April 1 MDS changes: Are you ready?

Caralyn Davis, Staff Writer

Keeping up with changes has become an almost constant battle for MDS coordinators and interdisciplinary teams (IDTs), and a new round of MDS changes is days away. On April 1, Version 1.08 of the RAI User’s Manual for the MDS 3.0 and Version 1.10.4 of the MDS 3.0 item sets will go into effect. (The updated RAI Manual, the Changed Pages and Change Tables Document, and the accompanying Errata Document can be found on the MDS 3.0 Training Materials webpage. Printable item sets are available on the MDS 3.0 Technical Information webpage.) AANAC’s master teachers offer the following last-minute suggestions for ensuring a smooth transition on April 1 and with any subsequent updates:

Check the status of your software.

The new rules will be effective for MDSs with an assessment reference date (ARD) of April 1 or later. However, the ARD represents the endpoint of the observation or look-back period. “The typical look-back period is seven days or 14 days,” points out Judy Wilhide Brandt, RN, RAC-MT, C-NE, president of Judy Wilhide MDS Consulting in Virginia Beach, VA. “So we need to start opening assessments and working on them (for example, coding interviews) in the days leading up to April 1.”

Consequently, updated software needs to be ready to go now, says Brandt. “New software should have been installed, beta-tested, and ready no later than two weeks into March.”

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Key takeaways From the MDS National Conference

While the 2012 MDS National Conference that CMS held in early March was packed to the rafters, many long-term care professionals were unable to attend for a variety of reasons, leaving them feeling like they didn’t know the secret handshake required to enter the executive suite of “MDS World.” However, AANAC is able to throw open the doors of knowledge thanks to Jennifer Pettis, RN, BS, WCC, RAC-MT, C-NE, director of program development at Harmony Healthcare International in Topsfield, MA, and chair of the AANAC Expert Advisory Panel. Pettis attended the conference, gleaning five key takeaways for MDS coordinators, directors of nursing, and other interdisciplinary team (IDT) members:

1. Care plans should be built on resident voice.

Providers should take heart from the “profound” message on the critical importance of care planning delivered by Karen Schoeneman, technical advisor of the Division of Nursing Homes at CMS, in the keynote, “Looking at the Rules in Our Head: What is Care Planning for?,” suggests Pettis.

As recently as 20 years ago, long-term care practice “was really dictated by the rules in your head,” says Pettis. Schoeneman suggested those rules revolved around institutional practices, including practices such as ensuring “every resident was up for breakfast” and any resident who wanted to rest could “only take naps at certain times during the day, and they needed to lie on top of the covers.”

“Back then I was a nurse’s aide, and it’s not that I was a bad nurse’s aide,” reflects Pettis. “The rules we followed were what our practice at the time told us was right, so that is what we did.”

Long-term care is now “heading toward full circle,” Pettis points out. “Karen really challenged us to think about care planning. We should be using the MDS and Care Areas to identify resident choices, and rather than our practice being dictated by all of these rules in our head, it should be dictated by what that resident is telling us is important to them. The RAI process is intended for us to end up with this individualized, person-centered care plan based on the goals of the resident, what their needs are, and what their strengths or limitations or risk factors are—not those institutional rules that sometimes overshadow resident choices.”

From an MDS standpoint, Schoeneman’s message boils down to “facilities should take a look at the process of the MDS,” asserts Pettis. “The focus of the MDS process shouldn’t just be the completion of this tool for reimbursement and survey compliance. Strong assessments are embedded into the MDS and the Care Areas. Many times, if we do a good job of using these assessment tools provided by CMS, we can get rid of other layers of paperwork that are burdening interdisciplinary team members because we’ll already have the individualized information we need to serve as the building blocks for the plan of care.”

2. Discharge assessments are getting shorter.

MDS coordinators will soon find the workload a little lighter for all discharge assessments, says Pettis. Currently, discharge assessments come in at a whopping 111 questions. However, continued on page 6
If software vendors have scheduled the update to occur on April 1, it may be too late to request earlier implementation this time around. Nevertheless, MDS coordinators should alert the administrator or other appropriate facility decision-maker to ensure the problem is resolved prior to future updates, suggests Brandt. “The software companies have to be responsive to our needs.”

**Prepare to work on paper.**

Facilities won’t be able to electronically open assessments with ARDs of April 1 or later until they have the new software. CMS doesn’t offer any wiggle room in setting ARDs timely, so providers should prepare for potential software issues by printing out a batch of blank MDS assessments, says Brandt. “If MDS coordinators need to get the ARDs established and they cannot establish them in the computer, they should be ready to set the ARDs on paper.” *Note: Page 2-8 of the RAI Manual states: “The facility is required to set the ARD on the MDS Item Set or in the facility software within the appropriate timeframe of the assessment type being completed.”*

**Review the MDS item sets.**

The ZIP file of MDS item sets for the April 1 release includes a 12-page document, MDS 3.0 Item Set Change History (aka MDS30_Item_Changes_v1.10.4.pdf). “This is a handy list of changes to the forms that providers can review,” says Brandt.

One positive change is “how much shorter the discharge assessment is going to be,” she notes. “Regardless of whether a discharge is unplanned or planned, the discharge assessment is going to be noticeably shorter. For example, column 2 in G0110 (ADL assistance) is not there, and the only item in O0100 (special treatments, procedures, and programs) is hospice care. CMS listened to providers about the burden of doing MDSs.”

Printing out a hard copy of the discharge assessment will help drive home the changes—and give MDS coordinators a reference to use when checking that their software has the new item set, suggests Brandt.

**Hand out updated manual sections.**

Brandt was recently in a facility where the dietitian was using Section K coding instructions from a draft 2009 RAI Manual. “Nobody had given her any updates in more than two years,” she notes. “We tend to forget about dietitians, social workers, and activities staff. However, all team members who code MDS items need to have a current version of the coding instructions.”

Similarly, Deb Myhre, RN-CNE, RAC-MT, a consultant with Ankeny, Iowa-based Continuum Health Care Services, recently visited a facility that didn’t understand isolation coding because they didn’t have a current Version 1.07 RAI Manual. “Keeping track of the updates can be difficult given all of the changes we’ve had, but MDS coordinators have to be able to go online and make sure team members have current information,” she stresses.

**Read and discuss the update.**

“This sounds really simple, but a surprising number of people don’t read the updates to the RAI Manual until after a problem occurs,” says Myhre. “When CMS publishes an update, the MDS coordinator sometimes will hand it out to the interdisciplinary team and then expect that those team members will do what they want to do with it. Consequently, manual updates sometimes sit on the back burner. Unfortunately, I’ve seen that happen many times.”

So not only do IDT members need their updated sections of the RAI Manual, “they have to read it and understand it, and if they don’t understand something, they need to ask questions”.

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before implementation occurs,” says
Myhre. One way that MDS coordinators
can prompt team members to read
the manual updates is to schedule
a 15-minute segment during a care
conference to review section changes.

When CMS issues an RAI Manual update, that might be a good time to find
ways to help the team, suggests Myhre. “One of the first things I look at to
reduce the MDS burden is the turnaround time—from when the ARD is set
to when the assessment is completed.”

“The team just needs to sit down and talk
about the changes for a few minutes,” she
explains. “This is an easy way for MDS
coordinators to fulfill their management
responsibility and ensure that each
person on the team knows what to do
with their particular section of the MDS.
I’m also a big believer that the whole
team should understand what each team
member is responsible for, and this type
of meeting will keep everyone informed.”
(Have questions about the April 1 update?
AANAC members have access to help from
a wide array of MDS experts via the MDS
Connection and LTC Network discussion
groups on AANACConnect.)

Highlight Section M changes.
Section M (skin conditions) includes
several revisions. Two that stand out are
the re-introduction of skin tears in item
M1040G and the addition of moisture-
associated skin damage (MASD) in item
M1040H, says Brandt.
MASD “has to be diagnosed correctly
and treated correctly in order to heal.
Pressure didn’t cause MASD, so relieving
pressure is not going to cure it,” she
points out. “With the inclusion of MASD
on the MDS, my hope is that MASD will
come to the forefront and that clinicians
will look with fresh eyes on correctly
diagnosing and treating the multi-
factorial skin issues that our frail elderly
typically have.”

Use updates as a catalyst
for improvement.
The burdens of the RAI process frustrate
a lot of IDT members. When CMS issues
an RAI Manual update, that might be a
good time to find ways to help the team,
suggests Myhre. “One of the first things
I look at to reduce the MDS burden is the
turnaround time—from when the ARD is set
to when the assessment is completed.”
With some exceptions, facilities have 14
days to complete the MDS. (Need details?
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However, many providers arbitrarily shorten the process. For example, Myhre visited one facility that always set ARDs on Mondays and gave the IDT members two days—Tuesdays and Wednesdays—to get the MDS done so the team could have care conferences on Thursdays of the same week.

“People are often resistant to change, but in this type of situation, making better use of the available days to complete the MDS and changing the care conference to a later day so that the team members have adequate time to review their assessments and make good coding decisions can alleviate a lot of frustration,” she points out.

Double-check Final Validation Reports.

“For the first few transmissions, providers should check their Final Validation Reports with a fine-tooth comb,” advises Brandt. Why? Sometimes software updates result in unintended changes or problems.

For example, there always is at least one facility whose software incorporates the wrong RUG grouper—even when an update isn’t supposed to include any SNF PPS changes. “So make sure that you have the right RUG grouper for federal RUGs, and if you are in a state with case mix, make sure that you’re not getting those warnings that say, ‘The RUG we calculated is different from the RUG that you submitted,’” says Brandt. “These are errors that always must be corrected because we cannot bill the wrong RUG.” (Section 5, “Error Messages,” of the MDS 3.0 Provider User’s Guide explains what the error messages mean and offers potential solutions.)

Tips to fight MDS change fatigue

Obtaining staff buy-in for the April 1 RAI Manual update should be relatively simple because “this latest round of changes primarily is a direct result of CMS listening to what we said was wrong,” says Judy Wilhide Brandt, RN, RAC-MT, C-NE, president of Judy Wilhide MDS Consulting in Virginia Beach, VA. “As a general rule, these changes clarify the MDS and make it easier and quicker. The major exception is the addition of moisture-associated skin damage in Section M, which is still a very good improvement because it will make our residents’ lives better if we more correctly identify that issue.”

Nevertheless, some IDT members likely will be resistant to any change—whether it’s perceived as good or bad—since they’ve already gone through so many updates, says Brandt. “I see MDS change fatigue all the time.”

The most important defense against change fatigue is a good attitude, suggests Deb Myhre, RN, C-NE, RAC-MT, a consultant with Ankeny, Iowa-based Continuum Health Care Services. “The MDS coordinator must be really positive any time CMS issues an update. That is difficult to do when we’ve had so many changes—and then the changes are changed. However, it’s the MDS coordinator’s responsibility as a manager to be the ‘good cheerleader’ for MDS changes. Everyone knows that when you have a grumpy leader, everyone else is grumpy too. So like any manager, the MDS coordinator needs to portray a positive attitude. The key is to be process-driven. Rather than grumble about individual changes, keep the team focused on what the whole RAI process is for—to have better care planning and improve quality of care and the lives of our residents.”

Another good leadership technique is for MDS coordinators to prepare IDT members for a cycle of changes every April and October, says Brandt. “Everyone needs to accept the fact that we are likely to have structural and other substantive changes involving either the MDS or SNF PPS every six months for the foreseeable future.”

Also, with any future updates, MDS coordinators should let the IDT members know as soon as they themselves learn about pending changes, suggests Brandt. “Some MDS coordinators say, ‘I’m not going to bring it up until right before the change because there is no sense in worrying about it.’ But forewarned is forearmed. It’s important that the team know what’s going on, even if their particular section doesn’t have any changes. For example, if the changes necessitate a software update, the team members have to plan their work schedules to allow time for the new software to be installed.”

It’s also important that MDS coordinators provide IDT members with some perspective. For example, with the April 1 update, a quick glance at the 300-plus pages of RAI Manual changes might inspire panic. “However, there are only a few substantive changes,” says Brandt.

For example, the changes include multiple instances of replacing “mental retardation” with “intellectual disability” and replacing “entry or reentry” and “admission or reentry” with “admission/entry or reentry.” In addition, there are numerous capitalization changes, for example, replacing “state” with “State.” So any time there is an update, MDS coordinators can calm a lot of fears by looking at the change document and boiling down “what we actually have to do differently,” says Brandt.
the April 1 update will cut planned discharge assessments to 89 questions and unplanned discharge assessments to a maximum of 77 questions. Those reductions—almost 20 percent for planned discharges and 31 percent for unplanned discharges—“should impact the time spent on those assessments positively,” she points out.

3. Interviews matter.

Nursing facilities that do not complete resident interviews when residents in fact could have participated in the interviews are engaging in a practice that places them at risk for citation during survey, according to Tom Dudley, technical advisor in the Division of Chronic and Postacute Care in the Office of Clinical Standards and Quality, who reiterated comments he made during an earlier Skilled Nursing Facility/Long-term Care Open Door Forum.

Why the crackdown? “The interviews on the MDS are central to the whole idea of the resident’s voice driving our practice in long-term care,” says Pettis. “In addition, the interviews are critical for publicly reported data, and they have a tremendous financial impact on facilities.”

So facility leadership (e.g., administrators, DONs, or reimbursement directors) should “vet the performance of all staff members who are conducting resident interviews,” she recommends. “No one would let a nurse administer medications before they were sure that the nurse could do it safely and appropriately. Facilities should take a similar approach to ensuring competence for those conducting resident interviews.”

CMS offers a number of resources to help IDT members conduct effective resident interviews, says Pettis. Chapter 3 of the RAI User’s Manual for the MDS 3.0 provides the basic instructions, interviewing techniques, and suggested language (i.e., the script) for conducting the interviews. In addition, two RAI Manual appendices offer detailed insights on interviewing techniques, as well as cue cards, that allow staff to make the most of resident interviews: Appendix D, “Interviewing To Increase Resident Voice in MDS Assessments,” and Appendix E, “PHQ-9 Scoring Rules and Instruction For BIMS (When Administered In Writing).” (Note: Appendix E includes cue cards for conducting the BIMS in writing.

Importantly, Appendix D offers methods and techniques to obtain better data from residents who may have impaired cognition. Providers can use the techniques of unfolding or disentangling that are described on pages D-2 – D-3 to break down questions into “digestible chunks,” notes Pettis. “I often liken it to the way that we help residents who have some impaired cognition pick out their clothes. We don’t open the closet and say, ‘Here are 40 dresses. What would you like to wear today?’ Instead, we start with a general question: ‘Would you like a dress or pants?’ And then we move into specifics: ‘You’d like a dress. I have pink or blue. Which color would you like?’ And then we get even more detailed: ‘Here are two pink dresses. Which one do you want to wear?’ So it’s the same idea that in practice we’ve been doing for years when we care for these residents in day-to-day life. It should be natural for us as clinicians to want to offer that same technique when we are conducting resident interviews.”

In addition, the cue cards are key to keeping interviews efficient, says Pettis. “Using the cue cards that CMS offers makes interviews go so much faster, as well as obtaining much better data in my opinion. If you go to the grocery store and are asked to sample and comment on a new product, you will often be given a list of options to choose an answer from. That’s because the list of options speeds the process along for the interviewer. With resident interviews, using the cue cards means you don’t have to repeat the potential answers every single time. The answers are right there in front of the residents, and they are very easily able to point to the response they want to give. Residents aren’t pressured to remember all of the options that the interviewer just told them.”

4. Inactivation rules may force changes in facility practices.

John Kane, a health insurance specialist with the Division of Institutional Postacute Care, confirmed that another
skilled nursing facility prospective payment system update document is forthcoming, says Pettis. (Watch “Need to Know” at AANAC.) Additionally, a key issue that Kane discussed at the conference was the inactivation of MDS assessments.

“Once you have submitted that MDS, it is too late to change these items, so you need to take the time to double-check that what is being submitted on the MDS is what you think it should be.”

When an MDS assessment includes an inaccurate event date (e.g., an assessment reference date or a discharge date) or an inaccurate reason for assessment, “providers cannot inactivate that assessment, and then take the same assessment and just correct it and resubmit it,” says Pettis. “When you inactivate an assessment, for all practical purposes that assessment doesn’t exist anymore. You can’t simply fix the problem and re-upload that MDS. You have to create a brand-new assessment, including setting a current ARD. The day that you begin that process of inactivation is the earliest day that you could set the ARD.”

This policy has “very serious potential payment implications,” she points out. “There is no question that CMS heard providers at the conference express concerns about that, and they definitely are considering suggestions as to how that could be better handled.”

But what can providers do in the meantime? “Make the best possible use of the encoding period,” suggests Pettis. Providers have seven days following the completion of a resident’s MDS assessment to encode the MDS data. (To learn more, see Chapter 5 of the RAI Manual.) At most facilities, IDT members now enter assessment data directly into facility software rather than on a paper MDS, so few providers take advantage of—or even remember—the available seven-day encoding period.

“Once you have submitted that MDS, it is too late to change these items, so you need to take the time to double-check that what is being submitted on the MDS is what you think it should be.”

ARDs and reasons for assessment. Once you have submitted that MDS, it is too late to change these items, so you need to take the time to double-check that what is being submitted on the MDS is what you think it should be.

5. Quality measures will include four survey-only measures.

The quality measures (QMs) are coming back to the traditional survey process. Since October 2010, surveyors have been following the instructions in survey-and-certification letter S&C-10-27-NH to replace Tasks 1 – 5C in the traditional survey process as defined in Appendix P “Survey Protocols for Long-term Care Facilities,” in the State Operations Manual. CMS’ Karen Schoeneman advised conference attendees to “rip up that survey-and-certification letter and go back to Appendix P for the traditional survey process,” says Pettis. (Note: The Quality Indicator Survey, or QIS, process will continue to use Quality of Care and Life Indicators, or QCLIs, to drive the survey process.) The survey QMs will include many of the same QMs that will be publicly reported on Nursing Home Compare. However, CMS deemed some of the publicly reported measures unnecessary to the survey process, particularly the pneumococcal vaccine and influenza vaccine measures. In addition, CMS has...
developed four survey-only QMs that have been “recreated from the old QIs [quality indicators],” says Pettis. The four survey measures that won’t be made available to the public are long-stay measures that address these issues:

- **Falls.** The publicly reported QMs include a “fall with major injury” measure. However, the survey measures will include a falls measure that identifies any long-stay resident who has had a fall in the look-back scan, regardless of whether a major injury occurred, says Pettis.

- **Behavior symptoms affecting others.** “Several behaviors will go into this measure and potentially could flag that as an area to be investigated during survey,” notes Pettis. “Providers should make sure everyone is on the same page about how they code behaviors affecting other people. Ask, ‘Are we consistently following the rules?’”

- **Psychoactive medications, in the absence of psychotic or related conditions.**

- **Anti-anxiety/hypnotic medications.**

With both of the medication-focused survey QMs “a resident is going to flag when you use these medications, and there is not an appropriate associated condition,” says Pettis. “When an appropriate associated condition is present, the resident will be excluded from that reporting.”

Many appropriate associated conditions are diagnosis-based and come from MDS Section I. However, two of these excluding conditions are in Item E0100 (potential indicators of psychosis), specifically E0100A (hallucinations) and E0100B (delusions), notes Pettis. “In most nursing facilities, staff do a good job of capturing hallucinations, which are a sensory perception of something that

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Regarding coding respiratory therapy on the MDS, do competencies for lung sounds have to be done by a respiratory therapist or can they be done by a nurse?

To capture respiratory therapy on the MDS, treatments must be provided by a respiratory therapist or a trained respiratory nurse, according to Appendix A of the RAI User’s Manual. It says that respiratory therapy services are for assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function, and that respiratory therapy services include “coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc.”

It goes on to say, “A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.” Who provides the training is not specified by the regulation. As a former DON, my preference is to have a respiratory therapist provide training, validate return demonstrations, and check key competencies annually. But a nurse with demonstrated competency and experience in these areas can provide the training.

As a former DON, my preference is to have a respiratory therapist provide training, validate return demonstrations, and check key competencies annually. But a nurse with demonstrated competency and experience in these areas can provide the training.

A resident returned from the hospital after having a qualifying stay for Medicare Part A. The readmission date was Feb. 17. We did a Significant Change/5-day assessment with an ARD of Feb. 29 (Day 8). The RUG was Rehab High. The 14-day assessment ARD was March 2 (Day 15), which also was day 7 of COT observation. The RUG score went to Rehab Very High. I told therapy that we would need to do a COT OMRA, because the RUG score increased. Therapy disagrees with me. Which is right?

You don’t have to complete a COT OMRA when day 7 of COT observation falls on the ARD of a scheduled assessment, but you have the option and would want to do it in your benefit. You will not be able to do a SOT OMRA for this resident, because there was not enough therapy provided by the 7th day after the start of therapy to correctly place this resident into a Rehab RUG. The next scheduled assessment will be when you will be able to realize the rehab RUG.

A resident was admitted Feb. 10. PT started Feb. 15 (day 6), and the resident was seen by PT on Feb. 15 and 16 for a combination of 95 minutes. Next day of service for PT was Feb. 22 (day 13). The resident was seen on consecutive days from Feb. 24 to 27 (days 16 – 18). Without a SOT OMRA, the resident does not classify into a rehab RUG. If I do the SOT with day one being Feb. 15, how would this resident classify into a rehab RUB if only seen twice in that seven day window. Any help is much appreciated.

Our Quality Assurance Committee is lacking in focus. I am the chairperson, so I feel responsible to give it meaning. Can you give me suggestions?

F520 Quality Assessment and Assurance contains excellence guidance in order to have a successful QAA effort. Give particular attention to the definition of “Quality Deficiencies” that differ from deficiencies cited by the survey team. Quality deficiencies can be related to facility operations and practices that cause negative outcomes, or to enhancing quality of care and improving quality of life. The QAA Committee should decide which areas to investigate based on issues that are meaningful in your setting. The decision on how to proceed can be both corrective and preventive in nature. The regulation requires that the DON, a physician, and at least three
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<td>Sandy Biggi</td>
<td>May 1 – 3</td>
<td>Rochester, NY</td>
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<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>May 1 – 3</td>
<td>Windsor, VT</td>
</tr>
<tr>
<td>LeadingAge New York (formerly NYAHSA)</td>
<td>Sandy Biggi</td>
<td>May 1 – 3</td>
<td>Rochester, NY</td>
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<tr>
<td>Pathway Health Services, Inc.</td>
<td>Cynthia Perrault</td>
<td>May 8 – 10</td>
<td>Green Bay, WI</td>
</tr>
<tr>
<td>LeaderStat</td>
<td>Lisa Hohlbein</td>
<td>May 8 – 10</td>
<td>Detroit, MI</td>
</tr>
<tr>
<td>LeaderStat</td>
<td>Lisa Hohlbein</td>
<td>May 15 – 17</td>
<td>Silver Spring, MD</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>May 15 – 17</td>
<td>King of Prussia, PA</td>
</tr>
<tr>
<td>KHCA—Kansas Health Care Association</td>
<td>Becky LaBarge</td>
<td>May 16 – 18</td>
<td>Topeka, KS</td>
</tr>
<tr>
<td>Hill Educational Services, Inc.</td>
<td>Carol Hill</td>
<td>May 21 – 23</td>
<td>Mobile, AL</td>
</tr>
<tr>
<td>Pathway Health Services, Inc.</td>
<td>Cynthia Perrault</td>
<td>May 22 – 24</td>
<td>Spokane, WA</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>May 22 – 24</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Duran Consulting Services</td>
<td>Sandy Biggi</td>
<td>June 4 – 6</td>
<td>Portsmouth, NH</td>
</tr>
<tr>
<td><strong>MEDICARE UNIVERSITY WORKSHOPS</strong></td>
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<tr>
<td>Harmony Healthcare International</td>
<td>Jennifer Pettis</td>
<td>June 4 – 6</td>
<td>Charleston, SC</td>
</tr>
<tr>
<td>Judy Wilhide MDS Consulting</td>
<td>Judy Wilhide Brandt</td>
<td>June 5 – 7</td>
<td>Virginia Beach, VA</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
Feeling overwhelmed with the fast-approaching April 1 CMS revisions to the MDS and RAI User’s Manual? So are your peers.

Join other AANAC members and the experts in discussing these updates on AANAConnect, your online discussion forum. AANAConnect is the perfect place for you to ask questions, receive clarification, and begin to understand the many updates that will be implemented in just over a week. In case you missed our recent webinar on these April 1 changes hosted by Jennifer Pettis, or Rena Shephard’s email with the detailed highlights, here are a few things you might be interested in discussing on AANAConnect:

- Assessment inactivations
- Interviews and unplanned discharges
- Carrying forward prior interview responses under limited circumstances
- Future item set changes/updates
- Assessment combinations
- Deciding on the ARD for unscheduled assessment after the ARD window closes
- Effect of early and late COT ARD on COT observation

The April 1 changes will most certainly affect you and/or your team. Make sure you are in-the-know and ready to implement these amendments to ensure you’re proving the best care possible according to the most current rules and regulations.

Change is never easy, but going through it with a network of support makes it a whole lot easier.

Login to AANAConnect today: connect.aanac.org.

Active Discussions this week on AANAConnect:

**LTC Network:**

Thread Subject: Clarify on COT and on Admit/PPS

Posted by: Tammy Spears

... After meeting in St. Louis I have become confused on COT.

I want to know that if I do a 5 day PPS on day 8 and then I do a COT review on day 15 but also have my 14 day scheduled for that day, I am okay so far. But now if therapy tells me they are ramping up the RUG on day 11 or 12 and I still plan to use day 15 but I set assessment into the computer on day 14 with a 14 day and a COT because the level is going up (and same if I knew it was going down). HERE’s where I am confused... If I set this assessment with the COT is this considered EARLY cause it is day 6 of the COT review that I actually put the COT for day 7 along with the 14 day, and so do I have to take a default for that one day?

_This is just one part of Tammy’s question. To read the full post, just click on the thread subject above._

**MDS Connection:**

Thread Subject: Interviews section C and J

Posted by: Kathy Greenwood

Hi—I have a resident who had a COT done 3/8/12 and I completed and did the interviews yesterday. This morning he went to the hospital and was admitted (3/9/12). For the interview sections, would you answer them as he did for the COT yesterday or would you state NO and interview staff? Any help would be appreciated.

Thanks!!

_This conversation generated a lot of conversation in the community. See how our experts Rena Shephard and Carol Maher answered this question by clicking on the thread subject above. Even better, Rena provides a little good news that has come from the April updates to the RAI User’s Manual. Just another reason why MDS Connection is the best place to get your MDS 3.0 questions answered fast!_
Reimbursement Tip
Ancillary services (e.g. therapy, labs) provided, to a Medicare Part A beneficiary, on the day of discharge are not separately billable to Medicare Part B. These charges should appear on the Part A claim.

Ron Orth

inside CMS, continued from page 8
doesn’t really exist. However, I’ve found delusions to be one of the most under-coded items on the MDS. Residents who have a delusion, or false, fixed belief, due to memory loss or dementia should still be coded as having a delusion. Take the example of a resident who says, ‘I have to get home. My child is two years old, and she’s home alone.’ Staff members try to reassure that resident, but she remains fixed on that idea that she has a child at home. According to the MDS, that is a delusion and should be captured as such, but many facilities fail to do so.”

From a process standpoint, the message for the new QMs is that facilities need to “understand the data underneath each measure,” she suggests. “Look at what sits underneath the exclusions and any other risk adjustments, and understand that the coding for those items is just as important as the coding that actually makes the measure itself flag. And then if you do have residents, for example on psychoactive medications, who flag, it will be worth your time to take that medical record and determine, ‘Are we missing something that would in fact exclude this resident from flagging in that measure?’”  

(Note: The QMs will be a significant focus in upcoming RAC-CT recertification classes.)

Editor’s note: For coding/technical details from the conference, see the article, “CMS National Conference Provides Updates, Clarifications” by AANAC Executive Editor Rena Shephard.

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!
other members of the facility staff serve on the committee. You will give added value to your efforts by including representation from nurses’ aides, therapists, staff nurses, social workers, and activities staff, as well as the administrator and the medical director. Assess processes and outcomes, conduct root cause analysis, assure compliance with standards of quality, and use an ongoing interdisciplinary approach to improve delivery of care and resident outcomes. Take copies of F520 to your next meeting to share at the beginning of your discussion so that the committee members understand just how important their roles are. Obtain F520 from the State Operations Manual Appendix PP by visiting http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf. The regulation is located near the very end of the manual.

Betty Frandsen, RN, NHA, MHA, C-NE (bmacfran@gmail.com)

What can we expect from a QIS survey med pass inspection?

Survey team nurses or pharmacists conduct this task using the Medication Administration Observation/Drug Storage worksheet, Form CMS-20056. One surveyor is assigned to organize and ensure completion of this task, and also review drug storage areas. A combined total of at least 50 medication administrations to at least 10 randomly observed residents from different units is included. Surveyors attempt to observe medications by multiple routes, and ask about the routes of administration. Adjustments are made to observations in order to include as many routes of administration as possible. Observations may not all be done in one day. Multiple medication-administration times may be observed for each resident. Refused medications are counted as observable medications, and the surveyor watches to see how the nurse addresses this issue. If any medications are not administered properly, the significance of each error is determined by considering the following elements: resident’s condition, medication category, and frequency of the error. The surveyors assigned the Medication Administration Observation task confer and calculate the error rate as follows:

- Combine all surveyor observations into one overall calculation for the facility
- Calculate the Medication Administration Error Rate (%) using the following formula:

\[
\text{Medication Administration Error Rate} \% = \frac{\text{Number of Errors observed}}{\text{Opportunities for Errors (doses given plus doses ordered but not given)}} \times 100.
\]

After the overall error rate is determined, the team decides if a citation is appropriate. If the error rate is 5% or greater, they cite F332, Free of Medication Error Rates of 5% or Greater. If any medication error is considered significant, they cite F333, Residents Are Free of Any Significant Medication Errors. You can obtain Form CMS-20056 which is utilized by the surveyors for the medication administration observation from https://www.qtso.com/qisforms.html under the category Mandatory Facility Task Pathway Forms. You can use this form as part of your QAA activities all year long.

Betty Frandsen, RN, NHA, MHA, C-NE (bmacfran@gmail.com)
LOOK AT WHAT YOUR COLLEAGUES HAVE BEEN UP TO!

C-NE Recipients
January 1 – March 15, 2012

Nancy Adams
Sharon Arnold
Jessica Boe
Elaine Brown
John Brown
Cristy Castleberry
Esther Field
Edie Galeener
Lynn Hild
Christopher Johnson
Thomas McVay
Malissa Nelson
Kathleen Rivers
Evanthe Rockwood
Holly Styles
Laura Windle
Linda Winston
Jennifer Young

MDS 3.0 RAC-CT® Recipients
January 1 – March 15, 2012

Jennifer Abela
Evelyn Abreu
Rochelle Adams
Leonilla Addeh
Anuradha Adhikari
Phoebe-Ann Agarin
Caroline Aghaje
Benedicta Agbi
Anne Ahern
Adam Airington
Nicole Alexander
Cathy Allen
Janene Allen
Julia Alvarez
Rhea Amponin
Adele Anderson
Allison Anderson
Elizabeth Anderson
Jane Anderson
Susan Anderson
Mark Andres
Tiffany Andrews
Rhonda Antoine
Marie
Apostol-Andes
Joy Aquino
Robi Arnica
Candice Arnold
Rhonda Arnold
Lacy Axtell
Irama Bacchus
Kathleen Backer
Ramonietta Bagnol
Denise Bailey
Patricia Bailey
Amy Baker
Deanna Baker
Heather Baker
Levon Baker
Rochelle Baker
Myrna Baleria
Nancy
Banfield Johnson
Tanya Banks
Susan Bardo
Zilphia Barney
Marget Barringer
Gay Barth
Staccey Bascue
Pamela Baumann
Kimberley Beals
Kandice Beard
Stacey Beard
Neva Bennett
Kathleen Bentely
Maricel Bernadas
Mary Berry
Mary Berryman
Janice Beyer
Leah Bily
Patience Bigbee
Familia Blackmer
Deborah Blake
Jill Blanchard
Craig Blevins
Sarah Blevins
Janet Blough-Black
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Ousman Bojang
Christine Bowen
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LaWanda Bradley
Tammy Bradley
Ava Braithwaite
Ruth Bratton
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Hope Bridges
Lydia Britschgi
Andrea Brown
Gary Brown
Jeana Brown
Deborah Brumle
Cathy Brunetti
Marina Bukhrashvili
Marianne Bunge
Cherri Burchard
Susan Burish
Jodie Burroughs
Evangelie
Cabanban
Beth Cagle
Patricia Call
Jennifer Cambron
Lizbeth Caminita
Carolyn Campanella
Janet Campbell
Karen Campbell
Julie Carlone
Diana Carlson
Jeffrey Carson
Barbara Carstens
Guenivere
Castanen
Lacy Castleton
Maria
Rosario Casuat
Blake Cavanagh
Ursula Cenedo
Danita Chambers
Patricia Charlot
Ruth Chaza
Cheri Childress
Youngsu Cho
Rashi Choudhary
Carmela Christie
Victoria Cisse
Jessica Claudio
Alexia Clayboin
Ann Cockerill
Ann Cohen
Carol Ann Coker
Jacqueline Collins
Linda Comfort
Julie Cook
Laura Cook
Lilibeth Corpuz
David Corriveau
Melinda Cotton
Heidi Courtright
Rhonda Craig
Jana
Creamer-Shatcosky
Angeline Cuevas
Maria Teresa
Cuevas
Tiffany
Cunningham
Diana Dai
Riza Danania
Randy Danan
Amanda Danberry
Beminda
Datuin-Pal
Gloria Daughtrey
Christina Davis
Stanley Davis
Heather Day
Dee Deckard
Patricia Decker
Klarisse Chantlle
Del Rosario
Loreta Del Rosario
Becky DeLaFuente
Amelia Deluna
Charina DeMille
Gloria Dennis
Rose-Marie Desir
Susan DiFate
Linda Diforte
Amanda Dillard
Elizabeth Disch
Seema Diwan
Nancy Dixon
Gail Doan
Erica Dodd
Gail Doetzl
Judith Dogbe
Jonette Domingo
Judith Donahue
Barbara Dornenburg
Patricia Duffy
Emma Duquette
Gloria Earnest
Joan Eastman
Melvina Echols
Shanna Eckberg
Lori Eckman
Rachael
Edmundson
Diane Ehmann
Leslie
Elliott-Manning
Houn Ellis
Heidi Engeman
Chonna
Josette Enriquez
Dee Erickson
Jessica Esquerra
Lualhati Espina
Annette Fairrow
Douglas Farley
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Janet Sekelsky       Theresa Sliez       Ann Steinkamp       Terrel Tetschner
Susan Sellers        Karol Sligo        Tamara Sterling     Elsa Turney
Andrea Serquina      Brianna Slone      Doris Stetson       Amber Umbricht
Jennifer Seymour     Diane Smack        Amy Stimpson       Michalina Umnova
Jennifer Shafer      Alma Smith         Valerie Stinson    Patty Unpingco
Tina Shannon         Jessica Smith       Marcie Stoup        Cynthia Thompson
Marla Shapiro        Laurie Smith       Lori Strittmatter  Heather Thompson
Nancy Sharrow        Loretta Smith      Lenora Sullivan     Idalina Thompson
Dawn Sheppard        Mary Smythe        Patricia Sullivan   Doris Thornburg
Sabrina Sheppard     Sonya Soboleski    Kyle Summers        Sheri Renee
Helen Shropshire     Sue Sochats        Shannon Summers    Thornburg
Georgia Shultz       Dorota Sohail      Brenda Sutherland  Tammy Thornton
Theresa Silkwood     Jenette Somers     Annie Swanson       Sue Thrower
Maricar Simene      Angela Spencer      Norman Taclob       Chingbee Tinio
Elizabeth Simes      Sara Spinney       Cathi Tampa        Kathleen Tipton
Carol Simpson        Micheline Spichal   Maria Tang         Rebecca Todd
Natasha Simpson      Amanda Spore       Shannon Tate       Ernestine Toe
Samie Singleton      Jennie Squire      Mary Tauer         Janet Toomey
Tiffanny Strichana  Alice Steck        Betty Taylor        Edwin Towers
Jami Skeen           Betty Stegall      Kelli Taylor        Danita Traxinger
Celia Slayden        Robin Stegenga     Ulysses Tayocnog    David Trimbach

Carol Trumbauer      Elsa Turney        Amber Umbricht     Michalina Umnova
Regina Vogt          Linda Vonfraenkel   Georgiana Walker   Patty Unpingco
Karen Walker         John Wallis        Frances Ware       Kimberly Vanderwal
Raquel Welsh         Kay Westbrook       Jill Weston        Ruby Whaley
Loraing VanMeter     Paulson Varghese   Felicia White      Karissa White
Laura Verbarg        Marie-Francoise    Brenda Williams    Linda Williams
Marise Vignier       Vaudreuil          Linda Williams     Nyka Williams
Lorena Villamor      Laura Verbarg      Sanyo Williams     Dina
Jamie Vistrand       Susan Villanueva Burgos
Sharon Williamson    Judith Vogel       Ana Wilson
Jackie Wilson        Debra Wolfe        Janet Wolken       Kilee Wolken
Vanessa Wolfsefer    Kira Wood          Brandi Woods       Vickie Worden
Beverly Wright       Linda Wright       Dawn Wylie        Elna Yambao
Debra York           Cora Young         Mary Zabel         Mary Ziegler
Theresa Zielinski    Sheila Zion-Self   Jack M. Zietz       Jack M. Zietz

MDS Interview Forms

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daRT Chart Systems, LLC
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Evergreen Healthcare
Extendicare Health Services, Inc.
Five Star Quality Care, Inc.
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The Goodman Group
Goshen Care Center
Greystone Health Care Management
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
Plott Healthcare
Preferred Care Partners Management Group
Prestige Healthcare
Regent Care Center
Rockport Healthcare Services
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