Learn Tips for Accurate Transfer Documentation
Caralyn Davis, staff writer

Transfer (MDS item G0110B) is one of the four late-loss activities of daily living (ADLs) that impact resident placement in all 66 RUG-IV groups. (To learn how the total ADL score is calculated, see page 6 – 19 of the MDS 3.0 RAI User’s Manual.) Key issues that MDS nurses should address when teaching certified nursing assistants (CNAs) about transfer include:

The full definition of transfer
The RAI User’s Manual defines transfer as “how resident moves between surfaces including to or from: bed, chair, continued on page 4

Survey Readiness: Preparing for Tasks 6 & 7
Betty Frandsen, RN, NHA, MHA, C-NE

The fifth and final article in our series on survey readiness addresses traditional standard survey tasks 6 and 7. These tasks focus on surveyor analysis of observations of the resident, delivery of services by the facility staff, interviews, and record reviews with comparison of that information to long-term care regulatory requirements.

Task 6—Information Analysis for Deficiency Determination
During task 6 surveyors review and analyze collected information to determine if regulatory requirements are met or not met, and whether the team needs to conduct an extended survey. Their pool of information builds throughout the survey, and they hold daily meetings to discuss observed problems, areas of concern, and possible failure to meet requirements.

[Surveyors’] pool of information builds throughout the survey, and they hold daily meetings to discuss observed problems, areas of concern, and possible failure to meet requirements.

continued on page 6

Moderation. Small helpings. Sample a little bit of everything. These are the secrets of happiness and good health.
—JULIA CHILD
GETTING AROUND AFTER THE UPGRADE

Understand the small changes that make a big difference in your AANAC website experience

Membership Menu

1. JOIN Sign up to become an AANAC member
2. RENEW Keep your membership current by renewing yearly
3. BENEFITS Review what you receive as an AANAC member
4. CORPORATE SPONSORSHIPS Information about our Corporate Sponsor program
5. DOWNLOAD MEMBER GUIDEBOOK In case you lost your original
6. MEMBER CENTER Change or check your password, login and personal information in a snap

Navigation

Member Center

1. EDIT PROFILE Control your personal information including address, phone, facility and email
2. CHANGE PASSWORD Make sure you never forget your password by choosing one with personal meaning
3. CHANGE LOGIN No more randomly generated characters!
4. MY DOWNLOADS Pick up your course PDFs here after purchasing
5. MY TRANSACTIONS See what you’ve bought, and print your receipts on the spot
6. MY DUES Another way to check on your membership status and renew

continued on page 3
After much hard work and dedication from the AANAC staff and (much appreciated) patience from our membership, we have completed the first phase of our system upgrade. While many of the changes that we implemented were “behind the scenes,” there have been some changes to the AANAC.org website which will help improve functionality and navigation for our members. We’ve put together this spread to point out some of the places where you might see a noticeable change. If you have any questions, or difficulties, please don’t hesitate to contact us at 800.768.1880 or by emailing info@aanac.org.
Transfer Documentation, continued from page 1

wheelchair, standing position (excludes to/from bath/toilet).” Sometimes CNAs focus solely on how the resident transfers from the bed to the chair. “However, transfer includes the chair to the bed and the chair to the wheelchair as well,” says Jane Belt, RN, MS, RAC-MT, manager of the Clinical Group at Plante & Moran PLLC in Columbus, Ohio. “Transferring in and out of a wheelchair is a lot more difficult than getting in and out of a chair, so MDS nurses should ensure that nursing assistants take credit for the help they are providing with that.”

**Limited assistance vs. extensive assistance**

Belt tries to avoid the terms “limited assistance” (2) and “extensive assistance” (3) when teaching transfer self-performance (G0110B1) because they often confuse CNAs. “Most nursing assistants grasp what ‘independent’ (0), ’supervision’ (1), and ‘total dependence’ (4) mean fairly quickly,” she notes. “Limited and extensive assistance is where I see the greatest problem with all of the ADLs, but particularly with transfer.”

So Belt teaches CNAs to pay attention to where their hands are—on top or on bottom. “Limited assistance is contact. If I put my hand on top of the resident’s arm, for example, I am making contact. Making contact does not take muscles, and it is limited assistance,” she explains.

“However, when my hand goes from the top to the bottom, or underneath, that arm, leg, or other body part, then the assistance I am providing becomes weight-bearing,” says Belt. “I’m using my muscles. It might be a little, or it might be a lot—to the point that I’m sweating—but it’s all weight-bearing, and that moves the assistance I am providing to extensive if the resident participates in any way or total dependence if the resident doesn’t take part in the transfer at all.” (See Plante & Moran’s slides, page 5.)

CNAs often fail to capture extensive assistance in transfer, agrees Deb Myhre, RN, C-NE, RAC-MT, a consultant with Ankeny, Iowa-based Continuum Health Care Services. Myhre uses the word “boost” to educate CNAs. “If I see a code of ‘2’ on transfer, I’ll ask the staff, ‘Was there a boost?’ Often, they will acknowledge that they lifted the resident, but didn’t capture it because ‘it was just a little one.’ MDS nurses should teach staff that a boost is a boost, whether it is a little one or a big one.”

**One-person physical assist vs. two-person physical assist**

CNAs may not be capturing all of the two-person assists (3) that they should be for transfer support provided (G0110B2). Consistent reports of one-person assists (2) on the night shift should be a red flag for potential undercoding, suggests Belt. “The MDS nurse needs to pursue what’s occurring on the night shift. Staff members tend to travel in twos at night. So if they go into a room and get a resident out of bed and into a standing

*continued on page 5*
position, for example, so the resident can go to the bathroom, is only one nursing assistant helping the resident while the other one watches and chats, or are they working as a pair and both providing assistance? It may be a one-person assist, but there's a good chance it was a two-person assist.”

The impact of transfer on bed mobility and toilet use.

While all of the ADLs are coded separately on the MDS, they are often intertwined out on the floor, says Belt. “Transfer can impact other ADLs significantly, particularly bed mobility and toilet use. If you aren’t capturing one accurately, you may not be capturing the others accurately either.”

For example, a resident’s needs in transfer support provided should generally correlate with his or her needs in toilet use support provided (G0110A2), says Belt. “Toilet use includes the act of transferring onto or off of the toilet. If two staff members are needed to transfer the resident from the chair to the bed, the odds are good that two are needed to transfer the resident off of the toilet, and vice-versa. It’s not an absolute that transfer and toilet use have to correlate, but it’s worth the MDS nurse investigating to ensure the nursing assistants understand the definitions of both items.”

Similarly, CNAs often code transfer as a two-person assist but code bed mobility (G0110A2) as a one-person assist. “So once the two staff members got the resident sitting on the edge of the mattress, did one of them walk away while the other staff member helped position the resident?” asks Belt. “Again, that could happen, but the MDS nurse should find out if staff understand the definitions.”

Editor’s note: To find out when Belt is teaching, see the AANAC 2011 workshop schedule, page 11.
holding daily de-briefings to share their observations of survey team interest in specific residents or issues, questions asked, and charts reviewed. Focus discussion on areas of care or the environment that the survey team is reviewing and specific questions they are asking. This will help identify problems that can be immediately addressed for correction. If the survey team is observing a concern, it is far better for staff to correct it in a few hours than to have the issue continue throughout multiple days of the survey unaddressed. Staff members must support each other and perform as a team.

The survey team’s decision-making process includes review of each surveyor’s concerns and evidence related to requirements the facility has potentially failed to meet.

The survey team’s decision-making process includes review of each surveyor’s concerns and evidence related to requirements the facility has potentially failed to meet. They work sequentially through the interpretive guidelines, section by section, to assess their gathered evidence related to each section. Their analysis includes consideration of both the adequacy of facility policies and protocols and the actual implementation of those systems. If no problems are identified for a particular tag number, then no deficiency exists for that tag and they move on. When failure to meet requirements of quality of care, resident rights, and quality of life is discovered, it typically falls into two categories:

1. Potential or Actual Physical, Mental, or Psychosocial Injury or Deterioration to a Resident, Including

continued on page 7

**Medicare University**

Do you find yourself mired in the confusing, complex and ever-changing regulations and requirements of Medicare? If so, this three-day intensive seminar is for you. From admissions to audits, our Master Teachers will guide you through the do’s and don’ts to ensure your facility is being reimbursed accurately and your residents are receiving the care they need.

**Topics to be covered include:**
- Medicare Basics
- Medicare A
- SNF Documentation
- Rehabilitation Therapy Under PPS
- PPS System
- RUG-IV
- Consolidated Billing
- Medicare Review Process

Example scenarios, flowcharts, checklists and other tools will help you apply the knowledge you gain in this seminar to real-life situations. This is a must-attend event for clinicians and anyone involved in the billing process.

**Upcoming Medicare University Workshops:**

**Taught by:**
**Judy Wilhide Brandt, RN, RAC-MT, C-NE:**
**July 12 - 14, 2011**
**Naperville, IL**

**Register today!**
[aanac.org/workshops](http://aanac.org/workshops)

The three-day Medicare University provides 7.5 CEs each day, for a total of 22.5 CEs for nurses.
Violation of Residents' Rights—
Situations that illustrate this level of harm include:
- Development of or worsening of a pressure sore
- Loss of dignity due to lying in a urine-saturated bed for a prolonged period
- Social isolation caused by staff failure to assist a resident to participate in scheduled activities
- Nurses’ aides who fail to wash their hands between caring for residents

2. Lack of or Potential Lack of Reaching the Highest Practicable Level of Physical, Mental, or Psychosocial Well-Being—
Examples include:
- Identification of a resident’s desire to reach a higher level of ability in which care was planned accordingly, but the plan was not implemented or not consistently followed, and the resident failed to improve
- A resident need was identified in the comprehensive assessment, but no care plan was developed or the need was not prioritized for plan development at a later time, so the resident was not given the opportunity to improve
- The resident’s need or problem was not identified so no care plan was developed to address the need
- Written procedures or oral explanations did not provide information about which resident should be fully informed, and a treatment was given that the resident may have refused if informed

continued on page 8
Substandard Quality of Care will be determined if one or more cited deficiencies under Resident Behavior and Facility Practices, Quality of Life, or Quality of Care rises to the level of immediate jeopardy to resident health or safety, or widespread deficiencies at severity level 2 or 3. If this occurs, an extended survey will be completed no longer than 14 days after the standard survey, if the team is unable to complete it within the standard survey time-line.

To prepare for surveyor scrutiny, develop a process similar to surveyor review. Throughout the year, assign your staff development coordinator and/or supervisors to systematically train staff members on the requirements of each F-Tag in the State Operations Manual (SOM) listed under the following five primary areas of surveyor focus:

- 42 CFR 483.10—Resident Rights
- 42 CFR 483.13—Resident Behavior and Facility Practice
- 42 CFR 483.15—Quality of Life
- 42 CFR 483.20—Resident Assessment
- 42 CFR 483.25—Quality of Care

The Quality Assurance and Improvement Committee should evaluate compliance with each grouping by conducting audits that target specifics of the regulations included in these categories.

continued on page 9
Task 7—Exit Conference

At the exit conference the survey team informs facility personnel of their observations and preliminary findings. The ombudsman and an officer of the Resident Council are invited by the surveyors, as well as one or two other residents. Staff have the opportunity to supply additional information they believe is pertinent as findings are shared by the survey team. This is why it is so important to be alert to issues identified by the survey team and to offer information that may refute findings before they become part of the Statement of Deficiencies. Scope and severity determinations are not discussed in the exit conference, but come later as part of the Statement of Deficiencies. If an extended survey is required and cannot be completed prior to the exit conference, the administrator is informed that deficiencies discussed in the exit conference may be amended.

Conclusion

Annual survey is a stressful time, even when a nurse leader has the foresight to establish a systematic approach to observing and auditing the nursing department’s activity and provision of care. As we can see by the vast information reviewed in this five-part series, the best way to remain survey-ready is to work on being ready all year long. A facility team that understands what needs to be done and commits to doing it the right way has the advantage over facilities that lack this vision. Preparation involves hard work and willingness to change when practices and systems are not bringing about desired results, but the effort is worth it. A job well done, consistent customer satisfaction, and good annual surveys are motivating rewards worth seeking.

The Surveyors are here today... and we didn’t expect them until later!

Never again be caught unprepared. AANAC provides strategies & resources to manage the moment for successful survey results.

- Teach your staff how to work confidently with surveyors when they arrive.
- Deficiencies can happen. AANAC will lead you through the easy steps to correct them.
- Let AANAC show you how to create an environment in your facility that shines during survey.
- Learn simple and manageable preparations for both the traditional and QIS.
- Craft a culture of wellness for your staff and residents that will allow you to show off the wonderful job you’re doing.
- QM is changing and AANAC will provide the steps to allow you to change with it.
- AANAC will walk you through the new age of quality assurance and performance improvement with easy QM data-collection techniques.
- The AANAC Quality Management guide will help show on paper the actions designed to create quality outcomes.

Visit aanac.org/store to order today!
2011
AANAC
FALL
EDUCATION
FORUM

San Diego, CA
Wednesday, October 12 &
Thursday, October 13, 2011
Hyatt Regency La Jolla
## AANAC 2011 WORKSHOP SCHEDULE

<table>
<thead>
<tr>
<th>TRAINING PARTNER</th>
<th>MASTER TEACHER</th>
<th>DATES</th>
<th>CITY/STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RAC-CT CERTIFICATION WORKSHOPS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aging Services of Michigan</td>
<td>Amy Franklin</td>
<td>July 12 – 14</td>
<td>Lansing, MI</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>July 19 – 21</td>
<td>Westmont, IL</td>
</tr>
<tr>
<td>IAHSA—Indiana Assoc. of Homes and Services for the Aging</td>
<td>Jane Belt</td>
<td>July 19 – 21</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>July 19 – 21</td>
<td>Tinton Falls, NJ</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>July 26 – 28</td>
<td>Greer, SC</td>
</tr>
<tr>
<td>RRS Healthcare Consulting Services</td>
<td>Rena R. Shephard</td>
<td>July 26 – 28</td>
<td>Los Angeles, CA</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>Aug 2 – 4</td>
<td>Seattle, WA</td>
</tr>
<tr>
<td>KAHSA—Kansas Assoc. of Homes and Services for the Aging</td>
<td>Ronald Orth</td>
<td>Aug 3 – 5</td>
<td>Wichita, KS</td>
</tr>
<tr>
<td>IAHSA (Iowa)</td>
<td>Deb Myhre</td>
<td>Aug 9 – 11</td>
<td>Des Moines, IA</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>Aug 9 – 11</td>
<td>Raleigh, NC</td>
</tr>
<tr>
<td>OHCA—Ohio Health Care Association</td>
<td>Robin Hillier</td>
<td>Aug 9 – 11</td>
<td>Columbus, OH</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>Aug 16 – 18</td>
<td>Pittsburgh, PA</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>Aug 23 – 25</td>
<td>Lancaster, NY</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>Aug 23 – 25</td>
<td>Brookfield, WI</td>
</tr>
<tr>
<td>Clinical Reimbursement Solutions, LLC</td>
<td>Ronald Orth</td>
<td>Aug 30 – Sept 1</td>
<td>Honolulu, HI</td>
</tr>
<tr>
<td>Idaho Health Care Association</td>
<td></td>
<td>Aug 30 – Sept 1</td>
<td>Boise, ID</td>
</tr>
<tr>
<td>Maine Health Care Association</td>
<td>Andrea Otis-Higgins</td>
<td>Aug 31 – Sept 2</td>
<td>Augusta, ME</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>Sept 13 – 15</td>
<td>Green Bay, WI</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>Sept 13 – 15</td>
<td>New Orleans, LA</td>
</tr>
<tr>
<td>RRS Healthcare Consulting Services</td>
<td>Rena R. Shephard</td>
<td>Sept 13 – 15</td>
<td>Atlanta, GA</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>Sept 13 – 15</td>
<td>Virginia Beach, VA</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>Sept 20 – 22</td>
<td>White Bear Lake, MN</td>
</tr>
<tr>
<td>TAHSA</td>
<td>Ronald Orth</td>
<td>Sept 20 – 22</td>
<td>Ft. Worth, TX</td>
</tr>
<tr>
<td><strong>MEDICARE UNIVERSITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Services Network</td>
<td>Judy Wilhide Brandt</td>
<td>July 12 – 14</td>
<td>Naperville, IL</td>
</tr>
</tbody>
</table>

The workshop schedule is subject to change and is updated regularly. To see a full AANAC Training Partner workshop schedule, visit aanac.org/workshops
AANAC’s Exclusive Analysis of the CMS RAI Manual changes

CMS has recently released RAI manual changes. AANAC has provided expert analysis and a summary of those changes, which are available on the AANAC website in the “Need to Know” section.

Decipher the encoded words in the statement below using the numbers and letters on the phone pad. Remember that each number can stand for 3 or 4 possible letters. Information may be accessed in the June 7 LTC Leader.

“The RAI User Manual included several edits designed to clarify that documentation must be in the 633225 732673 by a physician stating that the resident’s life expectancy may be less than 6 months.”

Reimbursement Tip
Bone stimulators are not excluded from PPS billing.
Ronald A Orth, President
Clinical Reimbursement Solutions
Milwaukee, WI

Treatment of Members Policy
AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

FAQ referral
Do you have a question you need answered NOW? Members of AANAC can go directly to the experts! Go to the FAQ section of the website. The answer may be right in front of you!
A resident was in a nursing home and dependent on a feeding tube for all nourishment. His Part A benefits were exhausted. He was discharged from the facility and was at home for 60 days with home health. Will he be eligible for a new 100 Part A SNF days after being readmitted to SNF after a three-day hospital stay?

Yes, he will, even if he continued to get 100% of nutrition and fluids per PEG, because he was not in a SNF. A Medicare beneficiary gets a new benefit period if he or she goes 60 consecutive days without an inpatient hospital admission and without receiving a skilled level of care in a SNF.

Ronald A. Orth, RN, NHA, CPC, RAC-CT
(raorth@clinicalreimbursement.com)

A resident was hospitalized for urosepsis and admitted to the SNF on Part A related to the urosepsis. Since then, he developed an unstageable pressure ulcer. It is now a stage 4 and therapies are getting ready to cut. Billing and social services are debating whether he should be continued on Part A for the wound, since it was not what he was hospitalized for. Can he be covered for this?

Chapter 8 of the Medicare Benefit Policy Manual specifies that coverage must be related to a condition that was treated during the 3-day qualifying hospital stay or the subsequent SNF Part A stay. So, if this pressure ulcer arose while he was on Part A in the SNF, assuming that the treatment is daily and skilled, the Part A coverage can continue.

Rena R. Shephard, MHA, RN, RAC-CT, C-NE
(rrs2000@aol.com)

Our billing office says we need to do a Start of Therapy (SOT) OMRA/5-day assessment when a resident is admitted on a Friday and not seen by therapy until Monday, even if the resident RUGs at RUC for the 5-day assessment. Is that right?

This is one of the biggest misconceptions with SNF PPS and MDS 3.0. SOT OMRA’s are OPTIONAL. We are never required to complete a SOT OMRA. 5-day assessments are required for Medicare payment. If you can obtain a Rehab RUG using a 5-day PPS assessment, it begins payment on day 1 of the Medicare A stay regardless of the therapy start date. The 5-day assessment works exactly the same in MDS 3.0 as it did in MDS 2.0. The 5-day PPS assessment begins payment on day 1 and pays through day 14 if the resident remains on Medicare A through day 14.

Carol Maher, RN-BC, RAC-CT
(cmahero1211@earthlink.net)
WE’RE WITH YOU EVERY STEP OF THE WAY.

Find out more at aanac.org

At every step in your long-term care journey, AANAC has the resources you need to succeed.