



Long Term Care Newsletter

Volume 7, Issue 2

Division of Long Term Care Publication

April 2007

Leadership Conference

The Long Term Care Division is pleased to announce the first in a series of Leadership Conferences. The intent of the Leadership Conference is to provide education in order to improve the health of residents in Indiana long term care facilities. The conferences will be presented twice a year with the focus on areas of concern identified in facilities. The conference audience will include LTC providers, LTC surveyors, LTC supervisors, provider associations, ombudsmen, and other interested guests.

The first conference, "Falls Management", is scheduled for June 14, 2007 at the Indianapolis Convention Center. The aim of this conference will be to improve the prevention and management of falls in LTC facilities. These Leadership Conferences are provided through the utilization of the civil money penalty funds.

SAVE THE DATE

Indiana Long Term Care Leadership Conference
"Improving the Health of Hoosiers"
"Falls Management"

Date: Thursday, June 14, 2007

Time: 8:30 a.m. - 4:00 p.m. EST

Place: Indianapolis Convention Center

Watch for further details and registration information

Scheduled Speakers

Judy Monroe, M.D., Indiana State Health Commissioner

Molly Morand, BSN, RN, the Morand Group, LLC, Cincinnati, Ohio

Representatives from the Centers for Medicare and Medicaid Services Region V Office

The second Leadership Conference is tentatively scheduled for October 30, 2007.

Reimbursement for NATCEP

42 CFR sec. 483.154(c)(3) provides that "If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must pro-

vide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide." Nursing facilities are required to reimburse employees for the cost of nurse aide training and competency evaluation programs incurred and paid by the em-

ployee. The nursing facility is reimbursed by the State for these costs through the direct care component of the Medicaid rate in accordance with 405 IAC 1-14.6-2(m). Nursing facilities should record these costs on the nursing facility financial report that nursing facilities are required to submit to the Office of

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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 14-17. 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.



Long Term Care Provider Survey Questionnaire

In October 2006, the Indiana State Department of Health’s Division of Long Term Care began distributing the “Long Term Care Provider Survey Questionnaire” at the start of every Survey. The purpose of the questionnaire is to improve the quality of the survey process through the responses to the questions contained in the survey. The information provided in the questionnaire will have no negative impact on the survey or subsequent survey activities in your facility. When a survey is returned to ISDH’s Long Term Care Division it goes to the Director of Long Term Care. The actual survey is not seen by the area supervisors or surveyors. The Division Director’s Administrative Assistant compiles the information and the aggregate information is then shared with survey staff. A copy of the

“Long Term Care Provider Survey Questionnaire” can be found on pages 12-13 or at the following website <http://www.in.gov/isdh/regsvcs/providers/professionals.htm>. If there are changes to the Questionnaire you would like to suggest you can contact Sue Hornstein, Director, Division of Long Term Care at 317-233-7289.

Foodborne Illness

The recent Food and Drug Administration (FDA) warning to consumers to not eat certain jars of Peter Pan or Great Value peanut butter due to the risk of contamination with Salmonella Tennessee (a bacterium that causes foodborne illness) has elevated foodborne illness into the national spotlight.

Foodborne illnesses are one of the major causes of distress in this country. The Centers for Disease Control and Prevention (CDC) estimates that there are around 76 millions cases of

foodborne illness per year in the United States. The cost of these illnesses are in the billions of dollars per year.

The majority of foodborne illnesses are caused by microbial pathogens such as viruses, bacteria, and parasites. Viruses, such as Norovirus and Hepatitis A, cannot reproduce in food but can be transported via food. Bacteria, such as Salmonella, Shigella, Ecoli, Bacillus Cereus, and Clostridium Perfringens, can reproduce and be transported via food. Parasites, such as

Cryptosporidium, Cyclospora, and Giardan can be ingested as cysts. Foodborne infection is caused by ingesting foods that contain bacteria, viruses, and parasites. Common symptoms of foodborne infection are: diarrhea, abdominal cramps, nausea, vomiting, and fever.

For more information on the food protection please call the ISDH at 317-233-7360 or visit the following website: <http://www.in.gov/isdh/regsvcs/foodprot/index.htm>.

Timing of Revisits

The State determines whether a provider is in substantial compliance with the nursing home participation requirements. If the survey of the provider finds that the provider is in noncompliance with federal or state requirements the State survey agency will begin an enforcement cycle. The effective start date of the enforcement cycle will be the survey exit date in which noncompliance was determined. The three month

(mandatory denial of payment for new admissions) and six month (mandatory termination) dates will be set from this survey exit date. If it is determined that a revisit is necessary, the revisit will occur between the last acceptable plan of correction date on the plan of correction and the 60th day from the survey exit date to confirm that the facility is in substantial compliance. Conducting a revisit before the 60th day allows time

for a notice of mandatory denial of payment for new admissions to be sent to the provider prior to the third month, if necessary. Providers should take this into consideration when setting their plan of correction completion dates. If corrections cannot be completed before this time, the provider should consider requesting a waiver of the federal or state tags that are not yet corrected.

INDIANA MEDICAL ERRORS REPORT RELEASED

INDIANAPOLIS— Governor Mitch Daniels and state health officials today released the first preliminary report of the Medical Error Reporting System (MERS), designed to provide reliable data on medical errors and improve patient safety. According to preliminary data, 77 medical errors were reported for 2006. Seventy-two events happened at hospitals, and five events occurred at ambulatory surgery centers.

Indiana joins Minnesota as the only other state with a medical error reporting system based on the National Quality Forum serious adverse reportable events. MERS requires hospitals, ambulatory surgery centers, abortion clinics, and birthing centers to report to the Indiana State Department of Health any of 27 serious reportable events in these categories: surgical, products or devices, patient protection, care management, environmental and criminal.

“Any avoidable death or injury is a tragedy, and we want Hoosiers to be the safest citizens in America. Many mistakes are simple to prevent. The data we get from this report will help reduce the frequency of medical errors by revealing causes and identifying statewide trends,” said Governor Mitch Daniels.

A 2000 report by the Institute of Medicine suggested that between 44,000 and 98,000 people die each year in U.S. hospitals as a result of medical errors.

State Health Commissioner Judy Monroe, M.D., said as awareness of reporting requirements increases,

the number of medical errors in future reports will increase.

“We are requiring health care providers to report errors not to punish them, but instead, to help to improve patient safety,” Monroe said. “This kind of transparency will help to create a health care culture that looks beyond blame and supports patient safety through collaboration and responsibility.”

According to the report, 23 reported events were stage 3 or 4 pressure ulcers acquired after admission to the facility. Other reported events include:

- Twenty-one events of retention of a foreign object in a patient after surgery.
- Nine events of surgery performed on the wrong body part.
- The remaining 24 events fell in the remaining categories, which can be found in the report on the State Department of Health Web site.

“One patient harmed is one too many,” said Kenneth G. Stella, president of the Indiana Health & Hospital Association. “Today’s first report on serious adverse events identifies weaknesses in care systems and processes, and it helps set an accelerated agenda for change. Gathering the data is only a first step in the improvement process. Each reporting hospital has studied the causes for the system failures and begun work to prevent their recurrence – not just in their facilities but in every hospital.”

“Indiana’s new reporting system centers on a basic tenet of health care delivery – preventing harm to patients,” said Betsy Lee, director of the Indiana Patient Safety Cen-

ter. “The system provides a catalyst for greater engagement of all health care stakeholders in the critically important work of redesigning health care processes to protect patients.”

“To achieve the best possible patient safety system and one that continuously improves, Hoosiers need a statewide network to identify, understand, and address medical errors,” said Joseph Pekny at the Regenrief Center for Healthcare Engineering at Purdue University. “The Indiana MERS will help provide the data needed to address medical errors in a timely, evidence-based, and effective manner.”

Each facility is required to report an event, as well as the facility where the event occurred, and the quarter and calendar year of the event. MERS only collects data on the number and category of reported events. It does not collect specific information about the event; distinguishing between events that result in death and serious disability; events that result in less than death or serious disability; “near misses;” and root cause analysis.

Facilities have approximately six months to review and report events, giving them until June 30, 2007. The final report will be issued in August 2007. On Jan. 11, 2005, Governor Daniels issued Executive Order 05-10 requiring the Indiana State Department of Health to develop and implement MERS. The report is available at www.statehealth.in.gov.

Update on INShape Indiana's 10 in 10 Challenge

Did you take the 10 in 10 Challenge? Are your pants a little looser? Are you finding ways to fit in some extra physical activity each day? Have you realized healthy food can also taste good?

If you answered yes to any of these questions, you are the heart and soul of INShape Indiana, and are well on your way to being a healthy role model for other Hoosiers!

One 10 in 10 Challenge participant received national exposure for her weight-loss success.

Arleen East, LAN Administrator for the Indiana Office of Technology, was featured in an Associated Press article about INShape Indiana and the 10 in 10 Challenge in March. Her story and photograph appeared in newspapers all across the country, inspiring thousands of people to sign up for INShape Indiana.

“Oh, I am on my way now,” said Arleen. “No stopping me at this point. I am feeling so great and now I look forward to working out.”

The healthy habits Arleen adopted are not dramatic, but with the slightest modifications to her diet and exercise regimen, the results are impressive. Not only is her weight going down, but her attitude and self esteem have risen to new levels.

“I have gone from 208 to 190, and I am already feeling so much better than I have for over a year now,” said Arleen. “My whole outlook on life is totally different.”

Chances are that by the time this article is published Arleen will have reached even higher levels of success! Arleen is a great role model for all Hoosiers who want to adopt a healthier lifestyle and reap the benefits.

It is not too late to lose 10 pounds in 10 weeks!

The official 10 in 10 Challenge may be over, but it is never too late to start improving your health. If you haven't already, go to www.inshape.IN.gov, or call (800) 433-0746 to join IN-Shape Indiana.



On the website you will find 10 weeks worth of nutrition and physical activity challenges that will help you reach your weight loss goals and adopt healthier habits. Soon, you can join Arleen in sharing your success story and inspiring other Hoosiers to live a healthy lifestyle.



Advancing Excellence Campaign is Working to Improve Quality

High quality nursing home care – where residents get the care that is right for them every time - is important for everyone. Nursing home residents, their families, and people who may someday choose a nursing home for themselves or a loved one should be able to expect the best possible care every time.

The *Advancing Excellence in America's Nursing Homes* campaign is the first national effort to measure quality by setting measurable clinical and process goals.

In Indiana, there are currently 97 nursing homes enrolled in the national *Advancing Excellence in America's Nursing Homes* campaign. The statewide steering committee or LANE (Local Area Network) is made up of representatives from Hoosier Owners and Providers for the Elderly (HOPE), Indiana Association of Homes and Services for the Aging (IAHSA), Indiana Health Care Association (IHCA), Indiana State Department of Health (ISDH), Indiana Ombudsman, Health Care Excel (HCE), United Senior Action, and Kindred Healthcare.

These 97 nursing homes will voluntarily work on at least three of eight measurable quality goals. A provider must select at least one of four clinical goals and at least one of four process-related goals.

Goal #1: Reducing pressure ulcers.

The campaign's first clinical goal (Goal 1) measures how nursing homes prevent or reduce pressure ulcers, also known as bed sores, for residents. The campaign goal is for 50,000 fewer residents to suffer from bed sores by September, 2008.

Goal #2: Reducing the daily use of physical restraints.

The second clinical goal (Goal 2) will help residents to remain independent as well as safe. While physical restraints were once regarded as necessary for the safety of some residents, today the practice is to greatly reduce and even eliminate restraint use in nursing homes. Research has proven that restraints increase the likelihood of injury and may cause serious problems that jeopardize health and quality of life. The campaign will help nursing homes to learn the best ways to minimize restraints, and the goal is for at least 30,000 fewer residents to use restraints by September 2008.

Goals #3 & #4: Improving the management of pain in long stay residents and short-stay residents.

The next two goals will help residents with painful medical conditions to lead more comfortable, pain-free lives by treating them for pain. By September 2008, 40,000 fewer long-stay (Goal 3) and 130,000 fewer short-stay (Goal 4) residents will experience moderate-to-severe pain on a daily basis, due to efforts of the campaign.

Goal 5: Setting individualized targets for clinical quality improvement.

In order to stay on track of their efforts to improve quality, nursing homes can set improvement targets in the Advancing Excellence campaign. Nursing homes that regularly set quality improvement targets are more likely to be committed to improving the quality of care they provide to their residents. The first of four process goals (Goal 5) is for 90 percent of all nursing homes to set annual clinical quality targets, using a system designed and assisted by Quality Improvement Organizations.

Goal #6: Measuring resident and/or family satisfaction and incorporating this information to quality improvement activities.

The campaign has a process goal for more than 80 percent of nursing homes to assess resident and family experience of care (Goal 6) and incorporate this information into their quality improvement plans.

Goals #7 & #8: Measuring nursing staff turnover and developing action plans to improve staff retention, and adopting "consistent assignment."

The last two campaign goals involve staffing issues. By September 2008, approximately 35,000 fewer staff will leave their jobs each year², and to improve quality of life, 80 percent of nursing homes will measure staff turnover and satisfaction (Goal 7). One-third of homes will adopt "consistent assignment" of CNAs to residents (Goal 8).

Regular campaign updates showing progress will be posted on the campaign Web site at www.nhqualitycampaign.org. In addition, the campaign will provide a listing of the homes participating to allow consumers, providers and organizations (such as state and national associations) to track which homes have enrolled. For more information or to enroll in this important initiative go to the Advancing Excellence website at www.nhqualitycampaign.org.

NPI – Will You Be Ready?

GET IT. The compliance date, **May 23, 2007**, is only **2 months** away. Covered health care providers have had 22 months to apply for their NPI – further procrastination could disrupt your cash flow. Act **now** if you still don't have your NPI! **It's easy and it's free!**

SHARE IT. Have your NPI and don't know what to do with it? Share it. Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g., those who bill for ordered or referred services). You should also share it with your business associates, such as a billing service, vendor, or clearinghouse. Pay attention to information from health plans with which you do business as to when they will begin accepting the NPI in claims and other standard transactions.

USE IT. Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Revisions to the NPPES Website

We are revising some of the language on the NPPES NPI Application Help page that relates to the selection of the Entity Type. Among other changes, our revision will remove a reference to "atypical services." This reference is being removed because entities who furnish only "atypical services" are not eligible to apply for NPIs.

NPI Disclosures by Industry Entities to Industry Entities

A new guidance document is available at <http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIDisclosures.pdf> on the CMS NPI web page. This guidance relates to the disclosure of health care providers' NPIs by health industry entities for the purpose of using NPIs in HIPAA standard transactions.

New Frequently Asked Questions (FAQs) Posted

CMS has posted new NPI FAQs on its website.

Questions include:

- I have been told to protect my National provider Identifier (NPI) and I have been told to share my NPI - How am I to protect my NPI if I must share it with others?
- With whom should I share my NPI?
- Am I required to share my NPI with health plans, other providers and any other entity that requests it?
- Does the National Plan and Provider Enumeration System (NPPES) handle applications for health plan identifiers, as it does for health care provider identifiers?
- May a health plan require that an individual health care provider obtain two NPIs if that provider has two separate business roles – for example, as a physician seeing patients at a group practice, and as a durable medical equipment (DME) supplier?

To view these FAQs, please go to the CMS dedicated NPI web page at <http://www.cms.hhs.gov/NationalProvIdentStand/> and click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated".

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Important Information for Medicare Providers

Reminder to Use the NPI and Legacy Identifiers on Medicare Claims

Medicare is accepting the NPI on claims; however, providers should also submit their Medicare legacy identifiers on their claims until further instructions are released.

Important Notice: Medicare Extends Date for Accepting Form CMS-1500 (12-90)

While Medicare began to accept the revised Form CMS-1500 (08-05) on January 1, 2007 and was positioned to completely cutover to the new form on April 1, 2007, it has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives which do not comply with the form specifications. However, not all of the new forms are in error.

Given the circumstances, **CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date.** In addition, during the interim contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to providers, we are able to make them aware of the situation so they can begin communications with their form suppliers.

The following will help to properly identify whether their version of the form needs to be updated. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. Checking the information at the upper right hand corner of the form is the best way to identify if that particular version is correct. On properly formatted claim forms, there will be approximately a 1/4" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Upcoming WEDI Events

WEDI will host the 16th Annual WEDI National Conference May 14 – 17 in Baltimore, Maryland. Visit the WEDI website for more details on this event, as well as others, at <http://www.wedi.org/npioi/index.shtml> on the web. Please note that there is a charge to participate in WEDI events.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Update on Aide Database

By Terry Whitson

The Indiana Office of Technology and the Indiana State Department of Health informed health care providers on March 14, 2007 that a file containing information on certified nurse aides, qualified medication aides, and home health aides was illegally accessed and copied. The file accessed was used to support the online aide verification system. The Indiana Office of Technology and the Indiana State Department of Health are deeply sorry for this security breach and the inconvenience that it has caused.

As of April 4, 2007, the Indiana State Department of Health has no evidence that the information has been wrongly used. As is prudent for all individuals, however, we encourage all aides to closely monitor their credit and obtain a free credit report from the three credit bureaus.

The compromised file was a nurse aide, qualified medication aide, and home health aide registry file containing the names of persons who are or have been a certified nurse aide, qualified medication aide, or home health aide. The information included on the file was the name, address, certification number, and social security number of approximately 72,000 aides. The specific file was an old file affecting individuals certified on or before July 29, 2005. Individuals certified or registered after that date were not included in the compromised information.

As for a description of the incident, a security breach occurred this year in early January when a hacker illegally accessed a State of Indiana Web site. The Indiana Office of Technology discovered the breach on January 25, 2007. Through an audit and investigation, the breach of the aide registry information was discovered on March 5, 2007. Through analysis of files that were accessed, it was determined later that week that the compromised file was an old list dating back to July 29,

2005. The United States Department of Justice has been investigating this incident and has a suspect in the case. An arrest and prosecution is likely.

The hacking incident apparently involves government Web sites of several states that were illegally accessed.

The Indiana Office of Technology and the Indiana State Department of Health have taken numerous steps to inform all aides affected by the incident and protect personal information. Our first action, as you would expect, was to secure the breach. The point of illegal entry was immediately closed and law enforcement agencies were notified of the security breach.

The U.S. Department of Justice has aggressively investigated this case and the Indiana Office of Technology and the Indiana State Department of Health are fully assisting the investigation. Second, the Indiana Office of Technology sent letters to the last known address of all approximately 72,000 individuals included in the breached file. These letters informed the aides of the security breach and what resources were available to assist them in assuring the security of their information. These letters went out beginning on March 13 with all letters sent by March 15. The Indiana State Department of Health notified nursing homes and home health agencies at the same time to try to reach as many individuals as possible. A second round of letters was later sent out to aides whose addresses were discovered to have changed. Third, a telephone hotline was set up to answer questions about the breach. As of April 6, the line has received 5,040 calls. Fourth, we are improving our security and changing databases to remove social security numbers from the online application where these numbers were stored. The application was disabled to prevent any further compromise of the information.

The online system allowing providers to verify the status of aides was

the source of the security breach.

This system was developed to assist health care providers in verifying that an aide is appropriately certified or registered. Upon discovery of the security breach, the point of illegal entry was immediately closed to secure the system. Upon continued review, the Indiana State Department of Health and Indiana Office of Technology decided to disable the application and upgrade the system to further enhance its security. The application was disabled on March 16.

The application has been redesigned so that the full social security number is no longer part of the database.

When searching for an aide, a search may now be accomplished using the name and last four digits of the social security number or the aide's certification number. We have also installed additional hardware that helps prevent intrusions as well as additional efforts to increase security of information. The redesigned online system was reposted on April 5 and is now available to providers.

The online verification system was developed several years ago and has proven to be a valuable tool for providers. The system utilizes an older operating system and has limited capabilities. The Indiana State Department of Health has therefore decided to upgrade the system. The agency is working with the Indiana Professional Licensing Agency to add the aides to the License2000 system. This is the same licensing system used by most Indiana healthcare professionals.

This system will allow for online renewal and many added features. Unlike the present system, there will not be a charge for using the system. Development of the new database and system has begun and we hope to have it completed this year.

Qualified Medication Aide (QMA) Renewal

All QMAs' certifications expired on March 31, 2007. Renewal requirements including the mandatory six (6) hours of medication / medication administration inservice and \$10.00 fee were due on or before March 31, 2007. Renewal requirements received after March 31, 2007 were accepted and renewal completed. Renewal requirements received after the expiration date of the certificate are assessed an additional \$10.00 fee. If the inservice form and fee is received more than ninety (90) days after the expiration date of the QMA certification the individual is removed from the registry as a QMA and must retake the QMA course and pass the competency test for reinstatement.

All QMAs with the renewal of their certification will also receive the revised Qualified Medication Aide Record of Annual Inservice Training form. A copy of this form can be found on pages 18-19. This form is to be used to maintain the inservice hours related to the QMA's recertification, other inservice hours should **not** be listed on this form. QMAs inservice hours must relate to medication / medication administration only. Any questions related to QMA recertification can be directed to Nancy Adams, R.N. 317-233-7480 or Nancy Gilbert 317-233-7616.

(Reimbursement continued from page 1)

Medicaid Policy and Planning's rate-setting contractor, Myers and Stauffer. Schedule E, Line 321 of the financial report is specifically dedicated for reporting costs associated with nurse aide training and competency evaluation programs (NATCEP). The costs include: (1) reimbursement made to nurse aides who personally incurred and paid the cost of the training classes, (2) wages for trainers, (3) costs associated with train-the-trainer, (4) training materials and supplies, and (5) costs for nurse aide testing. Questions related to the nursing facility financial cost report should be directed to Myers and Stauffer at 317-846-9521. Questions about nurse aide training and competency evaluation programs can be directed to Nancy Adams, R.N. at 317-233-7480.

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. 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.

Survey Checklist

By May 1, surveyors will have a packet they will provide facility staff at the entrance conference for all annual licensure/recertification surveys. The packet will include a Long Term Care Facility Survey Checklist which provides a list for facilities of all the information and documentation that the surveyors will need within the first hour of the survey and within 24 hours of the beginning of the survey. There is also a space for surveyors to add other information and documentation that they may need based on the surveyors' offsite preparation.

In addition to the Long Term Care Facility Survey Checklist (State Form [SF]51298, revised 4/07), there will be all of the forms that the facility must complete and return to the surveyors. These include state forms SF5440 Employee Record, SF33224 Facility Administration, and SF4332 Bed Inventory; and federal forms CMS-802 Roster/Sample Matrix, CMS-671 Application for Medicare/Medicaid, and CMS-672 Resident Census and Condition of Resident. A copy of these forms can be found on pages 20-35.

We hope that the entrance conference packets will help streamline the process for surveyors and providers as well as a time saver for both parties.



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

SUBJECT	CONTACT PERSON	EXTENSION
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
AREA SUPERVISORS		
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

Updated 08/2006

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>

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>

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

How to read a survey

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

**LONG TERM CARE
PROVIDER SURVEY QUESTIONNAIRE**

The Indiana State Department of Health, Long Term Care Division (LTC) recently performed a survey in your facility. Please evaluate the LTC survey performance by taking a few minutes to complete and return this questionnaire.

Your completion and return of this questionnaire will help the Long Term Care Division continue to improve the survey process, and thereby to serve you and others more effectively.

The purpose of this questionnaire is to improve the quality of the survey process through your responses to the questions contained herein. The information in this questionnaire will have no negative impact on the survey or subsequent survey activities in your facility.

Thank You,

Sue Hornstein, Director
Long Term Care Division

PLEASE RETURN THIS FORM TO: SUE HORNSTEIN, DIRECTOR OF LONG TERM CARE IN THE PROVIDED ENVELOPE WITHIN 2 DAYS OF SURVEY EXIT

Using the scale below, please check the number that applies.							
5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree NA: Not Applicable							
QUESTION:	5	4	3	2	1	NA	COMMENT:
1. Survey process was clearly explained.							
2. Surveyor conducted the survey in such a manner to minimize disruption of the facility's routine.							
3. Client/patient/resident reaction to the survey was positive.							
4. Communication with surveyor(s) was on-going during survey.							
5. Provider/facility had opportunity to discuss daily survey concerns with the surveyor(s).							
6. Received knowledgeable response from surveyor(s) if provider/facility requested clarification during survey process.							

Using the scale below, please check the number that applies.

5: Strongly Agree **4:** Agree **3:** Neutral **2:** Disagree **1:** Strongly Disagree **NA:** Not Applicable

QUESTION:	5	4	3	2	1	N A	COMMENT:
7. The survey was conducted in a professional and courteous manner – surveyor(s) interacted with staff in a respectful manner.							
8. Surveyor(s) interacted respectfully with facility residents.							
9. Surveyor(s) maintained confidentiality and privacy of residents/clients during conversations and survey observations.							
10. Adequate information was provided during the exit conference to allow facility staff to understand any areas of non-compliance. Surveyor(s) were receptive to materials provided by the facility and appeared to conduct a review of those materials in consideration of voiced concerns.							

Additional comments or information about the onsite survey process:

Please recommend one change that would improve the survey experience:

Type of on-site survey conducted (please identify all that apply):

- Medicare/Medicaid Certification
 State Licensure Only
 Follow-up Survey
 Complaint Investigation
 LSC/Physical Environment
 Other

Facility Name: _____

Facility Address: _____

Date of Survey: _____

**NOTICE OF TRANSFER OR DISCHARGE**State Form 49669 (R4 / 11-06)
Indiana State Department of Health-Division of Long Term Care

Resident Name		Date Issued (Month, Day, Year)	
Facility Name (<i>Facility resident is being discharged from</i>)			
Facility Street Address (Number and Street)		Facility City	Facility ZIP Code
Transfer or Discharge Effective Date (Month, Day, Year)			
Resident is being transferred to:			
<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>)			
Transfer or Discharge to Address (Number and Street)		Transfer/Discharge to City, State, ZIP Code	
Reason for Transfer or Discharge (<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.			
APPEAL RIGHTS			
<p>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.</p> <p style="text-align: center;">To appeal this transfer or discharge, use the attached State Form 49831 and mail it to:</p> <p style="text-align: center;">Indiana State Department of Health Division of Long Term Care 2 North Meridian St. Section 4-B Indianapolis, IN 46204</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:

IMPORTANT NOTICE

CERTIFICATION/RECERTIFICATION/REINSTATEMENT and IN-SERVICE EDUCATION REQUIREMENTS FOR QUALIFIED MEDICATION AIDE (QMA)

Effective January 1, 2005, the QMA certification process and in-service education requirement is mandatory every year. This is in accordance with Indiana Administrative Code 412 IAC 2-1-10. Under this rule all QMAs must meet the following three (3) requirements:

- 1. Be certified by the Indiana State Department of Health every year;**
- 2. Obtain a minimum of six (6) hours per year of in-service education in the area of medication administration; and**
- 3. Submit appropriate fee to Indiana State Department of Health with recertification request.**

RECERTIFICATION:

At least 30 days prior to the expiration of the certificate, the individual must:

- obtain a minimum of six (6) hours per year of annual in-service education;
- submit to the Indiana State Department of Health a qualified medication aide record of annual in-service education on the form approved by the ISDH; and
- submit to the ISDH the appropriate fee.

The 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.

REINSTATEMENT:

If the recertification fees and/or in-service education form is received by the ISDH ninety-one (91) or more days after expiration of the QMA certification, the individual is removed from the QMA registry and must be reinstated. For reinstatement as a QMA following removal from the QMA registry, the individual must:

- complete an ISDH approved QMA course;
- submit to the testing entity an application approved by the ISDH;
- pass the written competency test in three (3) or fewer attempts with a passing score of 80%.

IN-SERVICE EDUCATION REQUIREMENTS:

Annual in-service education shall include medication administration. If facility policy allows the QMA to perform such functions in the facility, **annual in-service education shall also include:**

- medication administration via G-tube/J-tube;
- hemocult testing;
- finger stick blood glucose testing (specific to the glucose meter used).

QMA certificates are effective upon issue and expire on March 31 of the next year. The annual in-service education requirement period begins each year on March 1 and concludes on the last day of February of the next year. In the case of an initial certificate, the annual in-service education requirement period begins on the QMA certification effective date and concludes on the last day of February of the next year. The in-service education requirement period therefore ends one (1) month prior to the expiration of the certification.

Qualified Medication Aide Record of Annual In-service Training form and fee (\$10.00 check or money order payable to Indiana State Dept. of Health) should be submitted to ISDH. The form and fee must be sent to:

Indiana State Department of Health
Cashier's Office
PO Box 7236
Indianapolis, IN 46207-7236

Failure to submit certification in a timely manner may result in additional fees or removal from the QMA registry. (Removal from the registry will require completion of a QMA course and passing of the QMA competency test for re-instatement).

If you have additional questions, please call Nancy Adams at 317/233-7480 or Nancy Gilbert at 317/233-7616.



LONG TERM CARE FACILITY SURVEY CHECKLIST

State Form 51298 (4-07)

Indiana State Department of Health-Division of Long Term Care

FACILITY NAME: _____ **FACILITY NUMBER:** _____

THE FOLLOWING DOCUMENTATION AND/OR INFORMATION MUST BE PROVIDED TO SURVEYORS DURING, OR WITHIN 1 HOUR OF, THE CONCLUSION OF THE ENTRANCE CONFERENCE:

- A copy of the actual working schedules for LPNs and RNs for today and all days of the survey
- List of key facility personnel and their locations, including:
 - Administrator
 - Rehabilitation Services Staff
 - Pharmacy Consultant
 - Medical Director
 - Director of Nursing
 - Charges nurses
 - Plant engineer
 - Housekeeping Supervisor
 - Directors of finance, social services and activities
 - Dietitian or food supervisor
 - Persons responsible for infection control and QA
 - Health information management professional
- A copy of the written information that is provided to residents regarding their rights
- Meal times, dining locations, copies of all menus to be served during the survey
- Medication pass times (by unit, if variable)
- List of admissions during the past 30 days
- List of transfers/discharges, including destinations, for past 90 days
- A copy of facility layout, if requested
- A copy of each admission contract(s) for all residents, i.e., Medicare, Medicaid, other payment sources
- Facility abuse prohibition policies and procedures and name of contact person on the abuse protocol
- Evidence of the facility's procedures for monitoring incidents/accidents and grievances, including:
 - System to investigate incidents/accidents and grievances
 - Method and location of documentation of incidents/accidents
 - System to prevent and/or minimize further accidents/incidents
- A list of any residents age 55 and under
- A copy of the current activity calendar
- List of residents receiving dialysis services
- List of residents receiving hospice benefits
- List of residents who use non-oral communication devices or who do not speak English
- Title of organized resident/family groups and name of group's leader.
- Employee record form (SF5440), including QA Committee members and CNAs who have worked less than 4 months
- Completed Roster/Sample Matrix (CMS-802)

THE FOLLOWING INFORMATION/DOCUMENTATION MUST BE PROVIDED TO SURVEYORS WITHIN 24 HOURS OF THE CONCLUSION OF THE ENTRANCE CONFERENCE:

- APPLICATION FOR MEDICARE/MEDICAID (CMS-671)
- Resident Census & Condition of Resident (CMS-672)
- List of Medicare residents requesting demand bills during last 6 months
- Facility Administration (SF33224)
- List of Waivers (Room, etc.)
- Bed inventory sheet (SF4332), listed by payor source
- Written evidence of 2-3 abuse, neglect or misappropriation investigations since last survey
- For any survey conducted outside of the influenza season (October 1-March 31), the name of the staff person who is responsible for coordinating and implementing the facility's immunization program and a list of current residents who were in the facility during the previous influenza season, October 1 to March 31.

THE FOLLOWING INFORMATION/DOCUMENTATION MUST BE PROVIDED TO SURVEYORS, IF REQUESTED:

✓	ITEM	TIME NEEDED	DATE/TIME RECEIVED
	In-services		
	Consultant logs		
	Nurse Aide Training Program Documentation		
	Time Sheets (last 2 weeks, as worked)		
	Pet Policy		
	Orientation documentation for pool personnel		
	Resident funds accounting records		

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

Extended Survey

From: F1 To: F2
MM DD YY MM DD YY

From: F3 To: F4
MM DD YY MM DD YY

Name of Facility		Provider Number		Fiscal Year Ending: F5 <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY	
Street Address		City	County	State	Zip Code
Telephone Number: F6		State/County Code: F7		State/Region Code: F8	

A. F9

- 01 Skilled Nursing Facility (SNF) - Medicare Participation
- 02 Nursing Facility (NF) - Medicaid Participation
- 03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes No

If yes, indicate Hospital Provider Number: F11

Ownership: F12

For Profit

- 01 Individual
- 02 Partnership
- 03 Corporation

NonProfit

- 04 Church Related
- 05 Nonprofit Corporation
- 06 Other Nonprofit

Government

- 07 State
- 08 County
- 09 City
- 10 City/County
- 11 Hospital District
- 12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes No

Name of Multi-Facility Organization: F14
--

Dedicated Special Care Units (show number of beds for all that apply)

- | | |
|---|---|
| F15 <input type="text"/> <input type="text"/> <input type="text"/> AIDS | F16 <input type="text"/> <input type="text"/> <input type="text"/> Alzheimer's Disease |
| F17 <input type="text"/> <input type="text"/> <input type="text"/> Dialysis | F18 <input type="text"/> <input type="text"/> <input type="text"/> Disabled Children/Young Adults |
| F19 <input type="text"/> <input type="text"/> <input type="text"/> Head Trauma | F20 <input type="text"/> <input type="text"/> <input type="text"/> Hospice |
| F21 <input type="text"/> <input type="text"/> <input type="text"/> Huntington's Disease | F22 <input type="text"/> <input type="text"/> <input type="text"/> Ventilator/Respiratory Care |
| F23 <input type="text"/> <input type="text"/> <input type="text"/> Other Specialized Rehabilitation | |

- | | | | |
|---|-----|------------------------------|-----------------------------|
| Does the facility currently have an organized residents group? | F24 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility currently have an organized group of family members of residents? | F25 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility conduct experimental research? | F26 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is the facility part of a continuing care retirement community (CCRC)? | F27 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: F28 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hours waived per week: F29 _____
Waiver of 24 hr licensed nursing requirement.	Date: F30 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hours waived per week: F31 _____
	MM DD YY	

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes No

FACILITY STAFFING

	Tag Number	A			B				C				D			
		Services Provided			Full-Time Staff (hours)				Part-Time Staff (hours)				Contract (hours)			
		1	2	3												
Administration	F33															
Physician Services	F34															
Medical Director	F35															
Other Physician	F36															
Physician Extender	F37															
Nursing Services	F38															
RN Director of Nurses	F39															
Nurses with Admin. Duties	F40															
Registered Nurses	F41															
Licensed Practical/ Licensed Vocational Nurses	F42															
Certified Nurse Aides	F43															
Nurse Aides in Training	F44															
Medication Aides/Technicians	F45															
Pharmacists	F46															
Dietary Services	F47															
Dietitian	F48															
Food Service Workers	F49															
Therapeutic Services	F50															
Occupational Therapists	F51															
Occupational Therapy Assistants	F52															
Occupational Therapy Aides	F53															
Physical Therapists	F54															
Physical Therapists Assistants	F55															
Physical Therapy Aides	F56															
Speech/Language Pathologist	F57															
Therapeutic Recreation Specialist	F58															
Qualified Activities Professional	F59															
Other Activities Staff	F60															
Qualified Social Workers	F61															
Other Social Services	F62															
Dentists	F63															
Podiatrists	F64															
Mental Health Services	F65															
Vocational Services	F66															
Clinical Laboratory Services	F67															
Diagnostic X-ray Services	F68															
Administration & Storage of Blood	F69															
Housekeeping Services	F70															
Other	F71															

Name of Person Completing Form	Time
Signature	Date

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
ADL	Independent	Assist of One or Two Staff	Dependent	
Bathing	F79	F80	F81	
Dressing	F82	F83	F84	
Transferring	F85	F86	F87	
Toilet Use	F88	F89	F90	
Eating	F91	F92	F93	

A. Bowel/Bladder Status

- F94___ With indwelling or external catheter
- F95 Of total number of residents with catheters, ___ were present on admission.
- F96___ Occasionally or frequently incontinent of bladder
- F97___ Occasionally or frequently incontinent of bowel
- F98___ On individually written bladder training program
- F99___ On individually written bowel training program

B. Mobility

- F100___ Bedfast all or most of time
- F101___ In chair all or most of time
- F102___ Independently ambulatory
- F103___ Ambulation with assistance or assistive device
- F104___ Physically restrained
- F105 Of total number of residents restrained, ___ were admitted with orders for restraints.
- F106___ With contractures
- F107 Of total number of residents with contractures, ___ had contractures on admission.

C. Mental Status

- F108___ With mental retardation
- F109___ With documented signs and symptoms of depression
- F110___ With documented psychiatric diagnosis (exclude dementias and depression)
- F111___ Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type
- F112___ With behavioral symptoms
- F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program ___.
- F114___ Receiving health rehabilitative services for MI/MR

D. Skin Integrity

- F115___ With pressure sores (exclude Stage I)
- F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? ___.
- F117___ Receiving preventive skin care
- F118___ With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

- F119___ Receiving hospice care benefit
- F120___ Receiving radiation therapy
- F121___ Receiving chemotherapy
- F122___ Receiving dialysis
- F123___ Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion
- F124___ Receiving respiratory treatment
- F125___ Receiving tracheostomy care
- F126___ Receiving ostomy care

- F127___ Receiving suctioning
- F128___ Receiving injections (exclude vitamin B12 injections)
- F129___ Receiving tube feedings
- F130___ Receiving mechanically altered diets including pureed and all chopped food (not only meat)
- F131___ Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)
- F132___ Assistive devices while eating

F. Medications

- F133___ Receiving any psychoactive medication
 - F134___ Receiving antipsychotic medications
 - F135___ Receiving antianxiety medications
 - F136___ Receiving antidepressant medications
 - F137___ Receiving hypnotic medications
- F138___ Receiving antibiotics
- F139___ On pain management program

G. Other

- F140___ With unplanned significant weight loss/gain
- F141___ Who do not communicate in the dominant language of the facility (include those who use sign language)
- F142___ Who use non-oral communication devices
- F143___ With advance directives
- F144___ Received influenza immunization
- F145___ Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
---	-------	------

TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman office notified prior to survey? Yes No
- F147 Was ombudsman present during any portion of the survey? Yes No
- F148 Medication error rate ____%

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

GENERAL INSTRUCTIONS

THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is not a federal requirement for automation of the 672 form. The facility may continue to complete the 672 with manual methods. The facility may use the MDS data to start the 672 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the 672 to represent current resident status according to the definitions of the 672. Since the census is designed to be a representation of the facility during the survey, it does not directly correspond to the MDS in every item.

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds). For the purpose of this form "residents" means residents in certified beds regardless of payor source.

Following the definition of each field, the related MDS 2.0 codes and instructions will be noted within square brackets ([]).

Where coding refers to the admission assessment, use the first assessment done after the most recent admission or readmission event.

Complete each item by specifying the number of residents characterized by each category. If no residents fall into a category enter a "0".

INSTRUCTIONS AND DEFINITIONS

Provider No. - Enter the facility's assigned provider number. Leave blank for initial certifications.

Block F75 - Enter the number of facility residents, whose primary payer is Medicare. [code manually]

Block F76 - Enter the number of facility residents, whose primary payer is Medicaid. [code manually]

Block F77 - Enter the number of facility residents, whose primary payer is neither Medicare nor Medicaid. [code manually]

Block F78 - Enter the number of total residents for whom a bed is maintained, on the day the survey begins, including those temporarily away in a hospital or on leave. [Total residents in nursing facility or on bedhold]

ADLS (F79 – F93)

To determine resident status, unless otherwise noted, consider the resident's condition for the 7 days prior to the survey. [Horizontal totals must equal the number in F78; Manually re-code all "8" responses.]

Bathing (F79 – F81)

The process of bathing the body (excluding back and shampooing hair). This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. [F79: G2A = 0; F80: G2A = 1, 2, 3; F81: G2A = 4]

Many facilities routinely provide "setup" assistance to all residents such as drawing water for a tub bath or laying out bathing materials. If this is the case and the resident requires no other assistance, count the resident as independent.

Dressing (F82 – F84)

How the resident puts on, fastens, and takes off all items of street clothing, including donning or removing prostheses (e.g., braces and artificial limbs). [F82: G1Ag = 0; F83: G1Ag = 1, 2, 3; F84: G1Ag = 4]

Many facilities routinely set out clothes for all residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance with donning a brace, elastic stocking, a prosthesis and so on, securing fasteners, or putting a garment on, count the resident as needing the assistance of 1 or 2 staff.

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form CMS-672)

Transferring (F85 – F87)

How the resident moves between surfaces, such as to and from the bed, chair, wheelchair or to and from a standing position. (EXCLUDE transfers to and from the bath or toilet). [F85: G1Ab = 0; F86: G1Ab = 1, 2, 3; F87: G1Ab = 4]

Many facilities routinely provide "setup" assistance to all residents, such as handing the equipment (e.g., sliding board) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use (F88 – F90)

How the resident uses the toilet room (or bedpan, bedside commode, or urinal). How resident transfers on and off toilet, cleans self after elimination, changes sanitary napkins, ostomy, external catheters, and adjusts clothing prior to and after using toilet. If all that is done for the resident is to open a package (e.g., a clean sanitary pad), count the resident as independent. [F88: G1Ai = 0; F89: G1Ai = 1, 2, 3; F90: G1Ai = 4]

Eating (F91 – F93)

How resident eats and drinks regardless of skill. Many facilities routinely provide "setup" activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the extent of assistance, count this resident as independent. [F91: G1Ah = 0; F92: G1Ah = 1, 2, 3; F93: G1Ah = 4]

A. BOWEL/BLADDER STATUS (F94 – F99)

F94 - With an indwelling or an external catheter

The number of residents whose urinary bladder is constantly drained by a catheter (e.g., a Foley catheter, a suprapubic catheter) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., a Texas catheter). [H3c or d = check]

F95 - Of the total number of residents with catheters

The number of residents who had a catheter present on admission. For a resident readmitted from a hospital with a catheter, count this resident as admitted with a catheter. [H3c or d = check and A8a = 1 or A8b = 1 or 5]

F96 - Occasionally or frequently incontinent of bladder

The number of residents who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. [H1b = 2, 3 or 4 and H3c and d are not = check]

F97 - Occasionally or frequently incontinent of bowel

The number of residents who have a loss of bowel control two or more times per week. [H1a = 2, 3 or 4]

F98 - On individually written bladder training program

The number of residents with a detailed plan of care to assist the resident to gain and maintain bladder control (e.g., pelvic floor exercises). Count all residents on training programs including those who are incontinent. [H3b = check]

F99 - On individually written bowel training program

The number of residents with a detailed plan of care to assist the resident to gain and maintain bowel control (e.g., use of diet, fluids, and regular schedule for bowel movements). Count all residents on training programs including those who are incontinent. [code manually]

B. MOBILITY (F100 – F107)

[Total for F100 – F103 should = F78; Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.]

F100 - Bedfast all or most of time The number of residents who were in bed or recliner 22 hours or more per day in the past 7 days. Includes bedfast with bathroom privileges. [G6a = check and G5d is not = check]

F101 - In chair all or most of time The number of residents who depend on a chair for mobility. Includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. [G5d = check]

F102 - Independently ambulatory The number of residents who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. [G1Ac = 0 and G1Ad = 0 and G5a is not = check]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F103 - Ambulation with assistance or assistive devices

The number of residents who required oversight, cueing, physical assistance or who used a cane, walker, crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. [G1Ac or d = 1, 2 or 3 or G5a = check]

F104 - Physically restrained The number of residents whose freedom of movement and/or normal access to his/her body is restricted by any manual method or physical or mechanical device, material or equipment that is attached or adjacent to his/her body and cannot be easily removed by the resident. [Any P4c, d or e = 1 or 2]

F105 - Of total number of restrained residents, number admitted or readmitted with an order for restraint. [Code manually when criteria for F104 is met and P4c, d or e = 1 or 2 and A8a = 1 or A8b = 1 or 5]

F106 - With contractures The number of residents that have a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc. Includes loss of range of motion in fingers, wrists, elbows, shoulders, hips, knees and ankles. [Any G4Aa, b, c, d, e or f = 1 or 2]

F107 - Of total of residents with contractures, the number who had a contracture(s) on admission. [Code when criteria for F106 is met on admission or readmission assessment and A8a = 1 or A8b = 1 or 5.]

C. MENTAL STATUS (F108 – F114)

F108 - With mental retardation Identify the total number of residents in all of the categories of developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. [Any AB10b, c, e or f = check]

F109 - With documented signs and symptoms of depression The total number of residents with documented signs and symptoms of depression as defined by MDS (Mood and Behavior Section). [I1ee = check or E1a, e, l or m > 0]

F110 - With documented psychiatric diagnosis (exclude dementias and depression) The number of residents with primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, and atypical psychosis). [I1dd, ff, or gg = check. Code manually for other psychiatric diagnoses listed here]

F111 - Dementia: Multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type The number of residents with a primary or secondary diagnosis of dementia or organic mental syndrome including multi-infarct, senile type, Alzheimer's type, or other than Alzheimer's type. [I1q or u = check]

F112 - With behavioral symptoms The number of residents with one or more of the following symptoms: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resistive to care. (See MDS Section (Mood and Behavioral Patterns)). [Any E4Aa, b, c, d or e = 1, 2 or 3]

F113 - Of the total number with behavioral symptoms, the number receiving a behavior management program. The number of residents with behavior symptoms who are receiving an individualized care plan/program designed to address behavioral symptoms (as listed above). [Manually code when criteria for F112 is met and P2a = check and P2c or d = check]

F114 - Receiving health rehabilitative services for MI/MR The number of residents for whom the facility is providing health rehabilitative services for MI/MR as defined at 483.45(a). [Use item for Residents who meet F108 or F110, then code manually]

D. SKIN INTEGRITY (F115 – F118)

F115 - With pressure sores The number of residents with ischemic ulcerations and/or necrosis of tissues overlying a bony prominence (exclude Stage I). [Any M1b, c or d > 0 or M2a > 1 Code for first assessment after latest admission or re-admission]

F116 - Of the total number of residents with pressure sores excluding Stage I, the number who had pressure sores on admission or who were readmitted with a new pressure sore (exclude Stage I). [Code when criteria for field 115 are met and A8a = 1 or A8b = 1 or 5.]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F117 - Receiving preventive skin care The number of residents receiving non-routine skin care provided according to a physician's order, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.) [Any M5a, b, c, d, e, f, g, h, or i = check]

F118 - With rashes Enter the number of residents who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., but not limited to antifungals, cortisteroids, emollients, diphenhydramines or scabidiculs, etc.) [M4d = check]

E. SPECIAL CARE (F119 – F132)

F119 - Receiving hospice care Number of residents who have elected or are currently receiving the hospice benefit. [P1ao = check]

F120 - Receiving radiation therapy The number of residents who are under a treatment plan involving radiation therapy. [P1ah = check]

F121 - Receiving chemotherapy The number of residents under a specific treatment plan involving chemotherapy. [P1aa = check]

F122 - Receiving dialysis The number of residents receiving hemodialysis or peritoneal dialysis either within the facility or offsite. [P1ab = check]

F123 - Receiving intravenous therapy, IV nutritional feedings and/or blood transfusion The number of residents receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. [K5a = check or P1ac = check or P1ak check]

F124 - Receiving respiratory treatment The number of residents receiving treatment by the use of respirators/ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheotomy care or respiratory suctioning. [P1ag = check or P1al = check or P1bdA > 0]

F125 - Receiving tracheotomy care The number of residents receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. [P1aj = check]

F126 - Receiving ostomy care The number of residents receiving care for a colostomy, ileostomy, uretostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheotomy. [P1af= check]

F127 - Receiving suctioning The number of residents that require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the mouth, nasal passage, or tracheotomy stoma. [P1ai = check]

F128 - Receiving injections The number of residents that have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) [Review residents for whom 03 = 1, 2, 3, 4, 5, 6 or 7. Omit from count any resident whose only injection currently is B 12.]

F129 - Receiving tube feeding The number of residents who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). [K5b = check]

F130 - Receiving mechanically altered diets The number of residents receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). [K5c = check]

F131 - Receiving rehabilitative services The number of residents receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist. (Exclude health rehab. for MI/MR.) [P1baA or P1bbA or P1bcA > 0]

F132 - Assistive devices with eating The number of residents who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). [K5g = check]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F. MEDICATIONS (F133 – F139)

F133 - Receiving psychoactive drugs The number of residents that receive drugs classified as antidepressants, anti-anxiety, sedative and hypnotics, and antipsychotics. [Any O4a, b, c or d = 1, 2, 3, 4, 5, 6 or 7].

Use the following lists to assist you in determining the number of residents receiving psychoactive drugs.

These lists are not meant to be all inclusive; therefore, a resident receiving a psychoactive drug not on this list, should be counted under F133 and any other drug category that applies - F134, F135, F136, and/or F137.

F134 - Receiving antipsychotic medications

[O4a = 1, 2, 3, 4, 5, 6 or 7]

Clorazil (Clozapine)
Haldol (Haloperidol)
Haldol Deconate (Haloperidol Deconate)
Inapsine (Droperidol)
Loxitane (Loxapine)
Mellaril (Thioridazine)
Moban (Molindone)
Navane (Theothixene)
Olazapine (Zyprexa)
Orap (Pimozide)
Prolixin, Deconate (Fluphenazine Deconate)
Prolixin, Permitil (Fluphenazine)
Quetiapine (Seroquel)
Risperdal (Risperidone)
Serentil (Mesoridazine)
Sparine (Promazine)
Stelazine (Trifluoperazine)
Taractan (Chlorprothixene)
Thorazine (Chlorpromazine)
Tindel (Acetophenazine)
Trilafon (Perphenazine)

F135 - Receiving anti-anxiety medications

[O4b = 1, 2, 3, 4, 5, 6 or 7]

Ativan (Lorazepam) Serax (Oxazepam)
Centrax (Prazepam) Valium (Diazepam)
Klonopin (Clonazepam) Vistaril, Atarax (Hydrox-
Librium (Chlordiazepoxide) yzine)
Paxipam (Halazepam) Xanax (Alprazolam)

F136 - Receiving antidepressant medications

[O4c = 1, 2, 3, 4, 5, 6, 7]

Asendin (Amoxapine)
Aventyl, Pamelor (Nortriptyline)
Bupropion (Wellbutrin)
Desyrel (Trazodone)
Effexor (Venlafaxine)

Elavil (Amtriptyline)
Lithonate, Lithane (Lithium)
Ludiomil (Maprotiline)
Marplan (Isocarboxazid)
Nardil (Phenelzine)
Nefazodone (Serzone)
Norpramin (Desipramine)
Pamate (Tranlycypromine)
Paroxetine (Paxil)
Prozac (Fluoxetine)
Sertraline (Zoloft)
Sinequan (Doxepin)
Tofranil (Imipramine)
Vivactil (Protriptyline)

F137 - Receiving hypnotic medications

[O4d = 1, 2, 3, 4, 5, 6 or 7]

Dalmane (Flurazepam) Quazepam (Doral)
Estazolam (ProSom) Restoril (Temazepam)
Halcion (Triazolam) Zolpidem (Ambien)

F138 - Receiving antibiotics The number of residents receiving sulfonamides, antibiotics, etc., either for prophylaxis or treatment. [Code manually]

F139 - On a pain management program The number of residents with a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with alternative approaches (e.g., massages, heat, etc.). [Code manually when any J3a, b, c, d, e, f, g, h, i or j = check]

G. OTHER RESIDENT CHARACTERISTICS (F140 – F146)

F140 - With unplanned or significant weight loss/gain The number of residents who have experienced gain or loss of 5% in one month or 10% over six months. [K3a or K3b = 1 and K5h is not = check]

F141 - Who do not communicate in the dominant language at the facility The number of residents who only express themselves in a language not dominant at the facility (e.g., this would include residents who speak only Spanish, but the majority of staff that care for the residents speak only English). [code manually]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F142 - Who use non-oral communication devices (e.g., picture board, computers, sign-language). [Any C3b, c, d, e, or f = check]

F143 - Who have advanced directives (living will/ durable power of attorney) The number of residents who have advanced directives, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated. [Any A10a, b, c, f, g, or h = check]

F144 - Received influenza immunization The number of residents known to have received the influenza immunization within the last 12 months. [code manually]

F145 - Received pneumococcal vaccine The number of residents known to have received the pneumococcal vaccine. [code manually]

F146 - Ombudsman notice - LEAVE BLANK
This will be completed by survey team. Indicate yes or no whether Ombudsman office was notified prior to survey.

F147 - LEAVE BLANK This will be completed by the survey team. Indicate whether Ombudsman was present at any time during the survey, 1 (yes) or 2 (no).

F148 - Medication error rate - LEAVE BLANK
This will be completed by the survey team.

**FACILITY ADMINISTRATION**State Form 33224 (R2/1-03)
Indiana State Department of Health-Division of Long Term Care

ADMINISTRATOR	
Name	License Number
Date Appointed	Number Hours Per Week
E-mail Address	
Person Responsible in Your Absence	

DIRECTOR OF NURSING	
Name	License Number
Date Appointed	Number Hours Per Week
E-mail Address	

CERTIFICATION STATEMENT	
<i>I hereby certify that the information recorded above is true and accurate to the best of my knowledge.</i>	
PRINTED NAME	
TITLE	
SIGNATURE	DATE

INSTRUCTIONS: This form is to be completed and signed by the facility administrator.



BED INVENTORY

State Form 4332 (R8/1-02)
 Indiana State Department of Health-Division of Long Term Care

Name of Facility											
Street Address											
City				County				Zip+4			
PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS: Each room should be listed only once and listed in numerical order under each classification column.										Room No.	No. Beds
Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid All licensed beds must be listed.										8	2
										9	2
										10	2
										11	3
										12	2
										20	2
NCC = Non-Certified Comprehensive Residential Level of Care											
Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF		Total 19 NF				Total NCC		Total Residential	
Current SNF Census								<div style="border: 1px solid black; padding: 10px;"> <p>NOTE</p> <p>Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.</p> </div>			
Current SNF/NF Census											
Current NF Census											
Current NCC Census											
Current Residential Census											
TOTAL CURRENT CENSUS											
TOTAL LICENSED CAPACITY											
Completed by				Position				Date			



Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State
Department of Health
An Equal Opportunity Employer

March 21, 2007

TO: Local Health Departments
Long Term Care Facility Administrators

FROM: Judith A. Monroe, M.D. 
State Health Commissioner

SUBJECT: Investigation of Disease Outbreaks in Long Term Care Facilities

Recently there has been some confusion over jurisdiction of state-regulated and state-owned facilities, particularly long term care facilities, regarding disease outbreak investigation. According to Indiana Code 16-20-1-21, each local health department has the responsibility and authority to take any action authorized by statute or rule of the state department to control communicable diseases. According to the Communicable Disease Reporting Rule for Physicians, Hospitals and Laboratories (410 IAC 1-2.3, sec. 49), the local health department is responsible for performing any epidemiological investigation required and instituting control measures. In addition, food preparation areas in long term care facilities are addressed by the Indiana Retail Food Code (410 IAC 7-24) and may be assessed and enforced by local health departments. **With the exception of state Department of Correction facilities (this does not include county jails), there is no prohibition against the local health department taking any necessary action in state-owned or state-regulated facilities in its efforts to control the transmission of communicable diseases.**

The efforts described pertain only to disease investigation and do not include routine inspection activities normally performed by the Indiana State Department of Health (ISDH). When an incident occurs requiring disease investigation, the ISDH will provide any needed collaboration and support to the local health department conducting the disease investigation. Since the communicable disease reporting rule requires local health departments and health care providers to report any outbreak or unusual disease occurrence immediately, this first report would be an excellent opportunity to begin collaboration between the health care provider and the local health department and determine what assistance may be necessary. If the ISDH receives notification of an outbreak of illness, the ISDH will notify the local health department immediately. To report an outbreak of illness, please contact your local health department or call the ISDH Epidemiology Resource Center at 317-233-7125. Long term care facilities need to follow the ISDH Long Term Care Program's reportable occurrence policy for reporting outbreaks.

Thank you for your continued commitment to public health.

cc: Mary Hill, Deputy State Health Commissioner
Terry Whitson, Health Care Regulatory Services Commission
Scott Gilliam, Food Protection Program
Sue Hornstein, Long Term Care Program
Joe Hunt, Public Health Surveillance and Preparedness Commission
Pam Pontones, Epidemiology Resource Center
Robert Teclaw, Epidemiology Resource Center

Pneumococcal Polysaccharide Vaccination Pocket Guide

Indications

Vaccination with pneumococcal polysaccharide vaccine (PPV) is recommended for **all** persons who meet any of the criteria below:

- Age 65 yrs or older
- Age 2 to 64 yrs with any of the following conditions:
 - a. functional or anatomic asplenia (e.g., sickle cell disease, splenectomy)
 - b. immunocompromising conditions (e.g., HIV infection, leukemia, congenital immunodeficiency, Hodgkin's disease, lymphoma, multiple myeloma, generalized malignancy) or on immunosuppressive chemotherapy
 - c. organ or bone marrow transplantation
 - d. chronic renal failure or nephrotic syndrome
 - e. chronic cardiovascular disease (e.g., congestive heart failure, cardiomyopathies)
 - f. chronic pulmonary disease (not asthma)
 - g. cerebrospinal fluid leak
 - h. diabetes mellitus
 - i. alcoholism or cirrhosis
 - j. candidate for or recipient of cochlear implant

Who needs a second dose of PPV?

A second PPV is indicated for persons who are:

- Age 65 years or older and previously vaccinated with PPV before age 65 years (if 5 years have elapsed since first dose).
- At highest risk of serious pneumococcal disease or likely to have a rapid decline in pneumococcal antibody levels (categories a–d above).

Intervals Between Doses

- Children 2 years and older in need of a first dose of PPV who previously received pneumococcal conjugate vaccine (PCV) should wait at least 8 weeks following PCV before receiving PPV.
- Persons 10 years of age and older in need of a second PPV should wait at least 5 years following their first PPV dose.
- Children younger than age 10 years should wait at least 3 years following their first PPV dose before receiving their second dose.

Contraindications and Precautions

- Do not give PPV to patients who have a history of a serious reaction (e.g., anaphylaxis) after a previous dose of PPV or to a PPV component.
- Minor illnesses with or without fever do not contraindicate use of PPV vaccine.

Vaccine Dosing and Administration

Administer 0.5 mL PPV either intramuscularly in the deltoid (22–25g; needle length according to the patient's age/body mass [7/8"–1½"]), or subcutaneously in the upper-outer triceps area of the arm (23–25g, 5/8" needle).

Side Effects

Most common side effects from PPV are soreness and redness at the injection site, lasting 1–2 days.

Talking Points with Patients

- *Streptococcus pneumoniae* bacteria (i.e., pneumococci) are commonly found in the upper respiratory tract of most persons.
- Pneumococcal disease most often occurs in older persons as well as persons with a predisposing condition (e.g., pulmonary disease, asplenia).
- Pneumococcal disease most commonly presents as a serious infection in the lungs (pneumonia), blood (bacteremia), or brain (meningitis). It kills more people in the U.S. each year than all other vaccine-preventable diseases combined.
- PPV is 60–70% effective in preventing serious pneumococcal disease; it does not provide substantial protection against all types of pneumonia (viral and bacterial). It is not a "pneumonia" vaccine.
- PPV is usually given once in a lifetime; however, some people (see other side) need 2 doses.
- PPV can be given at any time during the year and can be given concurrently with all other vaccines, including influenza vaccine.
- Patients who can't remember if they've ever had PPV should get vaccinated now rather than postponing it.
- Medicare covers the cost of PPV and its administration for all Medicare beneficiaries.
- High risk children younger than age 5 years need both PPV and PCV.

To order additional pocket guides, go to www.immunize.org/ppvguide.
Immunization Action Coalition • www.immunize.org • (651) 647-9009

Item #R2203 (8/06)

MDS Coordinators, Take Note!



The Centers for Medicare and Medicaid Services have revised sections of the Long – Term Care Facility Resident Assessment Instrument User’s Manual (MDS).

To retrieve the updates visit the CMS website:

<http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20Update200703.pdf>

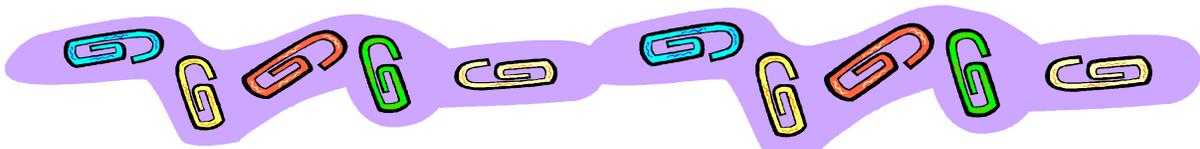
For questions contact:

Gina Berkshire, RN, MDS Coordinator

Indiana State Department of Health

317 233-4719

gberkshire@isdh.in.gov



Questions Submitted for Roundtable Discussion 2/2/07

1. A provider has questioned whether the poster provided by the department regarding Universal Precautions can be retyped/reformatted, in that the original copy maintained by the facility is becoming illegible. In the context of prior instruction provided regarding this poster/information sheet, please note that there was a question in the September 2001 Roundtable Discussion as follows:

Question #9

“In a packet of information forwarded to providers in June 1994, regarding universal precautions, an approved model statement for public notice was included which has the ISDH address listed as 1330 W. Michigan Street. Providers were advised “although use of the included information sheet is encouraged, if it does not meet your facility’s needs, you may prepare an equivalent information sheet complying with requirements of this rule for ISDH approval. To submit facility-prepared information sheets for approval send them to Indiana State Department of Health, care of Universal Precautions Coordinator, 1330 W. Michigan Street, PO BOX 1964, Indianapolis, Indiana 46206-1964.”

The question posed at that time was, *“Does the Department intend to update the notice with appropriate address? If not, would a facility need to send in for an approval to change the address on the notice currently in use?”*

Response provided was: “facilities do not need to receive an approval to correct the address. This form was updated August 1996 (see attached).”

The current question at hand is “can a facility retype the information included on the form or must the exact form/posting distributed by ISDH continue to be utilized? Which would then provoke the question as to whether the facility must submit the facility-prepared information sheet for approval as per previous instruction?”

RESPONSE:

The original instruction and informational sheet was sent to facilities in 1994 by Dr. Bailey. ISDH will review this instruction and will then provide guidance as to instructions for use.

2. RE: Self Reported Medication Errors

The current unusual occurrence guidance mandates that the facility report *“medication errors that caused resident harm or require extensive monitoring for 24-48 hours.”* When a medication error occurs, the facility should respond to the error itself, assess for other residents who could potentially be affected (as well as other staff who could make the same mistake), address those issues, as well as proceed to analyze/revise systems as warranted and implement QA measures to monitor for ongoing compliance thereafter. Facilities are concerned that even though the above process is followed after a medication error requiring monitoring has occurred, due to self-reporting, a complaint survey is conducted and a finding of “actual harm” is assigned due to the fact that the event occurred. There is no dispute that the event occurred, as it was reported as such. In this current system, facilities are penalized for reporting the occurrence, regardless of the corrective actions taken. **Please clarify the logic in the facility reporting, knowing that the result (regardless of corrective actions taken) will result in a citation in that the medication error did, in fact, occur and required extensive monitoring as reported to ISDH.**

RESPONSE:

ISDH reports that less than 1% of incidents reported to ISDH are converted to on-site visits and findings in direct response to the facility reporting. Providers are reminded that, per ISDH policy, should the incident not warrant an immediate on-site visit following initial reporting, all reported incidents will eventually be reviewed during a subsequent on-site visit (e.g., annual, PSR, etc.).

It has been reported that surveyors continue to request from the facility (when visiting for annual or revisit) copies of all incidents reported since the time of last visit. This is not the manner in which reviews of reported incidents are to be conducted. If a surveyor is assigned to review an incident, he/she shall have a copy of said incident in his/her possession. Thus, surveyors will be reminded during upcoming training that it is not appropriate to request that facilities provide all copies of previously reported incidents while conducting on-site visits.

3. Within the interpretive guidance of F 329, there are examples of tools that may be used by facility staff, practitioners or consultants to determine baseline status as well as to monitor for effectiveness and potential adverse consequences. There is a disclaimer that states that the tools include, but are not limited to, the following...”

A provider was concerned that they have utilized a dementia scale other than the scale listed in the guidance. It is the assumption of the industry that given the fact that the disclaimer states “may include, but are not limited to” that other tools are acceptable for use. Please confirm.

RESPONSE:

As stated, the guidance states, “may include, but are not limited to.” Thus, it is at the discretion of the provider as to what type of assessment tool is to be utilized and to ensure the content is appropriate to attain the desired assessment information.

4. The interpretive guidance of F 329 addresses gradual dose reductions for antipsychotics as well as tapering for sedative hypnotics. The guidance addresses attempting a gradual dose reduction in two separate quarters (with at least one month between the attempts) unless clinically contraindicated for those residents with ordered antipsychotics. After the first year, the gradual dose reduction must be attempted annually, unless clinically contraindicated. Specifics as to psychopharmacological medication (other than antipsychotics and sedative hypnotics) are the same. For sedative/hypnotics that are used routinely and beyond the manufacturer’s recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated.

The question was posed as to if a resident is already on a psychopharmacological medication (of any of the above categories) and is now to the point of annual reviews, and the dose is increased, does the clock “restart” for gradual dose reduction or tapering during at least two separate quarters due to the increase in dose, OR does the facility continue with annual attempts in that the medication itself remained the same?

RESPONSE:

Keep in mind that the medication regimen review is conducted by the consultant pharmacist on a monthly basis, thus all medications are closely monitored for efficacy ongoing. Per the Interpretive Guidance, there is no directive to “restart” the clock when a dose is increased for a psychopharmacological medication previously ordered for the resident.

5. Within Table 1 (Medication Issues of Particular Relevance) under the heading of anti-diabetic medications, issues and concerns include a note that states: *“continued or long term need for a sliding scale insulin for non-emergency coverage may indicate inadequate blood sugar control.”*

Providers are concerned with this statement, in that many long term care residents continue to be provided insulin per sliding scale. **Should providers be concerned in regard to this note or should this be brought to the attention of the Indiana Medical Directors Association for closer review/scrutiny/education?**

RESPONSE:

It is anticipated that Residents with ordered sliding scale insulin require the same due to diabetic instability. This type of rationale should be documented in the medical record. This could be noted via monthly medication regimen reviews conducted by the consultant pharmacist, via documentation made by the physician, or other means. No further “rationale” is anticipated other than notation that the resident’s instability/fluctuating blood sugars warrant sliding scale insulin to be administered. It would, however, be anticipated that periodic lab testing would be in place to monitor the resident’s status. It is at the discretion of the provider to address the continued need of sliding scale insulin and securing of rationale explaining the same with the physician/Medical Director.

6. Within the investigative protocol for unnecessary medication-medication regimen review, section #3 (Medication Regimen Review) questions how the pharmacist approaches the medication regimen review process for short stay residents. Further, in F 425 (Pharmacy Services), under services of a licensed pharmacist, it again states: *“establish procedures that address medication regimen reviews for residents who are anticipated to stay less than 30 days or when the resident experiences an acute change of condition as identified by facility staff”*.

It was questioned by a provider that should a medication regimen review be conducted for a resident and that resident should then be discharged from the facility prior to recommendations being received and/or communicated to the physician caring for the resident, how is the facility anticipated to proceed? For example, should the recommendations be communicated to the resident and his/her responsible party (who can then address them with the physician)? Should the pharmacist’s recommendations be forwarded directly to the physician who will oversee the resident’s care after discharge from the facility (if known)? **Please clarify the expectation of ISDH in regard to follow thru with medication regimen review results for those residents with a stay less than 30 days, when recommendations are received just prior to the time of discharge, or after the discharge of the resident.**

RESPONSE:

It is anticipated that the facility will communicate the medication regimen review for the resident with a stay of less than 30 days to either the resident, responsible party, or physician who will be following the resident after discharge from the facility. The manner in which this information is communicated is at the discretion of the facility, as per facility policy. The facility should be able to exhibit how this information was communicated either via documentation in the medical record or proof of communication of said recommendations. Again, the manner in which the facility accomplishes and communicates this review should be addressed in the facility policy.

7. F 428 (Drug Regimen Review), within the overview it states, *“during the MRR, the pharmacist applies his/her understanding of medications and related cautions, actions and interaction as well as current medication advisories and information. The pharmacist provides consultation to the facility and attending physician(s) regarding the medication regimen and is an important member of the interdisciplinary team. Regulations prohibit the pharmacist from delegating the medication reviews to ancillary staff.”*

Providers have reported that there are pharmacists who employ a registered nurse to assist in the conducting of the monthly medication regimen reviews. Further, there are pharmacy students who have been known to assist the pharmacist in the conducting of medication regimen reviews. **Would these individuals be prohibited from participating in the medication regimen review if said reviews are co-signed by the pharmacist providing oversight? OR does this interpretive guidance prohibit anyone from participation other than the pharmacist?**

RESPONSE:

The Interpretive Guidance states that the pharmacist can not delegate the medication review to ancillary staff.

8. F 428 Drug Regimen Review under “response to irregularities identified in the MRR”, states,

“for those issues that require physician intervention, the physician either accepts and acts upon the report and potential recommendations or rejects all or some of the report and provides a brief explanation of why the recommendation is rejected, such as in a dated progress note. It is not acceptable to document only that he/she disagrees with a report, without providing some basis for disagreeing”.

Providers are concerned that the physicians’ response will be deemed inadequate by the survey team. **Please clarify what type of explanation/content will be anticipated as acceptable.**

Secondly, in this regard, should there be communication with the Indiana Medical Directors Association regarding educating Medical Directors as to the anticipated acceptable explanation as to why a recommendation of the pharmacist is rejected?

RESPONSE:

- A. It is anticipated that a brief explanation will be provided as to why the recommendation is rejected. If the physician fails to do this, the licensed nurse can inquire of the physician and document the physician’s verbal explanation for rejection of the consultant pharmacist’s recommendation(s). The nurse’s entry of explanation must then be signed by the physician to denote accuracy of the explanation as documented.
It is at the discretion of the facility to address appropriate response to consultant pharmacist’s recommendation(s) with the attending physicians and/or facility Medical Director.
- B. Communication with Medical Director Association
There is no requirement for this. If the attending physician does not concur with or take action on the report, the facility and the pharmacist should contact the facility’s Medical Director for guidance and possible intervention. A procedure should be in place if the attending physician is also the Medical Director.

9. Within the revised interpretative guidance, there are repeated references to consulting the pharmacist in regard to medication regimen review at the time of admission, re-admission, change of condition, etc.

A provider questioned whether the facility must always contact the contracted consultant pharmacist, or whether the facility can inquire of other available pharmacists and document the same in regard to questions relative to medications, side-effects, etc.

RESPONSE:

First, one would question why a facility would contact another pharmacist other than the consultant pharmacist, particularly if the conversation would address confidential information about the resident (e.g., diagnosis, medical condition, etc.). Thus, response to this question would be dependent upon the nature of the question being posed to a pharmacist. General questions about a medication and its potential adverse reactions might be an example of a question posed; however there is concern and the facility is cautioned in regard to ensuring confidential information will not be disclosed to an individual who is not directly responsible for the care of the resident.

10. A provider reported that their consultant pharmacist was insisting that MRRs are required to be completed in a residential setting in the same manner as in the comprehensive setting.

Note that the residential rules (Sec. 6) state, *“A consultant pharmacist shall be employed, or under contract, and shall: review the drug regimen of each resident receiving these services at least once every sixty (60) days. The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility’s policy.”*

Will the facility’s policy still guide the medication regimen review process for the residential setting, and the interpretive guidance apply only to comprehensive settings, or will aspects of the interpretive guidance be anticipated to be applied to the residential setting?

RESPONSE:

The Residential Rules will continue to apply to licensed residential facilities. The recently released interpretive guidance does not apply to the Residential Rules/residential facilities. Should a facility “choose” to conduct the same reviews, etc., for both comprehensive and residential settings on their campus, this is at the facility’s discretion and per the facility’s own policy.

11. A provider has reported that their consultant pharmacist has insisted that ALL medications ordered for the residents MUST be addressed on the resident’s careplan. One might question if this opinion originates from determining the drug regimen to be free from unnecessary drugs *“without adequate indications for use.”* Also, interpretive guidance “II. Monitoring for Efficacy and Adverse Consequences” states, *“The information gathered during the initial and ongoing evaluations is essential to: -incorporate into a comprehensive care plan that reflects appropriate medication related goals and parameters for monitoring the resident’s condition, including the likely medication effects and potential for adverse consequences.”*

Facilities have been accustomed to address medications of concern to the resident’s condition(s); however, have not (as a standard) addressed every medication ordered. Please clarify the expectations of ISDH.

RESPONSE:

The Interpretive Guidance does not require that every medication be listed/addressed on the resident’s careplan. It is anticipated that if there is a concern in regard to a medication administered (e.g., need for specific monitoring, etc.), the same would be addressed appropriately, as the purpose of the careplan is to identify the needs of the resident and plan appropriate care in response to those needs. Presence/absence of a medication listed on the careplan could be dependent upon the applicable diagnosis and effect of the medication(s).

12. Prior interpretive guidance did not specifically address frequency of review/ reduction of antidepressant medications; however, current language addresses “all other psychopharmacological medications” as needing to be reviewed for tapering. **One would assume that antidepressants would fall into the category of “psychopharmacological medications other than antipsychotics and sedative/hypnotics,” thus would be reviewed for tapering. Please clarify.**

RESPONSE:

An antidepressant medication is considered a psychopharmacological medication, thus, would be reviewed for tapering. Keep in mind that a “review” must be conducted, however, if reduction is clinically contraindicated due to the resident’s maintenance or improvement in condition while taking the current dose of antidepressant medication, tapering is not mandated. Rather, documentation of review and rationale for continued use must be present.

13. The Train- the-Trainer program provided by ISDH to the three associations included “Job Aids.” Job Aid #10, under Sedatives/Hypnotics states: *“tapering must be attempted during the previous three quarters before it is considered clinically contraindicated for that year.”*

This language (stating, must be attempted during the previous three quarters...) does not appear in the interpretive guidance. **Was this a misprint from an earlier draft of F329, thus should be disregarded?**

RESPONSE:

CMS provided a corrected Job Aid #10 which deleted language that was not found in the Interpretive Guidance. The correct wording is, “for as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer’s recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated.”

14. **LTC NEWSLETTER CORRECTION:**

It was noted that the Transfer/Discharge instruction and form distributed in the January 2007 LTC Newsletter was inadvertently in error. Please note the following:

-Although it is stated that the forms are for “Involuntary Transfer or Discharge,” please note that the forms are to continue to be utilized for transfers/discharges as per previous instruction and NOT for Involuntary Transfer or Discharge ONLY.

-The forms provided do not have the Appeal Rights listed in 12 point font as required. Thus, forms will be revised and shall be made available on the ISDH website. In the interim, providers will not be held responsible should the provider have already implemented the use of the forms provided inadvertently by ISDH. Simply, replace the forms when the revised copies are available on the website.

15. Would you please confirm that if a resident prefers a certain brand of an item such as toothpaste or shampoo that is not provided by the facility, the resident may request the facility to reimburse them in an amount equal to the facility’s cost for the item that they do provide as part of the Medicaid per diem rate. For example, the facility provides Pepsodent toothpaste (facility cost of 50 cents per 4 oz tube.) The patient prefers Crest and has the family member purchase it from their personal needs allowance at a cost of \$1.50 for 4 oz. The patient could then request the facility to deposit 50 cents into their PNA account. Regardless of what price the patient pays for the items they prefer to use, the facility is only obligated to pay the amount that the item costs the facility.

RESPONSE:

If a resident wants a certain brand of a product that the facility does not have, the facility (or someone authorized by the resident) may secure that brand and the resident's personal funds account may only be billed for the difference (if any) between the two products. F162 Interpretive Guidelines supports this response.

16. Our DON is having some questions about staging of open areas. She has read the interpretive guidelines, but there are still some skin areas that are at times questionable. If we observe an area which is sheared or abraded (for example, tender skin which has been wiped with a washcloth), should the area be staged since it is just sheared off?

RESPONSE:

Staging of open areas applies to pressure ulcers. If the area is not from pressure, the facility would need to measure and describe the area, but staging would not be required. If the area worsens from pressure, then staging may apply.

17. We have 2 residents who scratch themselves raw, may be a dementia behavior. We lotion them liberally – do Aveeno baths, but no real success. Would thin cotton gloves like garden gloves be acceptable? Or would this be considered a restraint?

RESPONSE:

To determine if the gloves are a physical restraint, please assess the glove usage using the physical restraint definition. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Additionally, the facility needs to rule out any clinical reasons for the scratching. Has the resident had a dermatology consult? Review of meds by the pharmacist? Environmental causes? Are the residents given activities to occupy their hands and divert their attention from scratching?

18. Are refrigerators allowed in resident rooms?

RESPONSE:

Resident refrigerators are allowed in long term care facilities in Indiana in accordance with facility policy. The facility policy should address at minimum: Appliance safety prior to use and on-going preventive maintenance, cleaning and monitoring of the refrigerator.

19. F161 – “Assurance of Financial Security” – Please clarify the survey procedure found within the interpretive guidance which states: *“if your team has any concerns about residents’ funds, check the amount of the surety bond to make sure it is at least equal to the total amount of residents’ funds, as of the most recent quarter.”*

Does this direct to look at daily balances for the most recent quarter?

There have been a few facilities cited when there have been sporadic days in a month where a large deposit was made and then withdrawn a few days later. The deposit placed the facility over the surety bond amount. However, the balance did not remain consistently above the amount (for example, at month end, the balance was always below the surety bond amount).

To ensure that this never occurs, would require the facility to carry a surety bond in an amount in extreme excess of the facility's normal month end balance, in that the facility could never truly anticipate the potential deposit of a large amount of money. Should a large deposit be made and left in the account, the facility would certainly be obligated to increase the surety bond amount accordingly.

Does the surveyor look at month/quarter end or at all daily balances of the last quarter? Please clarify.

RESPONSE:

Refer to F161 Interpretive Guidelines. Surveyors are required as part of Phase 2 survey protocol to check the amount of the surety bond to make sure it is at least equal to the total amount of resident funds, as of the most recent quarter.

CNA's with verified findings as of 04/03/2007

A complete listing can be found at <http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>.

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

CNA's with verified findings as of 04/03/2007

A complete listing can be found at <http://www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm>.

CHATTIN, REBECCA J	CUMMINS, KATHY	ESHELMAN, KAREN
CHEEK, DIANA L	CUNNINGHAM, DANA	EVANS, ALISHA
CHILTON, TINA L	CURLIN, BARBARA A	EVANS, TAMIKA A
CLABAUGH, DEBRA J	CURTIS, JACQUELINE	EVANS, WHITNEY L
CLARK, ERNESTINE	CUSHINBERRY, SANDRA L	EWUMI, EMMANUEL A
CLARK, KIMBERLY	DAVIDSON, EDITH	FAITH, NANCY M
CLARK, KYMYATA T	DAVIS, DEDRIA L	FARKOS, MARJORIE
CLARK, SABRINA R	DAVIS, MAXINE -	FARRIS, AMANDA R
CLEVENGER, TARA	DAVIS, PAMELA D	FAULK, GABRIELLE L
CLONTS, DARNITA	DAVIS, SHAWN W	FAULKENBERG, MELISSA A
COBBS, RENITA Y	DAVIS, TABATHA A	FAVER, CASEY L
CODY, LESLIE L	DAVIS, VAUGHN L	FENNESSE, TAYNISHA
COFFEE, VALERIE	DAWS, CARLA S	FIDLER, STEVEN D
COFFENBERRY, EMMA J	DAY, COURTNEY A	FIELDS, BELINDA
COLE, PEGGY A	DEAN, MAGDALENE	FINDLEY, DOROTHY F
COLEMAN, KADIYATU W	DELONG, KATHY M	FISH, DONNA
COLLIER, LONNIE	DENTON, DELORES M	FLATER, SHARON K
COLLINS, TERESA	DICKERSON, MYLES A	FLEENER, VANESSA
COLVIN, HENRY	DIERINGER, SARA	FLEMING, DANA C
COLVIN, MARY A	DILDINE, ROBERT W	FLICKINGER, TRACY L
COMER, FAUNA E	DILWORTH, ANGELA	FOLEY, SHARON J
CONNER, ANGELA	DOSS, ALICIA E	FORD, YEVETTE
CONNER, YOLANDA I	DOWNES, MARY L	FOSTER, THERESA J
CONWAY, BONITA G	DRAKE, DAVID R	FOUNTAIN, MONICA
COOK, CHERYL	DRUMMER, DANIELLE	FOUST, JOSEPHINE L
COOK, CORY E	DUFFY, SOPHIA	FRANKLIN, JACQUELYN R
COPPOCK, KATHY	DUNN, AMBER	FRANKLIN, TARA
CORD, KRISTY A	DUNTON, HUMBERTO	FREDERICK, SHERRY L
CORY, DOLLIE	DYER, LILLIAN	FRISQUE, ASHLEY
COSTELLO, TERRI L	DYKES, GARY	FULKERSON, BONNIE J
COUCH, CAROLYN	EAKLE, LEORA C	FULTZ, JESSICA M
COULTER, BETSY J	EARLYWINE, CARRIE	FUSON, CINDY
COUTS, GENISE T	EASTON, SHARON E	GAINES, FAITH L
COX, NANCY -	EASTRIDGE, LORIA E	GAMMON, CLIFFORD
COX, TAWNDA S	ECHTERLING, DARREN R	GAMMONS, JEFF
CRAFT, MISTY D	EDMONDS, LISA M	GANN, JULIA K
CRAIG, ANITA	EDMONDSON, MAKEDA J	GANT, CHARISE E
CRAIG, RUTH M	EDMONDSON, MOLLY S	GARDNER, BRENDA F
CRAWFORD, ANGELA D	EDWARDS, CHERYL L	GARRETT, ALLYNE
CRAWFORD, CYNTHIA L	EIRK, ANN	GARTRELL, CRISTINA R
CREWS, PAULINA S	EISELE, VIVIAN	GASAMA, MARGARET
CRICK, AMANDA	ELKINS, CASANDRA	GEE, TERRI L
CRIDER, KENNETH W	ELLIOTT, SARAH D	GEISE, JUANITA
CRIDGE, WILLIE J	ELLIS, GLENETTA I	GENTRY, TAMIKA L
CRONIN, REBECCA J	ELLIS, SUZANNE	GHOLSON, MARSHA A
CROSS, KRISTY J	ELPERS, APRIL M	GIBAT, JANET M
CUFFEL, PRAMOTE L	ELSEA, RACHEL K	GIBSON, ROSE M
CULPEPPER, YVONNE R	EMMONS, ROBERT	GIBSON, TYNEKA
CUMMINGS, KEVEN	ENGLEMAN, BETTY M	GILBERT, MELINDA G
CUMMINGS, VALERIE J	ENYEART, CASEY S	GILLESPIE, TRACY A

CNA's with verified findings as of 04/03/2007

GILMORE, THERESA D	HAWKINS, FANNIE	HUNKER, DEAN
GLEASON, TIMOTHY L	HAWKINS, HELEN P	HUTCHENS, HEATHER J
GODBERRY, DAVID	HAWKINS, LENA M	HUTCHINS, CAROL
GODWIN, DAVID C	HAYES, JERRY P	HUTCHISON, TANYA
GOHEEN, DONNA P	HAYNES, MARTHA J	HYATT, MINDY
GOINS, MILES B	HAYNES, RANDALL W	INDERSTRODT, JAMES R
GOLISH, CATHY	HEBB, SONJA	INMAN, SHIRLEY A
GORMAN, MC COUDRA	HENDERSON, LANONDRIA	IRVINE, NATHAN A
GRAFF, ADLEN A	HENDERSON, SHERRY L	ISBELL, JENNIFER G
GRAHAM, ANNA J	HENNING, DAVE L	JAMISON, DENISE
GRANT, DWAYNE E	HENSLEY, NORMAN T	JEWELL, NYLA J
GREEN, KENNETH	HIATT, CONCEPCION M	JINADU, OKE I
GREEN, MARILYN K	HICKS, MIKOLA R	JOHNSON, DEVIN L
GREENE, LILLIE D	HIGHSMITH, KATHY	JOHNSON, HELEN G
GREHAN, HEATHER M	HILL, PATRICIA	JOHNSON, JAUNITA M
GRIMES, SHARRON R	HILL, PORTIA	JOHNSON, JOHN
GRIMES, WESTON	HILL, REGINALD	JOHNSON, LARRY D
GROSS, MADALENE A	HILLIARD, DANIELA T	JOHNSON, LISA
GRUBBS, VICKY	HILLMAN, ANGELA K	JOHNSON, MARK
GUY, PAMELA J	HINTON, DONNA E	JOHNSON, MARY A
GUZMAN, ISAAC	HOBBS, ROSE A	JOHNSON, MURICE L
HACKMAN, MELINDA	HOFFMAN, THOMAS L	JOHNSON, ORILL G
HAGERTY, RHONDA	HOLBERT, KELLY L	JOHNSON, TISHA
HALL, LOUIS M	HOLDERMAN, VICKIE L	JONES, ARMETTA J
HALL, WILLA D	HOLECHKO, NELL A	JONES, BENEDETTA C
HALLIBURTON, SHARON B	HOLLEY, MARIE A	JONES, BRIAN W
HAMBY, JANICE A	HOLLIS, SHARNELL	JONES, DALE A
HAMILTON, AMANDA L	HOLLOWAY, ERICA	JONES, ELIZABETH A
HAMILTON, DONNA	HOLMGREN, DIANA L	JONES, GABRIELLE
HAMPTON, CAROLYN W	HOMMEL, SHANNON R	JONES, KERAH
HAND, KRISTIN	HONORABLE, RACHELLE	JONES, LANA K
HANKINS, PEGGY D	HOOD, LAURA -	JONES, MARY F
HANSFORD, SANDRA K	HOOTEN, MICHAEL	JONES, MICHAEL P
HARDIMAN, GAIL L	HORN, SANDRA A	JONES, VANESSA
HARDY, CYNTHIA	HOSKINS, ELLISA I	JORDAN, ANTONIA F
HARMON, VALERIE J	HOSTETLER, SHANNA	JORDAN, KELLY
HARMS, KRISTIE N	HOTTMAN, SANDRA L	JORDAN, SHARON E
HARNESS, MICHELLE	HOTZ, KAREN L	JOSEPH, PAMELA M
HARRIS, ANGIE	HOUPT, MARY E	KANKEL, GREGORY A
HARRIS, JUANITA -	HOUSER, BARBARA	KARCH, MELISSA J
HARRIS, NIKITA	HOWARD, CHARLOTTE A	KAUFMAN, SKYE
HARRIS, TINA S	HOWELL, PHYLLIS S	KAWZINSKI, JUDY
HARROLD, MICHAEL E	HUBBARD, DUWAYNE	KEESLING, JUANITA
HARTING, RAE ANNA L	HUDICK, SANDRA L	KELLY, JENEE' M
HARTMAN, BARBARA A	HUDSON, CATINNA	KENNY, DAVID S
HARVEY, DORIS J	HUDSON, LULU	KERSCHBAUM, AMBER
HARWELL, RICHARD	HUGHES, CYNTHIA K	KERSEY, VANGELEEN
HATFIELD, MARY	HUGHES, DEBORAH K	KESSNER, BRENN A D
HATTER, VICKIE L	HUGHES, LACY J	KEY, ANDREW W
HATTON, DIONTREIA	HUGHES, MICHELLE	KEYES, SANDRA

CNA's with verified findings as of 04/03/2007

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KHUKIE, JAMBO	LYONS, SAN D	MORRIS, CARLENE E
KILGORE, PAUL	MACON, CONSTANCE L	MINION, DELORES (LOIS) M
KING, ANTHONY P	MADDEN, ANGELA D	MINKOSKY, BLANCHE
KING, MELISSA A	MAGEE, PAULA J	MINNIS, RACHEL M
KING, SHIRLEY A	MAGEE, YVONNE A	MITCHELL, LEROY M
KINSER, DARLENA L	MALONE, TAMMY K	MONCRIEF, PAMELA A
KIRK, JANICE M	MANNA, CYNTHIA M	MONTGOMERY JR, CHARLES
KNIGHT, ANGELA Y	MARCRUM, DONALD C	MOORE, CHERYL Y
KNIGHT, CHUCK	MARTIN, BRONDA U	MOORE, LISA
KOEBKE, KENNETH A	MARTIN, DONALD T	MOORE JR, EVERETT F
KOERS, ANNIE	MARTIN, MARCUS E	MORRIS, STACEY D
KOORSEN, TERESA L	MARTIN, RHONDA	MORTIMER, VICKI L
KREISHER, HANNAH M	MARTIN, SWANSETTA	MORTON, TRACEY S
KRUK, NANCY J	MASON, FRIEDA L	MOSER, CAMELLA E
KUJAWA, AMANDA	MASON, MARY L	MOSS, MATTHEW T
KUSTER, JAMES E	MASON, MELISSA K	MOYER, SANDRA
LAISURE, SHIRLEY	MASUNAS, KATHLEEN J	MTHAWANJI, RINA
LAMB, JANE A	MATANO, RUTHIE L	MUMFORD, MEDINA N
LANDON, DOROTHY	MATHIS, TROY L	MURPHEY, SHEILA -
LANDWER, KATHLEEN	MATNEY, DONNETTE J	MURRAY, PATRICIA M
LANE, CINDY	MATTHIE, MICHELLE	MYER, BRIDGET E
LANGER, SUSAN	MAXWELL, JAMESE	MYERS, ELISHA
LAPCZYNSKI, JUANITA K	MAY, ROSIE -	NANCE, BERNITA J
LASTER, ANGELA L	MC CLAIN, VERONICA	NANTZ, JENNIFER
LAWLER, MARGUERITE E	MC CORDUCK, NORA I	NASH, RITA M
LAWSON, STEPHANIE A	MC INTOSH, BONNIE S	NEAL, BARBARA
LE MANSKI, VALERIE M	MC KENZIE, PAMELA A	NEAL, TOINETTE Y
LEE, DELONNA F	MC NEILL, STACEY L	NELSON, RUBY J
LEE, EDNA L	MCBARNES, KEVIN P	NELSON, SHAWNE
LEON, DAVID	MCBRIDE, BRADLEY D	NEWLIN, JUDY J
LESHER, JOY	MCCLOSKEY, JOHN S	NEWPORT -BUSSING, JEANETTA S
LESLIE, ANGELA K	MCCRAY, VERMELL L	NOENS, EMILY
LETNER, CATERINE	MCGOWEN, CAROL M	NOWLAN, BARBARA J
LEWIS, CRAIG A	MCGRUDER, NENA	OLINGER, KATIE H
LEWIS, RITA K	MCINTYRE, KATHY R	ORCUTT, DANIELLE M
LIPE, TIMOTHY R	MCMILLER, GREGORY L	OSBORNE (ADKINS), LISA K
LIPSEY, LISA V	MCMILLIN, BEVERLY J	OWALABI, ISAAC O
LOCKRIDGE, MICHAEL W	MCCROBERTS, MELODY G	OWENS, DANNY
LONBERGER, DEVONNA M	MEADS, STACEY	OWENS, PAMELA K
LOPEZ, SYLVIA	MEDINA, KAREN S	PACE, NAQUITA
LOTT, JOHNNIE B	MELCHI, PATRICIA M	PADGETT, JAMES R
LOUDEN, CARRIE L	MEREDITH, CYNTHIA M	PALMER, NICHOLE M
LOUDEN, HESTER A	MIDDLETON, CHERYL	PARKER, AMBER N
LOWERY, CANDY	MIDDLETON, ROBERT K	PARKER, SANDRA A
LOWTHER, JAMES R	MILLER, ANGELA M	PASSLEY, DARLENE
LOYD, GWENDOLYN J	MILLER, CARRIE	PATEL, MEENA S
LUNDSFORD, KAREN E	MILLER, DAWN M	PATRICK, STEPHANIE L
LUNN, MELISSA V	MILLER, MINNIE L	PATTERSON, JOY
LUNSFORD, JEREMY	MILLER, SHAWN E	PATTERSON, MELISSA
LYNN, MENDELLA J	MIMS, DORIS L	PAYNE, KATHARINE -

CNA's with verified findings as of 04/03/2007

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PAYNE (KELLER), RACHEL L	ROBERTS, MARGARET	SHOWEN, TAMARA L
PEARSON, SAMUEL -	ROBERTSON, KIMBERLY	SHROUT, BESSIE E
PEASE, LAURA K	ROBERTSON, ROBBIN L	SHULTZ, GLORIA G
PENNELL, JR., JAMES G	ROBINSON, GLORIA	SIDEBOTTOM, SEAIRRA S
PENNINGTON, HAROLD M	ROBINSON, MARY LOU	SIGLER, CYRILYN
PEREZ, FREDDIE	ROBINSON, MICHELLE	SILK, CRYSTOL
PEREZ, RHONDA	ROBINSON, SCHEREE L	SIMPSON, KAREN
PERRINE, KARA L	ROGERS, CHERYL	SINGLETON, JILL L
PETERSON, JERMAINE L	ROSENBAUM, JILL	SIZEMORE, SHARON K
PETERSON, NATALIE	ROSS, EUDORA E	SKROPITS, TAMIKA C
PETTIT, ANGELA (ANGIE) -	ROSSOK, JESSICA D	SLATER, PATRICIA K
PFEIFFER, GEORGIA K	ROUNDTREE, CARLA	SLATTERY, PATRICK A
PHILIPS, LEROY E	ROWE, CHERYL L	SMALLINGS, ERIKA
PHILLIPS, CONNIE J	RUBAN, MICHAEL J	SMELKO, SHANNON
PHILLIPS, PATRICIA A	RUCKER, ANGELA L	SMITH, ALICIA
PHILPOT, KAREN	RUSE, CHERYL -	SMITH, ALVENIA D
PIONKE, SUSAN M	RUSH, SCOTTY D	SMITH, CHARLES D
PITTS, KATHERINE	RUSK, FRANCES H	SMITH, JACOB D
POWELL, EDWARD C	SANDERS, ALICIA M	SMITH, JANE M
PRITCHARD, CHRISTINA J	SANDERS, JANET S	SMITH, LANAE D
PRYOR, GERALDINE -	SARVER, TERRELL L	SMITH, MARGIE M
PURNELL, PATRICIA J	SAUCIER, AMEY	SMITH, MARY C
QUERTERMOUS, CALVIN	SAUNDERS, JOHANNA	SMITH, MELISSA J
RAINEY, AMY	SCARBROUGH, TIMMY L	SMITH, NINA
RALSTON, DANIEL	SCHILLING, DOUGLAS N	SMITH, PATRICIA J
RAMEY JOHNSON, COLLEEN S	SCHIMMEL, THELMA J	SMITH, RITA A
RAMIREZ, CORRIE M	SCHISLER, JOHN	SMITH, TYWANNA
RANDALL, DENISE	SCHOONOVER, MICHAEL H	SMITH, VERONICA R
RANKIN, WENDY K	SCHRIVER, TERESA C	SMITH JR, FRED J
RANKINS, TAVARES	SCOTT, ANGELETTA L	SNIDER, RONALD
READNOUR, ARDETH T	SCOTT, BEATRICE	SNYDER, LYNN M
REDDING, RENEE A	SCOTT, LAURIE A	SNYDER, MARK
REED, JUANITA M	SCOTT, SAMARTHA A	SNYDER, VIRGINIA -
REED, KATHY S	SCOTT, SASHA	SODDERS, LISA
REED, PERCIOUS	SEEHAUSEN, ROSEMARIE	SOOS, MARLENE
REED, SCHLUNDA -	SELF, BETTY	SOPHER, TONIA
REED, TAMARA	SELLERS, PAMELA	SOUDER, SHANNON K
REEVES, JULIA M	SERMERSHEIM, GUADALUPE	SOUTH, ELAINE M
REGAN, DAWN M	SESKE, TONIA	SPENCER, JERONE T
REINHARDT, MARY K	SEXTON, ANGELA D	SPRINGER, SHEILA Y
REVELL, STEPHEN W	SEXTON, SHARON S	STACY, SHARON N
REYNOLDS, ERIC J	SHAFFER, LORI D	STARK, BRANDY
RICE, BRANDY M	SHARLOW, SUSAN J	STARKEY, FLORENCE -
RICHARDSON, PAMELA R	SHAW, CARLA J	STARNES, LORENE L
RICHARDSON, PENNY S	SHAW, HEATHER S	STEAVESON, WILIAM
RICHCREEK, KATHLEEN	SHAW, ISAAC R	STEPHEN, HELEN M
RICHMOND, ROSE	SHELTON, ALICIA L	STEPHENS, APRIL
RIDDLE, RHONDA P	SHEPHERD, LONNA L	STERN, REBECCA -
RIGSBY, HEATHER M	SHOAEI, SANDRA J	STEVENSON, GARY
ROBERTS, CYNTHIA E	SHOEMAKER, TIMOTHY E	STEVENSON, SANDRA S

CNA's with verified findings as of 04/03/2007

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STRICKLAND, BRITTNEY L	UPDEGRAFF, GAYLE A	WILLIAMS, VANELLA -
STRICKLANDT, VELMA M	VANCE, JOYCE A	WILLIAMSON, KATHI
STRONG, TESSA G	VANOSDAL, AMANDA	WILLIS, JAIME L
SUMMERS, DONNA M	VEATCH, BRENT	WILLIS, RUBIN
SUTTON, CHRIS	VEST, TERESA F	WILSON, JOANETTE Y
SWANEGAN, DONNA I	VILLEGAS, DAMON R	WILSON, LEE K
SWARTZ, BRACIE	VINCENT, ANGELA G	WILSON, RHONDA G
SWEENEY, BILL J	WADE, KAREN S	WILSON, WENDY
SWEET, GREGG H	WALDON, MARCIA	WINFIELD, DORIS D
TABRON, ZAKKIYYA	WALKER, DEBRA C	WOLF, MARTHA
TATA, MEZZIA A	WALKER, JOSPEH E	WOLF, MYRL D
TAUBER, PATRICIA A	WALL, BARBARA S	WOLFE JR, SIDNEY E
TAYLOR, AMBER M	WALLS, SHARON	WOODRUFF, KIMBERLY
TAYLOR, DONNISHA M	WALTON, BRIGITTE N	WOODS, AMBER D
TAYLOR, HILDRED I	WARD, HELEN L	WOODS, DONALD C
TAYLOR, LISA	WARD, JOHNNIE L	WOODS, SHERYL L
TEAGUE, CAROLYN	WARD, TONYA A	WORLEY, JEFFREY T
TEMPLETON, SAMMIE L	WARE, BRENDA	WOZNIAK, SUSAN
TERESS, AARON L	WARNER, SHARON L	WRIGHT, DEBRA R
THOMAS, JENNY E	WARREN, ANN M	WRIGHT, SCOTT L
THOMAS, MARGARET J	WARREN, SHELIA -	WRIGHT, SHELBY
THOMAS, PAMELA	WASH, BENJAMIN S	WRIGHT, STEVEN V
THOMAS, TERESA	WASHINGTON, MONICA	YELDIG, BONNIE -
THOMPSON, LINDA S	WATERS, DEUNDREA	YODER, LYDIA
THOMPSON, MELISSA	WATKINS, CALANDRA S	YODER, SHANNON
THOMPSON, MICHAEL B	WATSON, CATHY J	YOUNG, DOROTHY
THRASHER, CARLA J	WATSON, JOYCE A	YOUNG, JOHN H
THURMOND, CAROLYN D	WATSON, TY'ASHA O	YOUNG, SHELLEY L
TILFORD, ROBERT M	WAYNICK, CHARITY	ZVIDZAYI, NYARADZO V
TIPTON, TANDI S	WEBSTER, HERMAN L	
TISON, CAROLYN S	WEDDLE, SEASON	
TONEY, CAROLYN	WEISNER, JANET L	
TOOMBS, RANDALL L	WELDON, KATRINA M	
TOWNSEND, JUDY L	WELDON, MICHELLE R	
TOWNSEND, MICHELLE L	WELDON, VIOLA M	
TREAT, ANITA A	WESTFALL, MARY	
TRENNEPOHL, KAMMA E	WHELCHER, ADRIANE L	
TRUAX, RHONDA K	WHITAKER, JACK A	
TRUE, JESSICA	WHITE, ANGELYCA	
TRUXAL, SARA L	WHITELY, SUE	
TSCHAENN, TAMMY L	WIGGINS, LASHONDA S	
TUCKER, KENDRA D	WILBERT, DANIEL	
TUCKER, TASHIKA M	WILIAMS, CHRISTINE N	
TUMEY, JO ELLEN	WILKERSON, ROBIN L	
TURNER, PATRICIA D	WILKINSON, MICHELLE	
TURPEN, JULIE L	WILLIAMS, CAROL J	
TUSSEY, PAMELA S	WILLIAMS, JANICE	
TYLER, ANGELA K	WILLIAMS, ROCHELLE	
UMPHRYES, JENNY M	WILLIAMS, SYLVIA	
UNVERZAGT, MICHELLE	WILLIAMS, TRACIE M	



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-10

DATE: January 12, 2007

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: **Multiple Providers** - 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, Intermediate Care Facilities for the Mentally Retarded – Medical Gas Storage and Usage Considerations

Memorandum Summary

- Up to 300 cubic feet of nonflammable medical gas may be accessible as operational supply rather than storage, when properly secured.
- An individual container of medical gas placed in a patient room for “as needed” (but regular) individual use is not required to be stored in an enclosure, when properly secured.

The purpose of this memorandum is to answer questions regarding storage requirements for small quantities of medical gas and what is considered when determining if a medical gas container is “in use.” These issues are not addressed by the 1999 edition of NFPA 99 Health Care Facilities but information on these issues can be found in the 2005 edition of NFPA 99 Health Care Facilities at 9.4.3.

Q1. Can up to 300 cu ft of nonflammable medical gas (12 E sized cylinders) associated with patient care be located outside of an enclosure at locations open to the corridor in a healthcare facility?

A1. Yes, up to 300 cu ft of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse’s station or in a corridor of a healthcare facility.

This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an “operational supply” and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in “crash carts” and in use on wheelchairs or gurneys.

Q2. When medical gases are used by patients on a “PRN” basis does the container have to be stored in an approved gas storage room when not being used?

A2. The term “PRN” means “as needed.” An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.

If you have any questions concerning this memorandum, please contact James Merrill at James.Merrill@cms.hhs.gov

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

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)



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-16

DATE: March 2, 2007
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Clarification of Provider Number Nomenclature

Letter Summary

- Following the implementation of the National Provider Identifier (NPI), the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers and used on all Survey and Certification, and patient assessment transactions.
- In order to distinguish its role from that of the NPI, the Medicare/Medicaid Provider Number has been renamed the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN).

By law, the NPI will become the only acceptable provider identifier on Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard Transactions (i.e., claims, remittance advice, eligibility inquiries, prior authorization and referral, and claims status).

However, post NPI implementation, the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers and used to verify Medicare/Medicaid certification on all survey and certification and resident/patient assessment transactions. In order to avoid confusion with the NPI, the Medicare/Medicaid Provider Number has been renamed the CCN. All applicable forms, data entry fields, systems, and manuals are being revised to reflect this new name and the role of the CCN versus the NPI. In some activities, both numbers will be used.

Effective immediately, 'CCN' will replace the term 'Medicare/Medicaid Provider Number' in survey and certification, assessment-related activities, and communications. This terminology change should be explained in those instances. When the NPI is called for on any form or transaction, it should be provided, if available. When the Medicare/Medicaid Provider Number (also known as the Online Survey, Certification, and Reporting (OSCAR) Number; Medicare Identification Number; or provider number) is requested, the CCN should be provided.

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NOTE: This policy does not apply to the Clinical Laboratory Improvement Amendments (CLIA) Number which will continue to be used as it has been.

Effective Date: This guidance is effective immediately. The State Agency should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all surveyors, survey and certification staff, their managers, and State and RO training coordinators. It should also be shared with certified providers/suppliers.

/s/

Thomas E. Hamilton

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