS, CHERYL	SIZEMORE, SHARON K	TAUBER, PATRICIA A
ROSENBAUM, JILL	SKROPITS, TAMIKA C	TAYLOR, AMBER M
ROSS, EUDORA E	SLATER, PATRICIA K	TAYLOR, DONNISHA M
ROSSOK, JESSICA D	SLATTERY, PATRICK A	TAYLOR, HILDRED I
ROUNDTREE, CARLA	SMALLINGS, ERIKA	TEAGUE, CAROLYN
ROWE, CHERYL L	SMEJKO, SHANNON	TEMPLETON, SAMMIE L
RUBAN, MICHAEL J	SMITH, ALICIA	TERESS, AARON L
RUCKER, ANGELA L	SMITH, ALVENIA D	THOMAS, JENNY E
RUSE, CHERYL -	SMITH, CHARLES D	THOMAS, MARGARET J
RUSH, SCOTTY D	SMITH, JACOB D	THOMAS, PAMELA
RUSK, FRANCES H	SMITH, JANE M	THOMAS, TERESA
SANDERS, ALICIA M	SMITH, LANAE D	THOMPSON, LINDA S
SANDERS, JANET S	SMITH, MARGIE M	THOMPSON, MELISSA
SARVER, TERRELL L	SMITH, MARY C	THOMPSON, MICHAEL B
SAUCIER, AMEY	SMITH, MELISSA J	THRASHER, CARLA J
SAUNDERS, JOHANNA	SMITH, NINA	THURMOND, CAROLYN D
SCARBROUGH, TIMMY L	SMITH, PATRICIA J	TILFORD, ROBERT M
SCHILLING, DOUGLAS N	SMITH, RITA A	TIPTON, TANDI S
SCHIMMEL, THELMA J	SMITH, TYWANNA	TISON, CAROLYN S
SCHISLER, JOHN	SMITH, VERONICA R	TONEY, CAROLYN
SCHOONOVER, MICHAEL H	SMITH JR, FRED J	TOOMBS, RANDALL L
SCHRIVER, TERESA C	SNIDER, RONALD	TOWNSEND, JUDY L
SCOTT, ANGELETTA L	SNYDER, MARK	TOWNSEND, MICHELLE L
SCOTT, BEATRICE	SNYDER, VIRGINIA -	TRAMILL, SARA D
SCOTT, LAURIE A	SODDERS, LISA	TREAT, ANITA A
SCOTT, SAMARTHA A	SOOS, MARLENE	TRENNEPOHL, KAMMA E
SCOTT, SASHA	SOPHER, TONIA	TRUAX, RHONDA K
SEEHAUSEN, ROSEMARIE	SOUDER, SHANNON K	TRUE, JESSICA

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Updates can be found at <http://www.in.gov/isdh/regsvcs/lc/cnafind/index.htm>.

TSCHAENN, TAMMY L	WILBERT, DANIEL
TUCKER, KENDRA D	WILIAMS, CHRISTINE N
TUCKER, TASHIKA M	WILKERSON, ROBIN L
TUMEY, JO ELLEN	WILKINSON, MICHELLE
TURNER, PATRICIA D	WILLIAMS, JANICE
TURPEN, JULIE L	WILLIAMS, ROCHELLE
TUSSEY, PAMELA S	WILLIAMS, SYLVIA
TYLER, ANGELA K	WILLIAMS, TRACIE M
UMPHRYES, JENNY M	WILLIAMS, VANELLA -
UNVERZAGT, MICHELLE	WILLIAMSON, KATHI
UPDEGRAFF, GAYLE A	WILLIS, JAIME L
VANCE, JOYCE A	WILLIS, RUBIN
VANOSDAL, AMANDA	WILSON, JOANETTE Y
VEATCH, BRENT	WILSON, LEE K
VEST, TERESA F	WILSON, RHONDA G
VILLEGAS, DAMON R	WILSON, WENDY
VINCENT, ANGELA G	WINFIELD, DORIS D
WADE, KAREN S	WOLF, MARTHA
WALDON, MARCIA	WOLF, MYRL D
WALKER, DEBRA C	WOLFE JR, SIDNEY E
WALKER, JOSPEH E	WOODRUFF, KIMBERLY
WALL, BARBARA S	WOODS, AMBER D
WALLS, SHARON	WOODS, DONALD C
WALTON, BRIGITTE N	WOODS, SHERYL L
WARD, HELEN L	WORLEY, JEFFREY T
WARD, JOHNNIE L	WOZNIAK, SUSAN
WARD, TONYA A	WRIGHT, DEBRA R
WARE, BRENDA	WRIGHT, SCOTT L
WARNER, SHARON L	WRIGHT, SHELBY
WARREN, ANN M	WRIGHT, STEVEN V
WARREN, SHELIA -	YELDIG, BONNIE -
WASH, BENJAMIN S	YODER, LYDIA
WASHINGTON, MONICA	YODER, SHANNON
WATERS, DEUNDREA	YOUNG, DOROTHY
WATKINS, CALANDRA S	YOUNG, JOHN H
WATSON, CATHY J	YOUNG, SHELLEY L
WATSON, JOYCE A	ZVIDZAYI, NYARADZO V
WATSON, TY'ASHA O	
WAYNICK, CHARITY	
WEBSTER, HERMAN L	
WEDDLE, SEASON	
WEISNER, JANET L	
WELDON, KATRINA M	
WELDON, MICHELLE R	
WELDON, VIOLA M	
WESTFALL, MARY	
WHELCHER, ADRIANE L	
WHITAKER, JACK A	
WHITE, ANGELYCA	
WHITELY, SUE	
WIGGINS, LASHONDA S	



## Gastrointestinal Virus Infection Control Measures

These guidelines have been developed to help stop the spread of viral gastroenteritis in health care facilities. These viruses are highly contagious and very resilient. The virus can survive chlorine levels up to 10 ppm, freezing, and heating to 140°F. Preventive measures should be continued for at least 3 days after the outbreak appears over. Infected persons continue to shed the virus for up to 2 weeks after they have recovered.

Norovirus can be transmitted by multiple methods: foodborne, waterborne, person-to-person, and fomite. Infected persons shed an extremely large amount of virus in feces and vomitus (> 1 million virus particles/ml). It is estimated that fewer than 100 norovirus particles can make a person sick. Contamination can occur either by direct contact with soiled hands or environmental surfaces that are contaminated with stool or vomit, or by tiny droplets from vomit that can become airborne. Although the virus cannot multiply outside the human body, once food, water, or fomites (environmental surfaces: furniture, railings, carpeting, doors, etc) are contaminated they can cause illness.

### 1. Personal Protective Equipment

- Disposable gloves – during patient contact and environmental disinfection measures
- Masks and/or face shield - may be necessary for contact with patient while vomiting and during disinfection of surfaces or materials contaminated with vomitus or feces that may become aerosolized
- Disposable gowns and booties - may be necessary to protect workers during extreme cleaning conditions of vomitus and feces and to avoid contaminating work clothing that could come into direct contact with other surfaces or persons

### 2. Disinfection and Sanitation

- Housekeeping staff should wear PPE when vacuuming, cleaning contaminated or potentially contaminated surfaces, or laundering
  - Minimize aerosolization while cleaning
- Use a bleach solution to frequently clean *all* common surfaces, as often as once per hour
  - The recommended disinfectant is *freshly made* 1:10 bleach solution (e.g. 1 cup bleach to 9 cups water)
  - Use a new freshly made bleach solution between each room or area cleaned
  - For surfaces that could corrode or be damaged by bleach, rinse the sanitized area with water or a 70% alcohol solution after applying the bleach solution
  - Commonly used quaternary ammonium disinfectants *are not* effective against norovirus
- Visible debris should be cleaned up with disposable absorbent material (double bag and discard)
- Contaminated carpets, upholstery, and mattresses should be steam cleaned at ≥158°F for 5 minutes or 212°F for 1 minute or cleaned with detergent, hot water (≥170°F), and hypochlorite (if bleach-resistant)
  - Carpets and upholstery must be allowed to air dry (or with assistance from a fan) before the area can be considered useable
- Linens (including clothes, towels, tablecloths, napkins, etc.)
  - Soiled items (with vomit or stool) must be separated from non-soiled items before laundering
  - Launder in 160°F at the maximum cycle length and add bleach during the rinse cycle (if possible)

- Dry at a temperature  $\geq 170^{\circ}\text{F}$

### 3. Contact Prevention

- Isolate ill persons from others by confining them to their rooms
- Group ill people together if possible in the same unit or section
- Group activities should be kept to a minimum or postponed until the outbreak is over
- Do not allow foodhandlers to come into contact with ill persons or infected units; this could mean nurses serving the meal trays directly to the ill persons
- It may be prudent to discontinue visitation until the outbreak is over
  - If visitation is allowed, visitors should go directly to the person they are visiting and not spend time with anyone else
  - They should wash their hands upon entering and leaving the room
  - They should not visit if they are sick
  - Signs should be posted explaining the risk of infection of ill patients/residents and ill visitors

### 4. Staff

- Interview each employee at the start of their shift regarding vomiting and/or diarrhea
- Exclude ill staff until asymptomatic
  - Private facilities may enact longer exclusion measures once asymptomatic due to prolonged shedding of the virus, ie: 72 hours after the cessation of symptoms
- Staff should be assigned to work with either well residents or sick patients/residents, but should *not* care for both groups
- Staff should wash and dry their hands when entering and leaving *every* patient/resident with soap and water for at least 20 seconds
  - During outbreaks, *do not* use alcohol sanitizers as a replacement for washing hands; many viruses are not affected by alcohol
- Staff should wear PPE when caring for ill patients/residents or when touching potentially contaminated surfaces
  - Gloves should be discarded and hands washed immediately after completing patient care

Please contact your local health department for assistance as soon as an outbreak is suspected. The ISDH laboratory can provide free testing of patients/residents and staff during an outbreak. During hospital outbreaks, we encourage hospitals to test their own bacterial agents as this will ensure a faster turn around of results. However, ISDH will test for both bacterial and viral agents upon request.

### References

1. The Alaska Department of Environmental Conservation. [www.dec.state.ak.us](http://www.dec.state.ak.us)
2. The Centers for Disease Control and Prevention (CDC). <http://www.cdc.gov/nceh/ehs/Topics/norovirus.htm>
3. The Michigan Department of Community Health. [www.michigan.gov/mdch](http://www.michigan.gov/mdch)
4. *MMWR*. (June 1, 2001). "Norwalk-Like Viruses" - Public Health Consequences and Outbreak Management. Vol.50, No. RR-9.
5. The Virginia Department of Health. [www.vdh.virginia.gov](http://www.vdh.virginia.gov)

## ICFMR Question and Answer

Below are questions recently submitted by some ICF-MR certified providers exploring options of new living environments for individuals with significant behavioral issues. Many of the issues raised are pertinent to situations current providers may face. Therefore, the questions are being included in this edition of the newsletter.

### ***1. Need a W197-W198 tutorial.***

The interpretive guidelines at W198 indicate individuals with the following characteristics do not necessarily require a continuous active treatment program in order to function or to achieve optimal independence.

If the individual transferring to the ICF-MR is already receiving the ICF-MR benefit in another certified ICF-MR, there should be little question as to if the individual can continue to receive the ICF-MR benefit, because the requirements for the two facilities are the same set of requirements, and the individual should have already been approved based on assessed needs in the previous placement. The only difference would be if the individual had made significant progress in the former ICF-MR and was very close to having acquired the skills necessary to live in a setting which didn't require active treatment.

Interpretive guidelines include individuals:

- Are independent without aggressive and consistent training;
- Are usually able to apply skills learned in training situations to other settings and environments;
- Are generally able to take care of most of their personal care needs, make known to others their basic needs and wants, and understand simple commands;
- Are capable of working at a competitive wage level without support, and to some extent, are able to engage appropriately in social interactions;
- Are engaged in productive work within the facility which is done at an acceptable level of independence (i.e., not done as part of a training program to teach the individual new skills);
- Are able usually, to conduct themselves appropriately when allowed to have time away from the facility's premises; and
- Do not require the range of professional services or interventions in order to make progress.

We do know that CMS has a current "Active Treatment Workgroup" which is attempting to come up with additional interpretive guidelines to assist surveyors and providers with determining who needs continuous aggressive active treatment. In the meantime, given that an ICF-MR is designed to teach adaptive daily living skills to successfully live in community settings, if a person has those skills, but psychiatric or behavior issues alone require a 24-hour setting which would prevent a person from learning to access the community (i.e. need for a locked facility with little opportunity to encourage or practice skills toward independence), the placement may be questioned. A significant lack of necessary social skills, attributable to the individual's diagnosis of mental retardation or a developmental disability (not psychiatric diagnosis alone), which would make them

vulnerable in community settings if left independently could be considered active treatment needs, if the level or intensity of the needs required aggressive training and behavioral intervention. This should be considered along with an individual's other identified needs and included in appropriate individual program planning.

W198 is cited when isolated findings of individuals not in need of active treatment services are admitted to the facility. If more than 50% of the facility's population is found to not be in need of active treatment services, as defined above, then W197 is cited along with the Condition of Participation: Active Treatment and the facility would face potential termination of the ICF-MR certification.

***2. Surveyors have, on occasion, insisted that people be moved from the facility when there have been issues (assault, aggression) of this kind. Given that our homes represent the system's last defense for people who will (predictably) offend toward one another, what can be done to massage the current practice so that people are not kicked out of placement when the behavior in question is the reason they are there?***

ISDH surveyors should not be insisting or recommending that people be moved from facilities. If a facility is cited at W197-W198 it is up to the facility's IDT team to determine if the individual(s) have alternative funding sources and if the facility can continue to serve individuals without the ICF-MR benefit. When a facility admits an individual to its ICF-MR, the facility agrees to meet the client's needs including but not limited to, active treatment, safety, behavior, and the need to ensure individual rights are proactively taught, and encouraged to be exercised. These rights include that every individual has the right to be free from physical, sexual and psychological abuse and neglect. If an individual displays behaviors that threaten, intimidate or harm themselves or other individuals admitted to the home, the facility must implement sufficient safeguards to prevent the occurrence of abuse. When those safeguards prove to not be sufficient and others are injured (harmed physically or emotionally) then the facility becomes non-compliant at ensuring clients the clients' rights to be free from abuse. ISDH would be required by the federal contract with CMS and the CMS State Operations Manual to consider if an Immediate Jeopardy exists and to cite the facility at appropriate the Condition of Participation(s) and/or standards. The facility may choose to move an individual to remove potential for future harm to others as a response to a deficient practice, but it is the decision of the facility and the individual's IDT. But the facility is required to determine and implement sufficient safeguards. ISDH does review and approve plans of correction which must include those safeguards when a deficiency occurs. If the ISDH review finds the Plan of Correction is insufficient, it is referred back to the facility to be amended. It is still up to the facility to determine the next course of action.

***3. Flight behavior is likewise predictable. In the past, surveyors has not been receptive to alarm systems on primary entrances even where consumers/guardians have consented and HRC approved it. Will this be handled differently, especially given Braddock's suggestion that homes have delayed egress locking systems?***

Alarm systems that are not intrusively loud (which affect the level and comfort of other residents) have been allowed to exist in homes, when used as a home security system. When an alarm is present surveyors are expected to ask about the purpose. If the reason is to control and monitor behavior of certain individuals, surveyors will look to see that individual rights issues have been addressed. For the individual(s) with the behavior, has the problem behavior requiring the use and alarm been addressed? Does the record indicate that the benefits of the use of the alarm outweigh the risk to the individual's rights? Is there an appropriate training plan to address the behavior which requires the alarm? Is the alarm being used in place of appropriate staff supervision relative to the client need? Has the restrictive technique been incorporated into a program designed to reduce the need for the restriction? Has the client and/or guardian provided written consent for the program? And has

Human Rights Committee approved the use of the alarm as a behavioral intervention? For individuals not identified as needing an alarm to monitor their movement, Surveyors will observe to see staff response to the alarm, and if clients not requiring the alarm are allowed freedom of movement without restriction. Regarding delayed egress, if doors are locked, surveyors will inquire regarding the need for locks using the same questions above. Surveyors would also look to see if individuals understand the concept of delayed egress and the potential a delayed egress system could have on an individual's current skills to independently use an entrance/exit. For individuals with significant cognitive abilities, a delayed egress door could have an adverse affect on the individual's current ability to understand the right to access of entrances and exits. This could have future implications on individual's ability to self-evacuate in the event of a fire. Delayed egress systems should be considered very carefully. While a home currently might have an entire census of individuals who are assessed as needing the system and understand the system, a future potential resident may not present with the same needs, or may not understand the concept of delayed egress. In those cases the system may have to be disabled in order to remain in compliance, making it a costly system not in use. In any case, for individuals not assessed as needing the restrictive techniques, the facility would be required to proactively ensure the right to freedom of movement for those clients, which would include ensuring provision so the right could be exercised independently (for example allowing those clients a way to independently unlock the door without the need for staff assistance.) It should be noted that there are systems available today to track and monitor individuals which do not impact the rights of others nearby.

***4. Also, there is a question about who and how individuals are forced to leave a group home, and if they don't leave, the certification of the home being in jeopardy. Does the term "198" help to identify this process? Is it a local process? Federal process? From Health?***

See responses to #1 and #2 above. The federal regulations require that individuals admitted to an ICF-MR be in need of and receiving Active Treatment Services. The definition of Active Treatment is found in the Interpretive Guidelines at W196 (which are too lengthy to be cited here) but can be found in Appendix J of the State Operations Manual provided by CMS and available online at [http://cms.hhs.gov/manuals/Downloads/som107ap\\_j\\_intermcare.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_j_intermcare.pdf)

***5. W 104: This tag addresses the Governing Body's responsibility to provide direction over the facility. It is often used when the Surveyor finds an area needing maintenance. We have found over the past few years that you can have the most beautiful home but if there is 1 dent on a wall they will cite you. This expectation seems unrealistic in a High Support home that will get hard usage.***

The governing body is expected to develop and implement a system to ensure the home remains in good repair and that the system shows maintenance needs are addressed within a timely fashion as they arise. When there are maintenance concerns or repair needs and the facility cannot demonstrate a system which shows the need has been identified and in a timely process of being addressed, then W104 is expected to be cited. This has been supported by past federal look-behind surveys and federal DOJ visits which both found patterns of unaddressed environmental issues in various group homes between state surveys.

**6. W124 (W125) - Ensure clients are not subject to abuse or punishment including injuries of unknown origin, placement with aggressive/assaultive individuals in the absence of adequate supervision and monitoring systems that prevent incidents from occurring. This also includes individuals feeling threatened.**

W124 and W125 address rights of individuals served by the ICF-MR. W125 specifically addresses the facility's need to proactively ensure individuals exercise their rights as clients of the facility. This could include the need to address grievances by individuals who express to the facility that they feel threatened or intimidated by others in the facility. CMS Region 5 has had provided recent clarification that an Immediate Jeopardy could exist in situations where clients feel or express that they are threatened by the actions of other individual's in the home, if, based on past history and actions, the potential exists for those individuals to be injured or harmed by the threatening client. ISDH recently cited at a Condition-level finding situations of client to client intimidation but without significant injury, where there was no staff intervention. CMS reviews of those findings determined the State Agency should have considered an Immediate Jeopardy based on the potential harm to the other residents. Appendix Q of the CMS State Operations Manual defines Immediate Jeopardy and the triggers surveyors use to determine if an Immediate Jeopardy exists. W157 addresses the facility's need to take sufficient action to prevent another occurrence once it has been determined, based on history or assessment that a potential for abuse, neglect mistreatment or injury exists. Failure to take sufficient action would result in a deficient practice and potentially lead to an Immediate Jeopardy finding, based on the specifics of the situation.

**7. W128- Ensure that clients are free from unnecessary drugs and restraints, chronic use of restraint may indicate that the individual's needs are not being met and appropriateness of placement should be questioned.**

The use of restraints is allowed by the federal regulations, but there are a number of regulations found between W266 and W317 (general to restrictive interventions) and specifically W295 to W307 (which address the use of restraints specifically.) Restraints should be used as a last resort and only to protect an individual from harming themselves or someone else. If it is used once as an emergency measure it is considered a best practice for the individual's IDT to meet and determine why the restraint was needed and the potential it may be required again in the near future. If it was determined the behavior was isolated and not likely to reoccur in the near future, then the use could be considered as an isolated emergency measure to protect the individual or others. But if it is determined there is the potential for reoccurrence then the restrictive restraint technique needs to be incorporated into the client's overall plan as an intervention, and employed with the sufficient safeguards to protect the individual from harm and protect their rights. ISDH recently had a Condition-level finding regarding injuries that had occurred during restraints, which included bruising, abrasions and minor swelling. CMS region 5 indicated an immediate jeopardy should have been considered based on the fact employees were not able to sufficiently employ the use of manual restraints without preventing injury and the potential existed for a more severe injury. When restraints are used the issues addressed previously will be explored by a surveyor; For the individual(s) with the behavior, has the problem behavior requiring the use of the restraint been addressed? Does the record indicate the benefits of the use of the restraint usage outweigh the risk to the individual's rights? Has the facility ensured the least restrictive type of restraint has been used? Is there an appropriate training plan to address the behavior which requires the use? Is the restraint being used in place of appropriate staff supervision relative to the client need? Has the restrictive technique been incorporated into a program designed to reduce the need for restraint usage? Has the client and/or guardian provided written consent for the program? And has the Human Rights Committee approved the use of the restraint as a behavioral intervention? Additionally, surveyors will look to see how the facility is monitoring the overall use of restraints and is there a pattern of restraints decreasing over time.

## **COP- Active Treatment**

### **8. W196- Continuous active treatment with individuals at all times.**

The components of Active Treatment can be best illustrated in a continuous loop. Accurate assessments lead to program development. Program development leads to program implementation (See response to question #9). Accurate data taken during implementation indicates the results of the effectiveness of the overall program planning. Review of that data leads back to the top of the loop (reassessment) and program revision occurs when necessary. When continuous aggressive Active Treatment breaks down, it can usually be traced to one or more of those components that are missing or dysfunctional. If a person is truly in need of adaptive daily living skills training (developmental, social, behavioral), training (formal and informal opportunities) should be evident at various times throughout the day. While your plan may call for data to be taken on a certain schedule, Active Treatment would involve consistent implementation of the training plan throughout the day, as the opportunity occurs. You don't necessarily need to take data during those informal opportunities, but staff should be knowledgeable to implement the program to further train or reinforce the skill being taught in the plan.

### **9. W249- Continuous active treatment should be evident by individuals performing scheduled active treatment activities. (Activity Schedules)**

W249 is the outcome standard regarding the development of the individual program plan. The IPP documents the training and behavioral strategies designed to address identified needs. Since Active Treatment is defined to be continuous and aggressive, implementation of training and behavioral strategies defined in the IPP should be visibly evident during observations both in formal training sessions and informal opportunities. If a person's training needs are behavioral, we would expect to see implementation of proactive behavior reduction and replacement behavior strategies throughout the day as well as reactive techniques when the behavior occurs.

### **10. W250- Active treatment schedule defined (too rigid)**

While a prescriptive "process requirement" of the federal regulations, surveyors will usually only ask to see Active Treatment schedules when they have concerns regarding the intensity and frequency of program plan implementation. The interpretive guidelines at W250 state:

*"to the extent possible, the schedule provides a range of options, rather than a fixed regimen. Individuals should have opportunities to choose activities and to engage in them as independently and freely as possible. Staff routines and schedules should be supportive of this goal and result in the presence of reasonable choices by individuals."*

While Active Treatment schedules are a requirement, the facility can and is encouraged to develop them in a manner that allows flexibility and the right to exercise client choice. Yet the facility still is required to implement the program plan objectives in sufficient number and frequency to support progress toward identified objectives. If an individual continually refuses to participate in Active Treatment services, the facility, as an active treatment provider, may have to determine if they can meet the needs of the client, remembering that the individual has the right to refuse the services of an ICF-MR (W124).

### **11. W263- Programs conducted with consent of individual or legal guardian (worried about obtaining consent from the individuals who don't have a guardian. Will State establish guardianships prior to people moving? Most of the clients identified for these homes do not have guardians. Will be an issue once they come into the group homes. Jon Cooper has stated that most of the individuals who do not have guardians do not need one. I have not seen any packets so cannot verify that.**

If individuals, who have not been adjudicated incompetent, are capable of understanding the issues to which they are consenting, then they can and should be encouraged to decide for themselves if they want to pro-

consent. This would include an individual, for example, being able to understand the purpose and reason a behavioral control medication is prescribed, the risks of the use of the medications and the right to refuse as well as understanding the potential ramifications of refusal. When a surveyor finds an individual who has restrictive behavioral techniques, significant medical concerns, and/or financial affairs being managed by others or other rights issues being affected, surveyors review assessment data and interview to determine if the client has the ability to make informed decisions in their own interest. Individuals who function at a more independent level or individuals with no major life decisions may not require the need of an appointment of a guardian or health care representative. But if the status changes during placement, the facility meeting the needs of the individual would be required to proactively ensure the client's right to due process is being met, which might be assisting the client in finding a guardian or health care representative (for health and treatment issues) should a need arise.

***COP- Client Behavior and Facility Practice***

***12. W278- Prior to the use of more restrictive techniques, client records must indicate the use of less restrictive techniques tried first have proven to be ineffective. This includes drugs and physical restraints.***

Yes, the record should document lesser restrictive, more positive techniques, in keeping with the philosophy of least restrictive environment. However, if a client is admitted to the facility, from another ICF-MR, verification of that documentation from the other ICF-MR in preliminary assessment data would be acceptable in setting up appropriate plans at admission. The new ICF-MR must take into consideration that changes in environment many times have an effect on behaviors (i.e. smaller settings have been known to decrease behaviors). The facility would need to be proactive in reducing restrictive techniques when it is determined the new environment is having a positive effect and is eliminating or reducing the need for restrictive interventions. A facility cannot employ restrictive techniques simply on potential, without documented evidence the potential truly exists and need is warranted based on recent past history and assessment.

***13. W304- Restraints must be designed and used so not to cause injury to the client. (I know this seems normal, but in the interpretation it talks about the use more than the design. I am just wanting some clarification because I see that there may be a bigger potential for injury.)***

Refer response to #7 above. In addition to the above, the use and design of restraints are equally important. If restraints are going to be used then it has to be ensured the restraint techniques can be employed without injury. If a facility cannot use restraints without injury then the facility's IDT team needs to identify a different way of keeping the individual and others safe.

***COP- Physical Environment***

***14. W407- The facility must not house clients of grossly different developmental levels and social needs.***

The interpretive guidelines state "individuals should live in the least restrictive grouping in keeping with their level of functioning. Prime consideration in the grouping of individuals is made according to social and intellectual development, friendship patterns, and commonality of interests." In addition to situations where wide discrepancy in ages exist which is addressed in the interpretive guidelines, it could also be considered a deficiency if you admit an individual with more independent skills into a home where every other client has limited communication skills and the individual with more independent skills does not have the opportunity to interact with peers in his functioning level. If an individual with more independent skills is aggressive and other residents are vulnerable, due to their functioning level and skills, this could also be a concern, but it would more likely be addressed at other standards.

**15. W122 Immediate Jeopardy: According to ISDH most immediate jeopardizes are cited for client-to-client abuse and because a family member or a neighbor has called in a complaint or concern. We could address the family issue by being very clear up front about the nature of the home and the issues we are dealing with. Controlling neighbor complaints is a much harder issue and may be a problem. Sue Hornstein indicated that safeguards could be put in place within the home, which can prevent the client from having to leave. What are the strategies and safeguards we could provide in the home that would be acceptable to ISDH?**

The safeguards in the home must be based on individually-assessed needs of those admitted to the home. The ICF-MR regulations do not permit a provider to employ systemic blanket restrictions that apply to all individuals residing in the home, unless the individuals are all assessed to require the restrictive intervention. In that case, the facility would have to be prepared to individually remove the need for the restrictive interventions as individuals show progress toward successful completion of behavioral goals, and this would most likely occur at individual rates. This means client A might have successfully completed gaining some skills necessary to remove or lessen the need for a restrictive technique, while client B has not progressed and still requires the full intervention. The facility would be required to remove or lessen the restriction for client A, while also responsible to continue to ensure the safety needs for client B are met. It should be noted that client to client abuse complaints come from many different sources, not just parents or neighbors. Under the ICF-MR regulations, the facility is required to prevent client to client aggression when it is aware the potential for the behavior can occur, regardless of what consents are provided by the parents.

**16. Assessments: Typically developed within 30 days after a person moves in. This scenario will not be successful with a group that needs a well thought out plan in place starting day 1. Can we complete the assessments prior to them moving in?**

If a client is admitted to the facility, from another ICF-MR, verification of that documentation from the other ICF-MR in preliminary assessment data would be acceptable in setting up appropriate individualized plans at admission. The new ICF-MR must take into consideration that changes in environment many times have an effect on behaviors (i.e. smaller settings have been known to decrease behaviors) and be proactive in reducing restrictive techniques as it is found the new environment is having a positive effect and is eliminating the need for restrictive interventions. A facility cannot employ restrictive techniques simply on potential, without documented evidence the need is warranted based on recent past history and assessment. If an individual is a choking risk or has swallowing difficulties, or has elopement behaviors, or needs adaptive equipment, regulations would require the facility address those needs at admission, based on prior admission assessment data. The facility is required to still assess the individuals within 30 days in order to have a baseline in the new environment, and assess for changes in status the new environment may affect.

**17. W195, W196, W197, W198, W242 / Active Treatment: In a group home, clients must receive continuous active treatment in basic fundamental skill areas. Basic skill areas include: toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs.**

If these areas are identified areas of training needs, these would need to be addressed in the individual program plans as part of the Active Treatment program.

**18. The guidelines in W242 states: "The receipt of training targeted toward amelioration of these most basic skill deficit areas is a critical component of the active treatment program needed by individuals who are eligible for the ICF/MR benefit, and therefore, is a required ICF/MR service." Many of the clients will need active treatment training to address behavioral issues but may function fine in the other domains of daily living. Does continuous behavioral training count towards the Active Treatment tags?**

See response to #1 above.

**19. Safety and Security Features/ Falls under Client Rights: Will we be allowed to lock up items? Have alarms? Cameras? Locked fence? Limit access to thermostat control?**

If a client has a pattern of repeated falls and there is a potential for injury, the facility must address to prevent injury, assess the reason the falls are occurring and provide necessary treatment to reduce falls while being proactive in preventing regression of skills. If a medical assessment indicates adaptive devices are needed to assist and protect the resident, the facility must provide those devices.

The need to have items locked should be based on individual personal assessment and addressed individually, addressing the program plan and human rights issues previously discussed in other questions. For those individuals not assessed as needing to be locked from access to items, provision needs to be made so they can independently, without staff assistance remain to have access while protecting individuals for which access would be a danger.

For alarms see #3 above.

Cameras are currently permissible in public access areas of long-term care facilities. The privacy needs of individuals (W129 and W130) would have to be ensured. Cameras would be considered a restrictive technique, if and when used to monitor specific individuals and are outside of public areas. Rights and programmatic issues previously discussed would be explored by the surveyor. Additionally, in these cases care would have to be exercised to ensure other individuals (i.e roommates or other housemates), not needing the monitoring, are not filmed by the camera.

Locked fences again would need to be based on individual assessment. Just because all individuals in the home have behaviors does not mean that a locked fence would be appropriate. Remember, an ICF-MR model is based on the least restrictive intervention philosophy. If a fence is determined by the facility's IDT to be appropriate to address the assessed behavior of specific individuals, the rights and programmatic issues previously discussed would be explored by the surveyor. Those individuals who reside in the home and do not require a locked fence would have to be provided with a way of independently (without staff assistance) gaining access. The fence also needs to be constructed relative to the character of the community. While a backyard privacy fence can fit in with the neighborhood, a fence surrounding the entire property, and is locked to prevent any resident's egress, may be found to be inappropriate for an ICF-MR, which by definition is designed to allow, teach and support community integration.

**20. W436: Can we limit adaptive equipment such as glasses, hearing aids, etc when there is a history of destruction? The regulation says with must furnish, maintain in good repair, and teach clients to use and to make informed choices about adaptive aids. It does go on to say that we must do this to the extent of the capabilities.**

If a person requires the use of adaptive devices, the facility must furnish, maintain in good repair and teach the use of those devices. The facility may find it necessary to limit access to adaptive devices for those who have a documented history of inappropriate care for the adaptive device and lesser restrictive training techniques have been attempted. In those cases a surveyor would look to see that the client is provided and/or being taught to use the devices when the opportunity is present or the device is needed. The restriction of access would need to be programmatically addressed and the rights issues previously discussed with restrictions would need to be addressed.

**21. Life Safety Issues: What if client refuses to exit or participate in a fire/tornado drill?**

From a Life Safety Code perspective the home would be rated as impractical during a life safety code survey and there are requirements an impractical home would need to meet.

An ICF-MR surveyor would have to consider if the refusal poses a risk to the individual or others, based on assessment data, interviews and records. The surveyor would explore how the facility would react with a refusal in the event of an emergency, and if the emergency drill has been anticipated and practiced. This could lead to a potential Immediate Jeopardy finding. In this situation surveyors would also refer to W448 and W449 to evaluate if the facility's drills are identifying potential evacuation problems and taking appropriate steps to resolve those issues.

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-22

**DATE:** July 14, 2006

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Privacy and Security of Beneficiary Information

**TO:** Survey and Certification Regional Office Management (G-5)  
State Survey Agency Directors  
All Contractors that Support Survey & Certification Functions

Letter Summary

Reminds survey and certification staff, State Survey Agencies, and Contractors that support survey and certification functions of the importance of protecting the privacy and confidentiality of personally identifiable health information.

Reminder to report to CMS management any breaches in ensuring privacy and security of beneficiary information.

The Centers for Medicare & Medicaid Services (CMS) wants to remind all Federal Survey & Certification Staff, State Survey Agencies, and Contractors who support Medicare survey and certification activities, of their obligation to abide by all Federal and State laws regarding confidentiality and disclosure of medical records, and other personally identifiable health information.

We further remind organizations of the necessity of effectively securing all beneficiary personally identifiable information, whether in paper or electronic format, in all locations, including the office, at home, in lodging quarters, at the provider site, and also when being transported. This includes ensuring that personally identifiable health information or data files are not saved on public or private computers when accessing corporate e-mail through the Internet and ensuring electronic systems are properly programmed for beneficiary mailings. Organizations should annually train staff on responsibilities to safeguard beneficiary information and the consequences of failing to secure sensitive beneficiary information. All organizations should either perform an internal risk assessment or engage an industry-recognized security expert to conduct an external risk assessment of the organization to identify and address security vulnerabilities. Weaknesses or gaps in your security program should be quickly remedied.

CMS considers security breaches involving beneficiary personally identifiable information to be an indication of an organization's significant non-compliance with the privacy and confidentiality

provisions in the 1864 Agreement or contracts. Failure to adhere to CMS contract terms or Agreement could lead to contract termination and/or imposition of penalties, sanctions, or remedies.

Contractors' compliance with the Health Insurance Portability and Accountability Act (HIPAA) Security and Privacy rules must be documented and kept current in response to environmental or operational changes affecting the security of the electronic protected health information. In addition, Survey & Certification staff, State Survey Agencies, and contractors should notify CMS management immediately upon discovery of any security breach compromising beneficiary personally identifiable information. For breaches involving the State Survey Agencies, the CMS Regional Office Survey & Certification management for your jurisdiction should be promptly notified. For breaches among contractors that support Survey & Certification functions, your project officer should be promptly notified.

**Effective Date:** This reflects current policy, guidance and instructions, but reminders to staff, State Survey Agencies, and contractors should take place no later than August 1, 2006.

**Training:** The information contained in this Survey & Certification Letter should be shared with all survey and certification staff, their managers, Survey & Certification Project Officers, and the state/RO training coordinators.

/s/

Thomas A. Hamilton

cc: CMS Survey & Certification Project Officers

Center for Medicaid and State Operations/Survey and Certification

Group

Ref: S&C-06-24

**DATE:** September 14, 2006

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** **Nursing Homes** - Issuance of Revisions to Tasks 2 and 5 as Part of Appendix P, State Operations Manual, and New Tag F334 (Influenza and Pneumococcal Immunizations) as Part of Appendix PP, State Operations Manual, Including Training Materials

### Letter Summary

- New guidance for long-term care surveyors regarding the provision of Influenza and Pneumococcal Immunizations becomes effective October 15, 2006.
- An advance copy of this guidance and training materials are attached. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the new guidance by the implementation date.

The Centers for Medicare and Medicaid Services (CMS) published a final rule on October 7, 2005 (70 FR 58834) that requires Medicare and Medicaid participating nursing homes to provide residents with the opportunity to be immunized against influenza and pneumonia. New surveyor guidance including interpretive guidelines and severity guidance has been developed for the implementation of this new regulation through the new Tag F334 – Influenza and Pneumococcal Immunizations. This new guidance for surveying long-term care facilities is to replace the survey instructions found in S&C-06-03 issued on November 17, 2005 and will become effective October 15, 2006. At that time, a final copy of this new guidance will be available at <http://www.cms.hhs.gov/Transmittals/> and ultimately incorporated into Appendix PP of the State Operations Manual. In addition, revisions to Appendix P (Task 2 – Entrance Conference and Sub-Task 5C – Resident Review) will be made at the same time to incorporate the new immunizations survey protocol.

Here we are providing an advance copy of the new Influenza and Pneumococcal Immunizations guidance, which contains the interpretive guidelines, investigative protocol, and deficiency categorization. The interpretive guidelines provide terminology and information regarding the provision of immunizations that surveyors will need to apply the guidance. The investigative protocol explains the investigation's objectives and procedures surveyors will need for their investigation and determination of compliance. The deficiency categorization provides criteria for the determination of the correct level of the severity of outcome to any resident(s) from any deficient practice(s) found at Tag F334. In addition, we have provided an advance copy of the revisions that will be made to Appendix P Task 2 – Entrance Conference and Appendix P Sub-Task 5C – Resident Review in order to incorporate the new immunizations survey protocol.

Also attached to this memo are training materials for the new Tag F334. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in this new guidance by the implementation date. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

Regional Office (RO) and State Survey Agency (SA) training coordinators shall document the completion of training on this new guidance for all RO and State nursing home surveyors within their region utilizing the Learning Management System (LMS) – a course code will be provided through one of the Survey and Certification Regional Training Administrator (RTA) teleconferences.

Enclosed with this memorandum are the following files:

- Advance copy of Influenza and Pneumococcal Immunizations – (PDF);
  - Training Instructor Guide – (PDF); and
- PowerPoint presentation file – (PowerPoint file).

For questions on this memorandum, please contact Susan Joslin at 410-786-3516 or via email at [Susan.Joslin@cms.hhs.gov](mailto:Susan.Joslin@cms.hhs.gov)).

**Effective Date:** October 15, 2006. The State Agency should disseminate this information within 30 days of the date of this memorandum.

**Training:** The materials should be distributed immediately to all State Agencies and training coordinators.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosures: Advance copy of Influenza and Pneumococcal Guidance  
PowerPoint Presentation  
Training Instructor Guide

**Enclosures can be viewed at the following link under downloads:**

[http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?  
filter-  
Type=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1186856  
&intNumPerPage=10](http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filter-Type=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1186856&intNumPerPage=10)

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-12-25  
Baltimore, Maryland 21244-1850



~~Center for Medicaid and State Operations/Survey and Certification Group~~

**Ref: S&C-06-29**  
(Revised: 9-20-06)

**DATE:** September 20, 2006

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** **Nursing Homes** - Issuance of Revised Surveyor Guidance for Unnecessary Medications (F329) and the entire Pharmacy Services section at §483.60 (collapsing current regulatory language into three tags (F425, F428, and F431) in Appendix PP, State Operations Manual, as well as medication related revisions in Appendix P Task 5 and Sub-Tasks 5A, 5C, and 5E: **REVISED**

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**NOTE:** An advance copy of the Interpretive guidance for F329 (unnecessary drugs) was originally issued on 9-15-06. The copy released on 9-15-06 contains erroneous information. The corrected version is attached to this communication. **Please delete the previous version.**

The following dosages have been changed in the Table 1 listing of medications:

- Clorazepate was inadvertently listed as 5 mg and has been revised to read Clorazepate 15 mg.
- Diazepam was inadvertently listed as 1.5 mg and has been revised to read Diazepam 5 mg.
- Clonazepam was inadvertently listed as 7.5 mg and has been revised to read Clonazepam 1.5 mg.

The original letter with corrections noted above follows:

#### Letter Summary

- Revised guidance for long-term care surveyors regarding Unnecessary Drugs, Pharmacy Services, Drug Regimen Review, and Labeling and Storage of Drugs and Biologicals will be effective December 18, 2006.
- ASPEN System changes in preparation for these revisions will be effective at the same time.
- An advance copy of the guidance and training materials is attached. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in the revised guidance by the implementation date.

Revised surveyor guidance for surveying Unnecessary Drugs, Pharmacy Services, Drug Regimen Review, and Labeling and Storage of Drugs and Biologicals and is scheduled to become effective December 18, 2006. At that time, a final copy of the new guidance will be available at <http://www.cms.hhs.gov/Transmittals/> and ultimately incorporated into Appendix PP of the State Operations Manual. (Note: System changes will be effective the same date.)

We have entirely revised interpretive guidelines for F329, Unnecessary Medications, including clarifications of several aspects of medication management and a new medication table that Page includes medications that are problematic to the nursing home population. We have provided an Investigative Protocol that also covers both Medication and Medication Regimen Review issues. and severity guidance for F329.

For Pharmacy Services at §483.60, we have combined regulatory guidance presently at Tags F425-431 into three remaining tags, F425 Pharmacy Services, F428 Drug Regimen Review, and F431 Labeling and Storage of Drugs and Biologicals. The new guidance speaks to the provision of pharmaceutical services for the entire distribution system, from ordering and acquisition to administration and disposal of medications to assure a safe system for each resident. We have also provided severity guidance for each of these F Tags.

Due to these changes to surveyor guidance in Appendix PP, we have made corresponding changes to certain survey tasks as follows:

- Task 5 – text added that describes the assessment of pharmaceutical services;
- Sub-Task 5A – text revised to state that each surveyor completing a medication pass observation will review drug storage on their assigned units;
- Sub-Task 5C – text added to guide the surveyor to use the investigative protocol for F329 for each Resident Review, deleted adverse drug reactions section of 5C, part G3; and Sub-Task 5E. – complete revision of text and renaming of 5E as Medication Pass and Pharmacy Services.

We are providing an advance copy of the revised guidance for Appendix P and PP. Also attached to this memorandum are training materials for the revised F Tags and the survey process changes. This training packet is to be utilized in assuring that all surveyors who survey nursing homes are trained in this new guidance by the implementation date. The training materials have been presented and discussed in teleconference with the CMS Regional Offices. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

RO training coordinators will document the completion of training on this new guidance for all RO and State nursing home surveyors within their region.

We will be providing additional training for F329, Unnecessary Medications in two two-day train-the-trainer sessions in Baltimore in November, 2006. Attendees of these sessions will be responsible for training surveyors on F329. In addition we will broadcast a satellite presentation on F329 on December 15, 2006 at 1:00 p.m. EST.

For questions on this memorandum, please contact Beverly Cullen at 410-786-6784 or via email at [Beverly.Cullen@cms.hhs.gov](mailto:Beverly.Cullen@cms.hhs.gov).

Page 3 – State Survey Agency Directors

**Effective Date:** The State Agency should disseminate this information within 30 days of the date of this memorandum.

**Training:** The materials should be distributed immediately to all State Agencies and training coordinators.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Enclosures:

Advance Interpretive Guidance for Tags F329(REV), F425, F428 and F431;  
Advance Appendix P changes;  
Training Powerpoints; and  
Training Instructor Guide

**Enclosures can be viewed at the following link under downloads:**

<http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?>

[filter-](#)

[Type=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1186880&intNumPerPage=10](#)

Center for Medicaid and State Operations/Survey and Certification Group

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Ref: S&C-06-30

**DATE:** September 29, 2006

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Nursing Homes – Exceptions to the Observation Requirement When Determining Significant Medication Errors

**Letter Summary**

Current interpretive guidance in the State Operations Manual at F333 directs surveyors to observe a medication preparation or administration before citing significant medication errors.

This letter revises that guidance and clarifies that it is acceptable for nursing home surveyors to cite a significant medication error at F333 based upon either resident review, and/or observation of medication preparation or administration.

The purpose of this memorandum is to clarify that it is acceptable to cite a significant medication error at F333 (CFR §483.25(m)(2)) in the absence of a medication pass observation, under certain circumstances. This clarification will soon be reflected in new surveyor guidance for unnecessary medications and pharmacy services.

The “Guidance to Surveyors” located in the State Operations Manual (SOM), Appendix PP, at F332 and F333 categorizes medication errors as either “significant” or “non-significant.” A “Significant medication error” is defined at F333 as one that causes the resident discomfort or jeopardizes his or her health and safety. The guidance indicates that professional judgment is used in the determination of whether a medication error is significant based on:

- The resident’s condition;
- The drug category; and
- The frequency of the error.

Current guidance provides direction for surveyors to cite medication errors at F332 and F333 when the preparation or administration is observed. Surveyors therefore have not cited F333 for medication errors, even if those errors were significant, unless they occurred during an observed medication pass. Instead, surveyors have cited tags that are more general and less appropriate for the nature of the non-compliance, such as F309 “Quality of Care.”

The underlying principle for identifying any medication error is the presence of evidence that the medication was delivered, administered, or managed in a manner not in accordance with physician's orders, manufacturer's specifications, or acceptable professional standards of practice. Citation of a deficiency at F333 requires the presence of evidence, whether based on reviews, interviews, observations or any combination. While observation is the preferred measure for citing medication errors, it is possible to cite medication errors based on a collection of supportive corroborating evidence from other sources. One example would be the result of a hospital's investigation that found that the wrong medication was administered to the resident in the nursing home by nursing home staff, contrary to physician's orders. Another example of the type of evidence that would support a finding of medication error at F333 would be the identification of an uncharacteristic change in the resident's condition that was determined to be the result of an error in the medication administration practice of the facility. In addition, the evidence supporting the medication error would be further substantiated by literature published by professional organizations, accreditation bodies, or other regulatory agencies.

The following three examples illustrate situations when observation of a medication pass would not be necessary to identify **significant** medication errors:

- A surveyor investigation found that a resident's family member reported to the local ombudsman that their family member received the wrong dose of Synthroid over a period of 10 days. The resident had an order for Synthroid 50mcg/day, however the pharmacist filled the prescription with Synthroid 0.5mg/day and the nurse administered the Synthroid 0.5mg (equivalent of 500 mcg/day), ten times the ordered dose, to the resident daily for ten doses. The resident complained of uncharacteristic palpitations and gastrointestinal upset and required hospitalization for symptom resolution.

Synthroid has a narrow therapeutic index requiring careful dosage titration to avoid the consequences of over-medicating. Adverse effects of such over-medication may include alterations in cardiovascular function, bone metabolism, cognitive function, emotional state, and gastrointestinal function. Although the error was not observed in a medication pass by the surveyor, the surveyor identified considerable evidence of the error through interviews with the staff, the resident and their representative, and review of the resident's medical record. Such evidence well supported a finding of non-compliance related to a significant medication error, even without observing a medication pass.

- During a complaint investigation, record reviews and interviews with staff revealed that a resident was administered medications prescribed for her roommate in addition to her own. The resident was administered 15 medications in error, including furosemide, potassium, prednisone, amlodipine, metoprolol, lisinopril, isosorbide dinitrate, gabapentin. Some of the medications may cause adverse reactions such as hypotension, feeling lightheaded or dizzy and increased confusion. An interview with the medication nurse confirmed that she had administered the above medications in error, had not reported the error, but had monitored the resident. The nurse stated that later in the day, she assessed the resident who was exhibiting increased confusion, was cold and clammy and had low blood pressure and pulse oximetry of 90%-91% on room air. The resident was transferred to the hospital for observation and treatment for low blood pressure due to the medication error.

- A review of a resident's medical record revealed that the physician ordered Dilantin 200 mg to be given by mouth daily in divided doses (100 mg given every a.m. and 100 given every p.m.). The surveyor found no other orders for Dilantin followed this order in the resident's medical record. A review of the resident's Medication Administration Record (MAR) identified written directions to give Dilantin 200 mg at 8 a.m. and 8 p.m., every day. The MAR also identified the medication administration nurses' initials recorded by every Dilantin 200 mg in the 8 a.m. and 8 p.m. column for every day from the date ordered until the date of the surveyor's visit. The surveyor interviewed the resident's physician, and together they reviewed the physician's orders. The interview and review confirmed that the order was for 100 mg of Dilantin twice a day. The physician also confirmed that no changes to the order occurred followed the original order. The surveyor interviewed the facility pharmacy supplier and learned that a transcription error 17 days earlier resulted in the Dilantin order being filled at the dose and frequency of 200 mg twice a day. The pharmacy confirmed that the resident's medication drawer was supplied less than twenty four hours prior to the surveyor visit with four 100 mg capsules. The surveyor observed the resident's medication drawer immediately following the interview with the pharmacist and found no Dilantin capsules. The surveyor interviewed one of the medication nurses who initialed and signed the MAR indicating he gave the Dilantin to the resident nine times over the course of seventeen days. The medication nurse confirmed that he gave two 100 mg Dilantin capsules to the resident each time he administered the medication. Although all staff could not confirm or deny giving the wrong dose over the entire course of seventeen days; the interviews with the physician, pharmacist and nurse, along with the review of the medical record, and the observation of the resident's medication drawer, provided the supporting evidence that collectively confirmed the medication error.

While in this example the resident may have received the wrong dose multiple times before the error was identified, Dilantin given above the prescribed dose for even **one dose potentially** has adverse consequences to the resident affecting the central nervous system, gastrointestinal system, and cardiovascular system to name a few. Dilantin given above the prescribed dose may also increase or decrease various lab values. Providers are cautioned to monitor elderly individuals receiving Dilantin because they tend to metabolize Dilantin slowly and may require reduced dosages.

Although there was no observation of a medication pass in any of the above examples, the record reviews and interviews corroborated the presence of significant medication errors.

This memorandum clarifies that a surveyor may cite a deficiency at F333 based upon either resident review, and/or observation of a medication preparation or administration.

Note: Significant and non-significant medication errors observed at 5% or greater should continue to be cited at F332. However, any **significant** medication error included in the F332 (5% or greater) citation should also be cited at **F333**.

For questions on this memorandum, please contact Debra Swinton-Spears at 410-786-7506 or via email at [debra.swinton-spears@cms.hhs.gov](mailto:debra.swinton-spears@cms.hhs.gov).

**Effective Date:** This policy is effective immediately. Please ensure that surveyors and all other appropriate staff are fully informed within 30 days of the date of this memorandum. This policy will be reflected in the next update to the SOM.

**Training:** The information contained in this announcement should be shared with all State and Regional Office nursing home surveyors and supervisors.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-33

**DATE:** September 29, 2006  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Some Basic Principles of Using Photography During the Survey

**Letter Summary**

This memorandum provides information to support State Survey Agencies that choose to incorporate photographic documentation into their survey process.

Although the use of photography during the survey process is not required, State Survey Agencies (SAs) may decide to collect photographic evidence to support a finding of non-compliance. To assist SAs, we wish to share some basic principles that the SAs can use to incorporate photographic evidence into their survey process. As photographs are optional, these principles are a tool and may be used at a State's discretion.

**Effective Date:** Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum, and disseminate the information to affected providers.

**Training:** The information contained in this announcement should be shared with all surveyors and supervisors.

/s/  
Thomas E. Hamilton

Attachment:

cc: Survey and Certification Regional Office Management (G-5)

## **Basic Principles of Using Photography During the Survey**<sup>1</sup>

Although the use of photography during the survey process is not required, the State Survey Agencies (SAs) may decide to collect photographic evidence to support a finding of non-compliance. We are providing some basic principles to assist States if they do use photographic evidence. The SA will be responsible for the acquisition, accountability, and security of the camera and film. The camera and film must be the sole property of the State; surveyors should not use their own personal photographic equipment, including cell phones with photographic capabilities. Additionally, the SA should develop guidance for using photography during the survey process and train staff in the proper use of the camera.

Surveyors may use photography as a tool, supplementing written documentation, to assure accurate and effective records of observations made during surveys with the intent to produce photographs that are relevant to possible deficiencies. However, without written documentation, photographs cannot stand alone and have little benefit.

Photographs may enhance findings of non-compliance by providing visual evidence of injury, scene, or other relevant components of a deficient practice. Photographs should not be included as part of the Form CMS- 2567. Surveyors should only reference photographs in their surveyor notes and not in the statement of deficiencies.

When taking photographs during a survey, remember the following basic principles:

### **1. Request the Resident/Patient/Client's or His/Her Surrogate's Written Permission Prior to Photographing Him/Her**

- Before beginning, ask the individual's written permission to take a photograph, to the maximum extent feasible.
- The health and dignity of the individual is always a paramount concern. A surveyor should respect an individual's refusal to be photographed.
- If the individual's genital or rectal or a female's breast area is photographed in order to document and confirm suspicions of care problems, a member of the nursing staff must be present at the time of observation, and the individual must give written consent.
- If the individual is unable to give consent (e.g., is unresponsive, incompetent), and the individual's legal surrogate<sup>2</sup> is present, ask the surrogate for written consent, unless the legal surrogate is the one suspected of abusing the individual.

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<sup>1</sup> Some material included in this document is from the Illinois Department of Public Health, Division of Long-Term Care Field Operations, "Guidelines for Photographic Evidence."

<sup>2</sup> Any person who may, under State law, act on the individual's behalf when he/she is unable to act for herself or himself

- If the individual is unable to give consent and the individual’s legal surrogate is not present in the facility, then the surveyor may use discretion in determining whether a photograph of the individual’s rectal or genital area (and for females, the breast area) is necessary to support a finding of noncompliance.
- Only a surveyor who is a licensed nurse, a physician’s assistant, or a physician may take a photograph of the individual’s genitals, rectal area, or, for females, the breast area.
- Surveyors should avoid taking pictures that will reveal an individual’s face or other uniquely identifying information that will interfere with that person’s right to privacy.

## **2. Get a Complete Series of Photographs**

Generally speaking, each relevant object in the scene should appear in at least three photographs: an overview, a mid- range photograph, and a close-up.

- Because a close-up does not indicate where the object was located, the overview photograph should cover the entire scene to bring out the relationships between the objects. Leave measuring scales and labels out of the overview photograph.
- The mid- range photograph shows a relevant object and its immediate surroundings.
- Each close-up photograph shows a key detail clearly. Have a “standard” in the close-up photograph to indicate the actual size of what is being photographed.
  - Measure scales and labels may be added to the close-up photograph. For example, placing a ruler with readable graduations next to a pressure ulcer will show its actual size in the photograph.
  - Other standards include tape measures, coins, or a pencil.

## **3. Documentation of Photographs**

A surveyor must handle a photograph of the individual with as much confidentiality as a medical record. Only non-personal identifiers should be used to document the photograph. When preparing the report narrative, any photographs taken must be integrated into the narrative, rather than just referenced. Photographs must enhance, not take the place of written documentation.

A reference in the notes should be made of each photograph even if it did not portray the expected image so there will be a sequential reference to all photographs taken.

- Immediately upon taking a photograph, document in surveyor notes the following:
  - Date;
  - Time;
  - The identity of the photographer;
  - A photograph identifying number (even if just one photograph is taken); Facility name;
  - Survey number, as applicable; and
  - Non-personal identifier.

(Note: Many conventional cameras and digital cameras have the capacity to imprint a date and time on the photographic image.)

- Photographs must enhance, not replace written documentation. A surveyor should be able to recall, after referring to her/his notes, the following information:
  - The object or situation that was being recorded;
  - Facts surrounding the photograph—where the photograph was taken;
  - Who took the photograph;
  - Purpose of the photograph; and
  - Date and time of photograph.
- Do not modify an original photograph. A surveyor who wants to stress a key detail in a photograph should identify the detail by using a transparent overlay that can be removed to show the unaltered print.

### **Examples of Photographic Evidence:**

- Evidence of abuse, such as contusions, bruises, lacerations, or burns
- Evidence of improper and dangerous use of restraints or other devices
- Evidence of improper positioning such as leaning, or hypo- or hyper-extension of neck and/or trunk
- Pressure ulcers
- Contractures
- Safety hazards
- Evidence of extensive pest infestation
- Evidence of faulty or dirty equipment



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-01

**DATE:** November 1, 2006

**TO:** State Survey Agency Directors  
State Fire Authorities

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Provisions of the Final Rule regarding Adoption of New Fire Safety Requirements for the Use of Alcohol Based Hand Rubs (ABHRs) and Installation of Battery Powered Smoke Alarms

**Letter Summary**

This letter highlights the final rule concerning fire safety requirements for Hospitals, Ambulatory Surgical Centers, Nursing Homes, Religious Non-Medical Health Care Institutions, Programs of All-Inclusive Care for the Elderly (PACE) Facilities, Critical Access Hospitals, and Intermediate Care Facilities for the Mentally Retarded.

Regarding ABHRs, the final rule clarifies terminology and adds a requirement for maintenance in accordance with manufacturer's recommendations.

Regarding battery powered smoke alarms, the final rule changed terminology and defined the terms "common areas" and "fully sprinklered." The maintenance requirements were modified to include manufacturer's recommendations.

This memorandum notifies States and the Centers for Medicare & Medicaid Services' (CMS) regional offices of the September 22, 2006 publication of the final rule entitled: "*Medicare and Medicaid Programs; Fire Safety Requirements for certain Health Care Facilities; Amendment*" (*Federal Register* Vol. 70, No. 184, Page 55326). A copy of the regulation is attached to this memorandum.

Previously, CMS provided guidance concerning the use of ABHRs and smoke alarms in two Survey and Certification letters (S&C-05-25 and S&C-05-33) which described the requirements of the interim final rule published on March 25, 2005.

The final rule adopts the substance of the April 15, 2004 tentative interim amendment (TIA) on the use of ABHR Solutions, which was published by the National Fire Protection Association (NFPA) as an amendment to the 2000 edition of the Life Safety Code. This amendment allows certain health care facilities to place ABHR dispensers in egress corridors under certain specified conditions.

The final rule also requires that nursing facilities that are not fully sprinklered at a minimum install battery-powered single station smoke alarms in resident and common areas if the facility does not have system-based smoke detectors in those areas. This final rule confirms as final the provisions of the March 25, 2005 interim final rule with changes and responded to public comments.

Although the final rule confirms for the most part the provisions of the interim final rule of March 25, 2005 several changes to the interim final rule were made. Those changes are highlighted below.

### **Alcohol Based Hand Rubs:**

The term “vulnerable populations” was deleted and the requirement now states: “The dispensers are installed in a manner that adequately protects against inappropriate access.”

A requirement was added that “The dispensers are maintained in accordance with manufacturer guidelines.” Regular maintenance is seen as a crucial step in making sure that dispensers neither leak nor the contents spill. If the manufacturer does not have specific maintenance requirements, the facility is expected to develop their own policies and procedures to ensure that the dispensers neither leak nor the contents spill.

### **Smoke Alarms:**

Terminology was altered in the final regulation in response to public comments received. “Smoke detectors” are now termed “smoke alarms,” “public areas” are now termed “common areas,” “sprinklers installed throughout” is now termed “fully sprinklered,” and “a hard wired smoke detection system” is now termed “system-based smoke detectors.” Additionally, definitions of the terms “common areas” and “fully sprinklered” were added to the definitions section of the regulation at 42 CFR 483.5 (d) and (e).

- The requirement for testing, maintenance, and battery replacement was modified to be more specific about what is required. A facility is now required to “have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer’s recommendations and that verifies correct operation of the smoke alarms.” This should help ensure that smoke alarms are consistently functioning and we expect that this program would be included in the facility’s own policies and procedures.

If you have any questions concerning this memorandum, please contact James Merrill at 410-786-6998 or via E-mail at James.Merrill@cms.hhs.gov.

**Effective Date:** This regulation is effective October 23, 2006. There is no phase-in period provided in the regulation. Please ensure that all staff are fully apprised of this information within 30 days.

**Training:** This information should be shared with all appropriate survey and certification staff, surveyors, their managers and state fire authorities and their staff.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

Attachment can be viewed at the following link under Downloads:

[http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?  
filter-](http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filter-)

[Type=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1188368&intNumPerPa  
ge=10](http://www.cms.hhs.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?filter-Type=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1188368&intNumPerPage=10)

Center for Medicaid and State Operations/Survey & Certification Group

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Ref: S&C-07-03

**DATE:** December 7, 2006

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 2.0 Web-based Training (WBT)

**Letter Summary**

- The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the launch of the MDS Version 2.0 WBT located on the Internet at [www.mdstraining.org](http://www.mdstraining.org).
- This WBT is an instructional training tool for use by RAI Coordinators, MDS Coordinators and interdisciplinary professional staff responsible for assessing residents in Medicare and/or Medicaid certified nursing homes.

The MDS 2.0 WBT is a comprehensive training tool designed to provide clinicians and other interdisciplinary professionals with detailed instructions on completing the Long Term Care RAI, MDS 2.0. The information contained in the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS version 2.0 is presented in an interactive and easily navigated manner in the CMS MDS WBT.

The online training covers the following main topic areas:

- Overview of the RAI
- The Assessment Schedule for the RAI
- Item-by-Item Guide to the MDS
- Completing the Resident Assessment Protocols & Linking the Care Plan
- Submission and Correction of the MDS Assessment
- Medicare Skilled Nursing Prospective Payment System (SNF/PPS)

The CMS MDS WBT contains many options to make the Web site user-friendly and effective as a training tool and reference. The training tools include glossary, topic index, search feature, resources, references and additional links. Navigation controls include a navigation bar, menu screens, sidebar index and a course map. User completion data is recorded so individual users can see their progress through the training. Extensive tutorials and help are available for users wishing to discover more about how to use the Web site or who encounter difficulties.

Also, the RAI/MDS Training Web site contains authentication that the new user is in the United States. When a new user registers on the Web site, he/she will be sent an e-mail with a link to click on that will complete the registration process. Users must ensure that pop-up blockers are set to allow the use of the link in the verification e-mail. The copyright to MDS version 2.0 of the RAI for long-term care outside of the United States is held by InterRAI; therefore, the MDS version 2.0 of the RAI/MDS manual is not to be reproduced outside the United States without permission of InterRAI.

Please tell others about this exciting new training resource. We hope this will prove to be a valuable tool in your efforts toward continued improvement in care to our Medicaid and/or Medicaid beneficiaries served in long term care nursing homes. For questions regarding this Web-based training program, contact Rosemary Dunn at 410-786-1372 or e-mail [Rosemary.Dunn@cms.hhs.gov](mailto:Rosemary.Dunn@cms.hhs.gov).

**Effective Date:** Immediately, the MDS 2.0 WBT is available and accessible on the Internet.

**Training:** The information contained in this announcement should be shared with all survey and certification staff, their managers, the state training coordinators and all long-term care providers.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-05

**DATE:** December 7, 2006

**TO:** State Survey Agency Directors  
State Fire Authorities

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** **Life Safety Code** – Exit Discharge Requirements and the Fire Safety Evaluation System (FSES)

**Letter Summary**

The FSES may be used when evaluating the level of safety provided for a Health Care occupancy that does not conform with the provisions of Section 7.7 “Discharge from Exits” NFPA, 2000 edition, including the use of unpaved exits under certain circumstances. See (NFPA 101A, Chapter 4, 2001 edition).

This memorandum clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding the use of the FSES when determining compliance with the Life Safety Code (LSC) where exit discharge paths are not paved.

“The Life Safety Code” (LSC) of the National Fire Protection Association (NFPA) (Section 7.7.1) requires that:

“...Exits shall terminate directly at a public way or at an exterior exit discharge...The principle addressed in 7.7.1 is that, once a building occupant reaches an exit (the protected portion of the means of egress), the level of protection afforded by the exit cannot be reduced or eliminated.”

The NFPA also included an annex note to this section of the LSC which observes that exterior walking surfaces within the exit discharge are not required to be paved and often are provided by grass or similar surfaces.

However, it has been unclear whether unpaved exits could also meet the requirements of another section of the LSC that establishes a requirement for maintaining full protection upon reaching an exit. Section 7.1.10 of the LSC states:

“Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency.”

Finally, it has been unclear whether the FSES can be used in cases where not all exits are fully paved. The FSES is a point-based system that, in effect, permits stronger-than-required protections to compensate in certain areas for protections that, by themselves, would otherwise fall short of the requirements. This memorandum reconciles these features of the LSC as they apply to Medicare and Medicaid certification.

On January 10, 2006, the NFPA issued a Formal Interpretation (FI) that states that the FSES/HC (NFPA 101A, Chapter 4, 2001 edition) can be used to evaluate the level of safety provided for a Health Care occupancy that does not conform with the provisions of “Discharge from Exits” (NFPA 101, Section 7.7).

CMS is adopting this NFPA formal interpretation effective immediately.

The 2001 edition of the FSES/HC (which currently is used by CMS) contains additional information on exit discharge requirements that were not included in the 1985 edition of the FSES. This additional information may be helpful to facilities using the FSES in complying with exit discharge requirements.

A facility that achieves a passing score on the FSES and submits it as a Plan of Correction may be certified based upon the FSES. Once a facility has been certified based on the FSES, it may continue to be certified on that basis in subsequent certification surveys after completion of the Form CMS-2786.

All FSESs, after review by the State Agency, are to be submitted to the CMS regional office for final review as required by S&C letter 04-33 issued May 13, 2004. Further instructions on the completion of the FSES are found in Appendix I of the State Operations Manual (SOM).

We hope this information is useful in clarifying these issues. If you have further questions regarding this matter, please contact James Merrill at [James.Merrill@cms.hhs.gov](mailto:James.Merrill@cms.hhs.gov).

**Effective Date:** The information contained in this memorandum is current policy and is in effect for all nursing home facilities. The State Agency should disseminate this information within 30 days of the date of this memorandum.

**Training:** This clarification should be shared with all survey and certification staff, State fire authorities, surveyors, their managers and the State/RO training coordinator.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-07

**DATE:** December 21, 2006  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Nursing Home Culture Change Regulatory Compliance Questions and Answers

#### Memorandum Summary

This memorandum provides the State Survey Agencies and CMS regional offices with:

1. Responses we have made to inquiries concerning compliance with the long-term care health and life safety code requirements in nursing homes that are changing their cultures and adopting new practices;
2. Summarizes questions and answers from a June, 2006 CMS Pic-Tel conference with leaders of the Green House Project (*Attachment A*); and
3. Provides information about an upcoming series of 4 CMS culture change satellite webcasts (*Attachment B*).

*Following are regulatory questions that have been sent from culture change organizations from 2004 to date, along with our answers:*

**Question 1: Tag F368 (Frequency of Meals):** You request a clarification that the regulation language at this Tag that “each resident receives and the facility provides at least three meals daily” does not require the resident to actually eat the food for the facility to be in compliance. You also ask for clarification about the regulatory language specifying that there must be no more than 14 hours between supper and breakfast (or 16 hours if a resident group agrees and a nourishing snack is provided). You state that some believe this language means all of the residents must actually eat promptly by the 14<sup>th</sup> hour, which makes it difficult for the facility to honor a specific resident’s request to refuse a night snack and then sleep late.

**Response 1:** The regulation language is in place to prevent facilities from offering less than 3 meals per day and to prevent facilities from serving supper so early in the afternoon that a significant period of time elapses until residents receive their next meal. The language was not intended to diminish the right of any resident to refuse any particular meal or snack, nor to diminish the right of a resident over their sleeping and waking time. These rights are described at Tag F242, Self-determination and Participation. You are correct in assuming that the regulation language at F368 means that the facility must be offering meals and snacks as specified, but that each resident maintains the right to refuse the food offered. If surveyors encounter a situation in which a resident or residents are refusing snacks routinely, they would ask the resident(s) the reason for their customary refusal and would continue to investigate this issue only if the resident(s) complains about the food items provided. If a resident is

sleeping late and misses breakfast, surveyors would want to know if the facility has anything for the resident to eat when they awaken (such as continental breakfast items) if they desire any food before lunch time begins.

**Question 2: F370 (Approved Food Sources):** You ask if the regulatory language at this Tag that the facility must procure food from approved sources prohibits residents from any of the following: 1) growing their own garden produce and eating it; 2) eating fish they have caught on a fishing trip; or 3) eating food brought to them by their own family or friends.

**Response 2:** The regulatory language at this Tag is in place to prohibit a facility from procuring their food supply from questionable sources, in order to keep residents safe. It would be problematic if the facility is serving food to all residents from the sources you list, since the facility would not be able to verify that the food they are providing is safe. The regulation is not intended to diminish the rights of specific residents to eat food in any of the circumstances you mention. In those cases, the facility is not procuring food. The residents are making their own choices to eat what they desire to eat. This would also be the case if a resident ordered a pizza, attended a ball game and bought a hot dog, or any similar circumstance. The right to make these choices is also part of the regulatory language at F242, that the resident has the right to, “make choices about aspects of his or her life in the facility that are important to the resident.” This is a key right that we believe is also an important contributing factor to a resident’s quality of life.

**Question 3: Tag F354 (Registered Nurse):** “Can the traditional DON role be shared with several registered nurses with each nurse responsible for one or more households or clusters?”

**Response 3:** The interpretive guidelines (i.e., Guidance to Surveyors) already contain this language: “The facility is required to designate an RN to serve as DON on a full time basis. This requirement can be met when RNs share the position. If RNs share the DON position, the total hours per week must equal 40. Facility staff must understand the shared responsibilities.” Thus, the position can be shared; however, a comprehensive set of duties and responsibilities of a DON is not specified in the regulations or interpretive guidelines. We interpret this role to encompass not only general supervision of nursing care for the facility, but oversight of nursing policies and procedures, overall responsibility for hiring/firing of nursing staff, ensuring sufficient nursing staff (F353), ensuring proficiency of nurse aides (F498), active participation in the quality assurance committee (see Tag F520), and responsibility to receive and act on communications from the pharmacy consultant about medication problems (Tags F429 and F430). A facility that desires to have various people share the DON position would need to consider how these DON duties will be fulfilled in a shared position. As long as these duties are fulfilled, we would consider the facility in compliance with F354, whether or not the position is being shared.

**Question 4: Tag F521 (Quality Assessment and Assurance):** You ask whether the regulatory responsibility for this committee to “meet” can be fulfilled if the physician member is not physically present, but is participating through alternate means, “such as conference calls or reading minutes/issues and giving input.”

**Response 4:** Yes, participation can be achieved through means of telephone conferencing, however, we do not accept the alternative of the physician merely reading documents before or after the meeting. We believe the purpose of these meetings is to provide a forum for discussion of issues and

plans, which cannot be adequately fulfilled if the physician is merely reading and commenting on documents, since this does not allow for the interchange of ideas.

**Question 5: (HIPAA and Principles of Documentation):** You express concern that the Statement of Deficiencies that surveyors write, which is a publicly posted document, may violate a resident's right to privacy, since the details may identify a specific resident to the public.

**Response 5:** We have received other comments on this issue, and have provided guidance to our State Survey Agencies and CMS regional offices on our interpretation of this issue in our Survey and Certification (S&C) memorandum #04-18. All our S&C memoranda are stored on the CMS website for public access at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp>

**Question 6 (Handrails):** Could the interpretive guidelines explain that handrails are not necessary at the very ends of the hallways on the very small sides of the door? This would allow for filling these unused areas with live plants, for instance, without obstructing egress and handrails would still be available up to the end of each hallway.

**Answer 6:** The purpose of the handrail requirements at Tag F468 is to assist residents with ambulation and/or wheelchair navigation. They are a safety device as well as a mobility enhancer for those residents who need assistance. The survey team onsite would need to observe the responses of residents to the placement of objects that block the portion of the handrails that is at the end of a hallway. They would also interview residents to gain their opinion as to whether the objects in question are interfering with their independence in navigating to the places they wish to go.

**Question 7 (Resident Call system):** Could the resident call system (F463) regulation that requires calls to be able to be received at the nurses' station be changed to also include nurses' work areas and direct care workers, as well as the nurses' stations? Many homes moving away from the institutional model are replacing nurses' stations with normal kitchens, living room and dining room areas, and using systems whereby resident calls connect directly to caregivers' radio/pagers. Because it is harder to change the text of regulation, could the phrase "at the nurses' station" be removed from the following sentence in the Interpretive Guidelines: "The intent of this requirement is that residents, when in their rooms and toilet and bathing areas, have a means to directly contact staff at the nurses' station."

**Answer 7:** We agree that it is desirable for residents and/or their caregivers or visitors to be able to quickly contact nursing staff when they need help. To meet the intent of the requirement at F463, it is acceptable to use a modern pager/telephone system which routes resident calls to caregivers in a specified order in an organized communication system that fulfills the intent and communication functions of a nurse's station. We will make a change in the Interpretive Guideline to reflect this position.

**Question 8 (Posting of Survey Results):** Would CMS consider adding to the posting requirements at Tag F156 [42 CFR 483.10(b)(10)], text similar to that stated in Tag F167 about posting of survey results, "...or a notice of their availability?" Although this may just be trading one posting for several, some homes really want to create a homey environment without so many postings and many homes are placing postings into a photo album or binder to minimize the institutional look of so many postings.

**Answer 8:** The purpose of the posting requirements at both F156 and F167 is for residents and any other interested parties to be able to know the information exists, and to easily locate and read the information without needing to ask for it. What you request above, namely one posting that advises the public of what information is available to meet requirements of both Tags, is acceptable, as long as the information itself is in public and easily accessible, such as in a lobby area in a marked (titled) notebook or album. This includes the following information:

- “A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit;” (F156)
- “Written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits;” (F156) and
- The facility, “must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.” (F167)

**Question 9 (Hallway Width):** Does the 8 feet requirement (at LSC Tag K39) continue to be necessary since evacuations are no longer done via wheeling a person out of the building in a bed? Could 6 feet meet the requirement? If 6 feet sufficed, this would again refer back to our question regarding the requirement for handrails when something else such as a bench might take up the other 2 feet.

**Answer 9:** The 8 foot corridor width is a requirement of the Life Safety Code (LSC). Corridors remain a route to use in internal movement of residents in an emergency situation to areas of safety in different parts of the facility. This movement may be by beds, gurney or other methods which may require the full width of the corridor. We do not believe it would be in the best interests of the residents to reduce the level of safety in a facility.

**Question 10 (Tag K72 and Exits):** In regard to LSC Tag K72 (no furnishings, decorations, or other objects are placed to obstruct exits or visibility of exits), can secured unit doors be disguised or masked with murals, etc.? Staff typically will be the ones to use these doors in the case of emergency and will know where they are. By disguising exit doors, resident anxiety of wanting to go out them may decrease.

**Answer 10:** The life safety code allows some coverings on doors, but not concealment. The code also specifically forbids the use of mirrors on a door. It is a judgment call by the survey team as to what would be considered concealment of the door, but in general the door must still be recognizable by a non-impaired person (such as a visitor). The code does not allow the removal or concealment of exit signs, door handles, or door opening hardware.

**Question 11 (Dining Together):** Is it permissible for staff and residents to dine together?

**Answer 11:** There is no federal requirement that prohibits this. We applaud efforts of facilities to make the dining experience less institutional and more like home. Our concern would be for the facility to make sure that residents who need assistance receive it in a timely fashion (not making residents wait to be assisted until staff finish their meals).

**Question 14 (Candles):** Can candles be used in nursing homes under supervision, in sprinklered facilities.

**Answer 14:** Regarding the request to use candles in sprinklered facilities under staff supervision, National Fire Protection Association data shows candles to be the number one cause of fires in dwellings. Candles cannot be used in resident rooms, but may be used in other locations where they are placed in a substantial candle holder and supervised at all times while they are lighted. Lighted candles are not to be handled by residents due to the risk of fire and burns. If you would like to discuss this issue, you may contact James Merrill at 410-786-6998, or via email at [james.merrill@cms.hhs.gov](mailto:james.merrill@cms.hhs.gov).

**Question 15 (Tablecloths):** Are cloth tablecloths and napkins permissible in nursing homes?

**Answer 15:** There is no regulation that prohibits it and, in fact, the use of these items is greatly preferable to the use of bibs, as bibs can detract from the homelike attractiveness of the dining room setting.

Beginning November 3, 2006, (see attached) CMS is broadcasting a 4-part series on culture change through fiscal year 2007. Three of the broadcasts, produced by the Quality Improvement Organizations (QIOs), will highlight culture change principles and outcomes from the QIO scope of work. The other broadcast, produced by CMS, will explore changes being made to medical and nursing care practices and policies in terms of compliance and the survey process.

We are including information on the series for your convenience. We believe this broadcast series will be of interest to providers and other stakeholders, as well as State Survey Agencies. We encourage States, CMS regional offices, and QIOs to consider setting up joint viewing opportunities for survey personnel, stakeholders, and nursing home staff when possible. As with all CMS broadcasts, these broadcasts may be viewed either live via satellite or internet, or via internet for a year after each broadcast.

For questions concerning this memorandum, please contact Karen Schoeneman at (410) 786-6855 or via e-mail at [kschoeneman@cms.hhs.gov](mailto:kschoeneman@cms.hhs.gov).

**Effective Date:** Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum, and disseminate the information to affected providers.

**Training:** The information contained in this announcement should be shared with all nursing home surveyors and supervisors.

/s/

Thomas E. Hamilton

Attachment

cc: Survey and Certification Regional Office Management (G-5)

**Attachments can be viewed at the following link under downloads:**

<http://www.cms.hhs.gov/surveyscertificationgeninfo/pmsr/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=2&sortOrder=descending&itemID=CMS1190743&intNumPerPage=10>