MDS Workload: When to Ask for Help—Part One
Caralyn Davis, Writer/Editor/Researcher

Workload too heavy? Here’s what to do
MDS nurses now have five full months of experience with the MDS 3.0. For some lucky nurses, their workloads are now dropping back to manageable levels following the frenzied pace of the transition. However, some MDS coordinators still are enduring 50 – 70 hour work weeks as they try to fulfill all of their responsibilities, according to anecdotal reports.

Rather than sink under the weight of too many responsibilities, overworked MDS nurses can ask for help, points out Ronald Orth, RN, NHA, RAC-MT, president of Clinical Reimbursement Solutions LLC in Milwaukee, Wis., and an AANAC-certified master teacher. “Some facilities have

CMS Revises Civil Money Penalty Regulations for Nursing Homes
Betty Frandsen, RN, NHA, MHA, C-NEx

On Friday March 18, 2011, the Centers for Medicare and Medicaid Services (CMS) published a new rule regarding civil money penalties, which goes into effect on January 1, 2012. This rule revises and expands current regulations regarding imposition and collection of civil money penalties when nursing homes are not in compliance with Federal regulations.

Among the enforcement remedies used to address a facility’s noncompliance are civil money penalties.

Medicare and Medicaid related surveys are used by CMS and State Medicaid agencies as the basis for determining whether to approve or deny a provider’s participation agreement, recertify a facility’s participation in the programs, or terminate a facility’s participation. Among the enforcement remedies used to address a facility’s noncompliance are civil money penalties. CMS expects penalties to motivate continuous compliance with CMS’ basic expectations regarding the provision of quality care.

The new rule establishes a new option for providers—the independent informal dispute resolution process (IIDR). Facilities will have a choice between the existing Informal

continued on page 4

continued on page 7

How beautifully leaves grow old. How full of light and color are their last days.
—John Burroughs
Terminal Palliative Sedation

Terminal palliative sedation involves an explicit decision to make the patient unconscious to prevent or respond to otherwise unrelievable physical distress. The word terminal is not meant to imply that the purpose is terminating life. In the context of far-advanced disease and expected death, life-prolonging interventions such as artificial nutrition and hydration, antibiotics, and mechanical ventilation are not instituted and are usually withdrawn if already in place. They are withheld during terminal palliative sedation because they could prolong the dying process without contributing to the quality of the patient’s remaining life. In end-of-life care, intensive symptom management coupled with the withholding of life-sustaining treatment has widespread ethical and legal support. However, because death is foreseeable, the act can be ambiguous.

What sequence of events might raise this issue? By law, a patient with the capacity to make decisions is permitted to refuse any medical treatment, even life-sustaining treatment. For example, if a partly paralyzed patient refused the only means of breathing—further ventilator support—you would surely agree the patient should be sedated before being subjected to slow suffocation. Similarly, a patient choosing to refrain from food or water merits sedation if needed. Artificial feeding has legally been deemed to be medical treatment. The Supreme Court made this clear in the case of Nancy Cruzan, who was in a permanent persistent vegetative state and whose parents, acting on her behalf, refused artificial nutrition and hydration by stomach tube. The issue was whether a patient who is not terminally ill may refuse life-supporting artificial nutrition and hydration. The Supreme Court affirmed “the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.”

continued on page 9
Carol Siem, MSN, RN, BC, GNP, Chair of the AANAC Board, was recently named the Alumnus of the Year at the University of Missouri. She is a clinical educator and team leader of the statewide Quality Improvement Program of Missouri (QIPMO), a cooperative program between the MU Sinclair School of Nursing and the Missouri Department of Health and Senior Services (DHSS).

An expert in gerontological nursing and the federal Minimum Data Set (MDS) assessment process, she most recently has also been training long-term care staff across the state of Missouri in the transition to the MDS 3.0. “My role in the AANAC benefits the state because I have new information coming in at the national level that I can feed into the state level to help local nursing homes,” said Siem.

Carol was awarded the alumnus of the year honor in a ceremony on Friday, April 15, 2011 at the University of Missouri. Congratulations Carol! You set an example for us all!

Carol’s Speech

“I would like to thank the Alumni Association for choosing me as the Alumna of the year. Little do you know that in my heart I am accepting this award for Dr. Marilyn Rantz’s QiPO team and all the nurses that work in LTC day in and day out. The Silver Tsunami is coming and in my job I help to prepare the nurses to care for the elders of tomorrow which will be all of us in this room. My education at MU helped me to prepare and find the job of my dreams. The job allows me to work with NH staff to improve the quality of life for those they care for. I would be remiss if I did not thank my husband for the support to follow my dreams and my 3 daughters and their families. I would like to end with the Serenity Prayer for the elders. We will all need it someday so please listen closely: God grant me the senility to forget the people I never liked anyway. The good fortune to run into the ones I do. And the eyesight to tell the difference.”
hired a half FTE or even a full FTE to meet the demand of this new process,” he notes. (An FTE is a full-time equivalent, or full-time worker.)

However, these days all facilities are on a mission to contain costs, says Orth. “We don’t want to increase FTEs except as a last resort.” So MDS coordinators need to be careful in how they frame such requests. Here’s what to do:

**Step 1: Gather assessment data**

MDS coordinators must do their homework before they approach administration with a request for additional staffing, says Orth. “They need to have facts. They need to have concrete proof: This is how many assessments we do a quarter and this is how many hours it takes to do them.”

**Number of assessments** Most MDS nurses can use their software systems to pull up three months’ worth of MDS assessment data, which will provide a good indication of their average workload, says Orth. Assessments of similar length can be divided into basic categories: comprehensive; Medicare, quarterly, and discharge; and entry, re-entry and death-in-facility tracking forms, he suggests.

**Time per assessment** “Then MDS coordinators should track the average time it takes them to complete the MDS, including the CAAs [care area assessments], for each assessment type,” says Orth. When evaluating the time per MDS, MDS nurses should focus on their current workload, adds Robin Hillier, CPA, STNA, LNHA, RAC-MT, president of RLH Consulting in Westerville, Ohio, and an AANAC-certified master teacher. “The first three months of MDS 3.0 implementation were difficult for everyone. Most MDS nurses were dealing with software-related coding and submission problems, as well as learning a new form. So many issues that contributed to increased workload during the transition won’t necessarily continue into this year.”

MDS coordinators also may want to delve deeper when compiling time data for discharge assessments, suggests Hillier. “They should look at how many are planned vs. unplanned, as well as how many are being combined with another scheduled MDS. Unplanned discharges potentially should take less time than planned discharges, so quantifying the types of discharges is important to evaluating the additional workload.”

**Total MDS 3.0 hours** Finally, MDS coordinators can multiply the number of assessments by the time per assessment to show the administrative team how much time they spend just completing the MDS process, says Orth. “In addition, you could gather data for the quarter prior to Oct. 1, 2010, to compare the workload under MDS 2.0 vs. MDS 3.0.” The goal of this evaluation is to “truly quantify how many additional assessments you are doing,” says Hillier. “What is the real increase in your workload? Are you doing 10% more assessments? Are you doing 75% more assessments? Answering this question will give you a clear picture of whether or not you need more staff.”

MDS nurses should review their financial data—including Medicare RUG-IV rates and case mix in Medicaid case-mix states—to determine whether the MDS 3.0 has contributed to revenue gains.

MDS, including the CAAs [care area assessments], for each assessment type,” says Orth. When evaluating the time per MDS, MDS nurses should focus on their current workload, adds Robin Hillier, CPA, STNA, LNHA, RAC-MT, president of RLH Consulting in Westerville, Ohio, and an AANAC-certified master teacher. “The first three months of MDS 3.0 implementation were difficult for everyone. Most MDS nurses were dealing with software-related coding and submission problems, as well as learning a new form. So many issues that contributed to increased workload during the transition won’t necessarily continue into this year.”

MDS coordinators also may want to delve deeper when compiling time data for discharge assessments, suggests Hillier. “They should look at how many are planned vs. unplanned, as well as how many are being combined with another scheduled MDS. Unplanned discharges potentially should take less time than planned discharges, so quantifying the types of discharges is important to evaluating the additional workload.”

**Total MDS 3.0 hours** Finally, MDS coordinators can multiply the number of assessments by the time per assessment to show the administrative team how much time they spend just completing the MDS process, says Orth. “In addition, you could gather data for the quarter prior to Oct. 1, 2010, to compare the workload under MDS 2.0 vs. MDS 3.0.” The goal of this evaluation is to “truly quantify how many additional assessments you are doing,” says Hillier. “What is the real increase in your workload? Are you doing 10% more assessments? Are you doing 75% more assessments? Answering this question will give you a clear picture of whether or not you need more staff.”

continued on page 5
Step 2: Gather financial data

MDS nurses should review their financial data—including Medicare RUG-IV rates and case mix in Medicaid case-mix states—to determine whether the MDS 3.0 has contributed to revenue gains. "Any time they can show that they have been generating more revenue, it makes their argument stronger for getting additional staff," says Hillier.

Similarly, MDS coordinators need to identify whether workload problems are resulting in late assessments, says Orth. "Are they getting any default payments because of late assessments? If they are, that is costing the facility money, and they need to bring it to the administrator's attention."

Step 3: Suggest no-hire solutions

MDS coordinators should examine how MDS assessment completion tasks are distributed within the interdisciplinary team (IDT), says Hillier. "Sometimes the issue isn't that more staff members are needed. Some interdisciplinary team members may have taken on more of the extra workload than other members. The tasks in the assessment process should be distributed among the team in an appropriate way."

For example, the MDS interview process can lack equitable workload distribution, says Orth. "Many facilities have taken an interdisciplinary approach to the interview process. For example, social services may be responsible for the BIMS (Brief Interview for Mental Status) in Section C and the PHQ-9 resident mood interview in Section D, and activities may be responsible for the preferences interview in Section F," says Orth. "But in other facilities, the MDS coordinator is doing all of the interviews. Certainly the MDS coordinator can do some of them, but one person doing all of the interviews is probably overwhelming."

In fact, even facilities that have distributed specific interviews to specific IDT members may be placing too large a burden on those staff members, says Orth. For example, "it may not be feasible for facilities with only one social worker to ask that social worker to conduct all of the BIMS and PHQ-9 interviews," he points out.

The bottom line is that "everyone can be trained to do resident interviews: social services, the MDS coordinator, and the nursing staff," suggests Orth. "With this flexibility, on Monday morning the interdisciplinary team can look at what interviews need to be completed, and then assign accountability to who is going to do those interviews this week. That need may fluctuate as the facility census fluctuates, but the key is that other people besides the MDS nurse and the social worker are trained to step in."

In addition to targeting the MDS assessment process, MDS nurses need to review their additional duties, says Orth. "MDS coordinators don't have a one-size-fits-all job description. In some facilities, the MDS coordinators strictly do the MDSs. But in other facilities, they historically have done, for example, restorative nursing, infection control, and quality assurance as well."

With the changeover to MDS 3.0, some facilities didn't relieve MDS nurses of any non-MDS responsibilities, says Orth. "But whenever Medicare changes a major process, you need to look at the bigger picture. Doing a work flow chart will help show the interdisciplinary

continued on page 6
team all the other responsibilities that are assigned to the MDS coordinator. Then the team can determine whether any of those tasks can be a better fit with another discipline.”

**Step 4: Use a non-emotional approach**

“Often, when MDS nurses decide they need to ask for help, they are way beyond the ‘I am so stressed out’ stage,” Hillier points out. “Consequently, their appeals for help come across as emotional—not data-based or process-based. They need to stay away from anecdotal complaining and try to rely on the facts that they have gathered.”

**Step 5: Don’t be vague about the amount and type of help needed**

If MDS coordinators determine that they definitely need extra hands on deck, they should be specific about how much help they need and why they need it, advises Orth. “Do they need a half-time employee or an FTE? What tasks do they need help with? Is it completing the MDSs? Is it the data entry? Is it scheduling? Where exactly do they need help with the MDS 3.0 system?”

---

**Reimbursement Tip**

The Default rate can be charged when an assessment is “late” and in some specific situations when an assessment is “missed”. See Chapter 2 of the RAI manual for further instruction.

Carol Maher  
Sr VP of Utilization Services  
Rockport Healthcare Services  
Vancouver, WA

---

**Build Your LTC Reference Library**

Need information that you can trust? Quickly? Newly updated AANAC manuals:

- **MDS 3.0 Coding for OBRA and PPS (AANAC Best Seller)**
  - Receive guidance to help you accurately code each item
  - Get clarification on ulcer staging in Section M0300
  - Complement to the RAI Users’ Guide

- **Administrative Oversight**
  - Learn how to support your nurses through the MDS/RAI process
  - Discover ways to promote strong quality measures which can boost survey outcomes
  - Create a collaborative environment designed to support culture change initiatives

- **Pressure Ulcer Prevention and Management**
  - Prevent pressure ulcers by using assessments that identify possible problems before they occur
  - Get the updated guidelines for managing pressure ulcers and preventing further exacerbations

- **Accurately Assessing for Physical Restraints and the MDS 3.0**
  - Prevent the need for physical restraint usage
  - Learn tactics that keep your residents safe from restraint-related injury and complications

Each manual gives you and your staff accurate guidance and reference information at your fingertips for more effective healthcare planning. Visit aanac.org/store to order today!
Civil Money Penalty, continued from page 1

Dispute Resolution (IDR) used to dispute cited deficiencies and penalties and the new IIDR which is available for cases where civil money penalties are imposed, money is collected, and deposited in an escrow account. Currently facilities can avoid paying a penalty for years while administrative appeals are ongoing. The revised rule is designed to eliminate a facility’s ability to defer the direct financial effect of civil monetary penalties until after a litigation process that often takes a prolonged period of time. The new IIDR is available only at the facility’s request, and is expected to be provided not later than 60 days after a timely request. Nursing homes will have the same 10-day time frame to request IIDR resolution as that which exists for the current IDR process. Notice of availability of the IIDR process will be sent from CMS.

Key Components of the New Rule

When civil money penalties are imposed, the rule offers an IIDR process designed to represent and balance the interests of both facilities and the residents. It establishes an escrow account that holds the civil money penalties until any administrative appeal processes have been completed. CMS will not collect penalty funds until the IIDR is complete, or 90 days have passed since notification of penalties, whichever is earlier.

When the IIDR appeal by the facility is successful, civil money penalties being held in escrow will be returned to the facility with interest. If the facility is partially successful in its appeal, a portion of the escrow funds will be returned.

IIDR allows for up to a 50% reduction in penalties when a facility self-reports and corrects its noncompliance based on the earlier of two options: correction of a self-reported deficiency within fifteen (15) calendar days from identification by the facility, or correction of the deficient practice within ten (10) calendar days from the imposition of a civil money penalty. If the facility attempts to self-report after surveyors identify the deficient practice, there is no reduction. Non-compliance at immediate jeopardy, pattern of harm, or widespread harm levels, or resulting in resident death is not eligible for reduction even if self-reported. To receive the 50% reduction, a facility must waive its right to a hearing. Currently, a facility may receive a 35% reduction in civil money penalties by the timely waiving of its right to appeal.

However, in order to receive the 50% reduction under the new rule, a facility must not only waive its right to a hearing, but also meet the previously listed conditions. The facility may receive either of these reductions, but not both. The effective date for penalties can be retroactive to the first day the facility is determined to be out of compliance, and will continue until substantial compliance is achieved or the facility is terminated from the program. When the IIDR appeal by the facility is successful, civil money penalties being held in escrow will be returned to the facility with interest. If the facility is partially successful in its appeal, a portion of the escrow funds will be returned. CMS has proposed that the money continue to be held in escrow until their appeals of the decision favoring the facility have been exhausted. If a final decision is made in favor of the facility, funds will be returned within 90 days.

It is expected that the new process will be conducted at the facility’s expense. User fees designed to cover the expenses of IIDR will be implemented by each State. The current IDR process will continue to be available to facilities at no charge. A facility may have the opportunity to use both processes if the traditional IDR is completed prior to the receipt of a letter notifying the facility of imposed civil money penalties for collection and placement in escrow.

continued on page 8
Navigating the Regulatory/Culture Change Crossroad

Do regulatory compliance and culture change intersect? Absolutely.

When you view the Center for Medicare & Medicaid Services’ regulations through a culture change lens, you’ll find they intersect at a place where you can comply with the regulations and honor resident voice and choice. This groundbreaking resource will explain the CMS regulations in easy-to-understand language and prescribe simple methods to facilitate compliance and foster person-centered care. This is an excellent resource for the entire interdisciplinary team.

Available at aanac.org, or call us toll free at 1.800.768.1880 to order your copy today.

Some States already charge a user fee which will not be affected by the new rule unless an imposed civil money penalty is subject to being placed in escrow. States will be required to submit plans for conducting IIDR to CMS for approval in order to assure consistency regarding process elements. A workgroup of State survey agency and CMS regional office representatives will be established to develop a template of key elements for inclusion in the IIDR process. These key elements are expected to include a process to assure timely completion of the IIDR, methodology for notification, and components of the IIDR written record.

The Rule’s Proposed Use of Civil Money Penalty Funds

Under the new rule, up to 90% of the civil money penalties collected by CMS must be applied directly to promote quality care and the well-being of nursing home residents. Activities considered appropriate for use include assistance to support and protect residents of a facility that closes or is decertified; projects that support resident and family councils and other consumer involvement in assuring quality care in facilities; and facility improvement initiatives approved by CMS, including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by CMS. A workgroup will be formed to make final decisions for the use of the monies.


Civil Money Penalty, continued from page 7
What if a competent patient seeking death refuses nutrition and hydration? Aside from the moral obligation to comply with a patient’s refusal, states would uphold a legal requirement: force-feeding or forcing a treatment or procedure on a patient is considered battery. “Living wills” were designed to permit patients to refuse life supports in advance, should they be unable to refuse later because of lost decision-making capacity. No change in law or tradition would be necessary for a patient to choose to die by refusing nutrition and hydration. But a profound legal change would be necessary if that life were terminated by a doctor’s supplying a lethal prescription. If, for the same patient and conditions, a doctor acted upon what was felt as a moral duty to comply with the patient’s request for a lethal dose of medication, in any states but Oregon, Washington, and (probably) Montana, he or she would be criminally liable.

Hospice and geriatric groups that opposed physician-assisted suicide (PAS) sent briefs to the Supreme Court stating they do not consider terminal palliative sedation and cessation of eating and drinking to be assisted suicide. It is a morally and clinically acceptable last-resort alternative because the physician does not directly or intentionally hasten death. Both sedation and refusal to eat and drink can be undertaken and supported within usual health care settings.

Concurring with the Supreme Court’s ruling against assisted suicide, Justice O’Connor wrote, “A patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication from qualified physicians to alleviate the suffering, even to the point of causing unconsciousness and hastening death.”

She was utilizing the widely accepted “double effect” principle, in which intention is the significant factor. When performing a good or neutral act, an evil outcome can be foreseen, but it is not intended. Giving pain medication to a suffering patient is a good act but may result in a foreseeable but unintended shortening of life. The intention is pain relief, not curtailing life. The outcome is proportionately good; therefore, the act is morally acceptable.

The conclusion is that a patient who refuses nutrition has no legal barrier to receiving medication that may cause unconsciousness and, in the absence of nutrition and hydration, death within a few weeks. Advocates of this technique consider that patients die from the disease that brought them to a terminal phase. The doctor is not actively advocating death, they argue; in fact, the doctor plays the beneficent role of relieving suffering caused by either the illness or the absence of food and fluid. They contrast this with assisted suicide, where the patient dies not from the illness but from the medication that a doctor must prescribe. Many clinicians who oppose PAS yet do not want to abandon their patient find that these options provide morally acceptable ways to respond to severe terminal suffering.

Opponents of terminal palliative sedation call it “slow euthanasia.” They argue that “double effect” is irrelevant because not only is death foreseen, it is intended. Whether or not the sedation plays a role, death will occur from dehydration, not the disease per se. Some believe such practices are more like than unlike assisted suicide.

Continued on page 10
Terminal patients are too often undertreated for pain because doctors and nurses fear prosecution if their palliative aim is misunderstood. Colorado practitioners, however, may employ terminal palliative sedation under protection of the law (CRS 18-3-104) concerning manslaughter, although it explicitly prohibits assisted suicide. Other states might consider such a law so patients do not suffer needlessly.

Must physicians and nurses support these practices? All patient inquiries about terminal palliative sedation or voluntary refusal of food and fluids should be explored for a basis in depression or symptoms that may respond to palliative measures. However, neither physicians nor nurses should be required to participate if it violates their fundamental moral precepts. Federal law protects their jobs despite their refusal to participate. In patient-centered care however, such caregivers who cannot find common ground with a terminal patient’s legal request have the responsibility to obtain palliative care or ethics consultations and to transfer care to doctors and nurses who are more receptive.

**Basic Clinical Guidelines**

Terminal palliative sedation and voluntary refusal of food and fluids must be preceded by informed consent, which includes assessing the patient’s capacity to comprehend the treatment and available alternatives. Although decision-making capacity is a requirement for voluntary refusal of food and fluids, terminal palliative sedation may sometimes be needed in acute symptomatic emergencies when the dying patient cannot respond. In such severe circumstances, appointed agents, family members, consultants, and other members of the health care team may have to represent the patient’s values.

A second cornerstone is the presence of severe suffering that cannot be relieved by any other means. The main indication for terminal palliative sedation is severe, uncontrolled physical suffering, such as intractable pain, difficulty breathing, seizures, or delirium. Information about terminal palliative sedation becomes important when patients express fears about dying badly or explicitly request a hastened death because of unacceptable suffering. Patients who, although not in pain, have unrelenting, persistent, unacceptable symptoms, such as extreme fatigue, weakness, or debility, may consider refusing food and fluids. If clinicians, patients, or families are considering either option when the suffering person is not imminently dying, second opinions should always be documented from mental health, ethics committees, and palliative care specialists.

Sedation that eliminates signs of discomfort (such as stiffening or grimacing spontaneously or with repositioning and nursing care) is maintained until the patient dies. Depending on the patient’s physiologic condition, death comes usually in hours to days. Continuous sedation usually requires a subcutaneous or intravenous infusion and intensive involvement by the health care team for observation, monitoring, and support. When a dying patient requires sedation, opioids for pain and other symptom-relieving measures should also be continued to avoid unobservable pain or opioid withdrawal. However, opioids are generally ineffective at inducing sedation and are not the primary medications of choice.

**Conclusion**

Medicine cannot sanitize dying or provide perfect solutions for all clinical dilemmas. When unacceptable suffering persists despite standard palliative measures, terminal palliative sedation and refusal of food and fluids are imperfect but useful last-resort options. Patients and families who fear that physicians will not respond to extreme suffering will be comforted when assurance of such options is made.
Unscramble the following words to answer the corresponding statement above each scrambled word. Transfer the shaded letters to the shaded area below to answer the following question regarding February 23 “Mastering A2400” article in the LTC Leader.

Entering the correct information about the most recent Medicare Part A stay is critical to what?

A2400A: This item asks that the ____________ bill to Medicare Part A.

A2400C: Date the ____________ was d/c’d from the facility.

A2400C: the 100th day is the day the SNF PPS benefit ____________.
### 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>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>Apr 26 – 28</td>
<td>Richmond, VA</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>Apr 26 – 28</td>
<td>Tampa, FL</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>May 2 – 4</td>
<td>Topsfield, MA</td>
</tr>
<tr>
<td>NYAHSA</td>
<td>Sandy Biggi</td>
<td>May 3 – 5</td>
<td>Binghamton, NY</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>May 10 – 12</td>
<td>Omaha, NE</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>May 10 – 12</td>
<td>Mobile, AL</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>May 10 – 12</td>
<td>Afton, WY</td>
</tr>
<tr>
<td>RRS Healthcare Consulting Services</td>
<td>Rena R. Shephard</td>
<td>May 17 – 19</td>
<td>San Diego, CA</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>May 17 – 19</td>
<td>Brookfield, WI</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>May 24 – 26</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>May 24 – 26</td>
<td>Knoxville, TN</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>June 6 – 8</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>June 7 – 9</td>
<td>Wausau, WI</td>
</tr>
<tr>
<td>CHCA—Colorado Health Care Association</td>
<td>Rena R. Shephard</td>
<td>June 7 – 9</td>
<td>Denver, CO</td>
</tr>
<tr>
<td>OHCA—Ohio Health Care Association</td>
<td>Robin Hillier</td>
<td>June 14 – 16</td>
<td>Columbus, OH</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>June 14 – 16</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td></td>
<td>June 21 – 23</td>
<td>White Bear Lake, MN</td>
</tr>
<tr>
<td>IAHSA (Iowa)</td>
<td>Deb Myhre</td>
<td>June 21 – 23</td>
<td>Des Moines, IA</td>
</tr>
<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>June 21 – 23</td>
<td>Allentown, PA</td>
</tr>
<tr>
<td>KHCA—Kansas Health Care Association</td>
<td>Becky LaBarge</td>
<td>June 22 – 24</td>
<td>Wichita, KS</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>
</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.
If resident has dysphagia and had a g-tube placed for nutrition and hydration and remains NPO, would we code difficulty with swallowing in K0100? If resident is on a pureed diet with nectar thick liquid and is deemed safe with these interventions, would we still code difficulty with swallowing in K0100? The question is whether the resident exhibited any of the s/s of swallow problem listed in the MDS item. If any of the signs/symptoms listed in A – D were observed during the 7-day look-back, check them on the MDS. For any of the listed signs/symptoms that were not observed, do not check them. The interventions that the resident received or did not receive are not relevant to the question—only what the resident actually did with regard to these signs and symptoms.

Rena R. Shephard, mha, rn, rac-mt, c-ne (RRS2000@aol.com)

We are having some debate about Medicare’s interpretation of 5-day a week therapy as it relates to the 60-day break in the spell of illness. That is, if two disciplines have a resident on caseload, each three times per week, and they alternate days so that the resident receives five calendar days of therapy but not one discipline for five days, would this be considered a skilled level of care so as to interrupt the count toward the 60-day break? Yes, this would be considered a skilled level of care, since the resident is getting skilled therapy on five calendar days per week. This is the same criterion as a skilled level of care to cover under Part A.

Ronald A. Orth, rn, nha, cpc, rac-mt (raorth@clinicalreimbursement.com)

We did a 5-day PPS assessment. Part A was discontinued on day 6. After a week, the resident was put back on Part A for skilled rehab. We did another 5-day (A0310B = 01), and I received warning message 1018, Inconsistent Record Sequence. Should I just ignore it, or do I have to do or change something? In this case, just ignore that error message. The federal database is not able to see that the resident was off of Part A for a few days, so it was expecting a 14-day assessment. You have complied with the assessment schedule correctly. Just ignore the warning message this time.

Error messages should always be investigated. Error messages regarding out of sequence errors often assist you to see when you have missed an MDS. Always double check your assessment schedule when you receive these error messages. But they are just warnings—if you find that you did everything right, then you can ignore it. (A fatal error is always a different situation—they are rejected records that must be corrected and resubmitted.)

Carol Maher, rn-bc, rac-ct (cmerho121@earthlink.net)
Dear Betty,

We need to improve our admissions process so that new residents are not so devastated by coming to a nursing home. Can you help us?

Seeking Ideas

Dear Seeking,

Begin the admission process with a warm welcome to allay fears and guilt. If possible have a staff member visit the individual in the hospital to explain what will happen once they arrive. For cognitively impaired individuals, also have that visit with the family. During this brief encounter relationship-building begins, preferences are learned, and respect is communicated. The presence of this familiar face provides comfort at the time of arrival. Provide staff with details that create a focus on the individual, not just their diagnosis. Discuss with the roommate that someone new is coming to be their neighbor. This is especially important if they were close to their previous roommate and are dealing with that loss. Provide a small welcoming gift the roommate can present on behalf of the neighborhood. Meet the new person at the door as they arrive and escort them to their room. It is a harsh welcome when a transport van attendant wheels the person through the lobby, into the elevator, and to their room, and no one provides an assuring greeting.

Once the new person is made comfortable in their room, offer refreshments for all who are present, including the roommate, observing dietary limitations noted on transfer papers. Assessments can wait a few minutes while everyone gets acquainted. Develop an orientation program that meets the needs of new residents – both short and long term. Provide a map showing locations such as visiting areas, dining rooms, offices, the chapel, activity space, etc. Explain the lines of responsibility in case they need assistance with an issue. Give a tour and repeat it the next day if they need reinforcement. Be creative and place a spotlight on the benefits of your facility.

The admission process can be overwhelming, so coordinate interview activities to avoid duplication. For example, while the therapist conducts an evaluation, the nurse can be present to document observations for the nursing assessment. Encourage conversation to learn preferences, interests, and personal history to communicate caring for the whole person. Respect the individual’s need for private time with loved ones. These are the people the resident wants to see most of all, so step back to allow family or a visitor the opportunity to give needed support.

Brainstorm with your team to identify ways your facility’s admission process can be improved. Often CNAs have the answer for how things can be done better. Your awareness that you need an improved admission process is a healthy first step toward presenting the clear message “Welcome! We are glad you are here.”

Betty

---

MDSCRAMBLER Answer Key

```
C I I F T L Y A
F A C I L I T Y
S R
N E
I S
D I
E D
T E
E N
R T
E X H A U S T S
H A T S S E U X
R E I M B U R S E M E N T
```
BUSINESS PARTNERS & CORPORATE SPONSORS

Diamond Business Partners

SimpleLTC

Platinum Business Partners

AHCA

CareTracker by Resource Systems

Eli Forest Pharmaceuticals, Inc.

Long-Term Living For The Continuing Care Professional

McKnight’s Long-Term Care News & Assisted Living

MED-PASS, Inc.

NYAHSA

Provider Magazine

Gold Business Partners

Accu-Med Services, Inc.

AIS Systems

Answers on Demand

Golden Living Centers

HCR ManorCare

Keane Care, Inc.

LeaderStat

MDI Achieve

PointClickCare

PointRight

SimpleLTC, Inc.

SunDance Rehabilitation

Therapy Times

Corporate Sponsors

Benedictine Health Systems

Brookdale Senior Living

Care Initiatives

Catholic Health Services

Centura Health at Home

Christian Homes, Inc.

Colavria Hospitality

ConvaCare Management, Inc.

Cornerstone Health Services Group

DaRT Chart Systems, LLC

Ecumen

Elim Care, Inc.

Ensign Facility Services, Inc.

Evangelical Lutheran Good Samaritan Society

Evergreen Healthcare

Extendicare Health Services, Inc.

Five Star Quality Care, Inc.

Friendship Health and Rehab Center

The Goodman Group

Goshen Care Center

HMG Services, LLC

Hattiesburg Medical Park Corporation

Health Dimensions Group

Horizon West HealthCare, Inc.

Kissito Healthcare

Lexington Healthcare

Lutheran Senior Services

Magnum Health Care Management

New Courtland Elder Services

NHS Management LLC

Paramount Health Care Company

Pinon Management Plantation Management Company

Preferred Care Partners Management Group

Prestige Healthcare

Regent Care Center

Riverside Health Care

Rockport Healthcare Services

SavaSeniorCare

Senior Care Centers

Skilled Health Care

St. Francis Health Services

Ten Broeck Commons

Trinity Senior Living Communities

TRISUN Healthcare

Vanguard Healthcare Services, LLC

A CAREER OF CARE

AANAC is proud to announce a new online job bank for LTC professionals called AANACareer. This service will provide members with expanded assistance in their career search including:

- Access to local and national job listings
- Automatic e-mail notifications of new job postings in your discipline and geographic location
- Post your resume to help employers find you
- Access to career advice + recruitment articles

By partnering with the HEALTHCAREERS Network, AANAC is able to provide our members with increased visibility to thousands of healthcare employers nationwide.

Expand your job search now.
Log on to www.aanac.org/careers to begin searching today.

AANAC Proudly Recognizes

National Nursing Home Week™ & National Nurses Week™

Our thanks to all the individuals who provide care and support to the LTC community on the...

1st Annual Nurse Assessment Coordination Day™

Tuesday, May 10, 2011

We invite all members of the interdisciplinary team to join the almost 18,000 members who “fulfill the promise” every day through unparalleled service and support to their residents.

Visit our website - aanac.org/join

AANAC
© 2011 AANAC. No part of this publication may be reproduced without written permission from AANAC. The information presented is informative and does not constitute direct legal or regulatory advice.