

# CONTINUUM

## HEALTH CARE SERVICES, L.C.

### “HEALTHLINE”

HEALTHLINE

THIRD QUARTER 2007

### Sales Tax



Often the question of paying sales tax arises in a nonprofit entity. Sales Tax does need to be paid by nonprofit nursing homes. They are exempt from Income Taxes only. The following is an excerpt from an Iowa Department of Revenue document.

“Nonprofit entities, churches and religious organizations are not automatically exempt from paying state sales taxes on taxable goods and services. This is true even if these entities are exempt from the payment of state and federal income taxes. State sales tax must be paid unless some other general sales tax exemption applies. Local option sales taxes must also be paid on purchases made in jurisdictions which impose the taxes.

Purchases made for resale are exempt from all sales tax. In other words, a nonprofit corporation, church or other religious organization is treated the same as any other private citizen for sales and use tax purposes when purchasing goods and taxable services at retail. “



### New Survey and Certification letters on PASRR and Medication Pass

The Centers for Medicare and Medicaid Services (CMS) have issued two new survey and cert

letters. Both letters are currently in effect. A printable copy can be downloaded at the following website:

[www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/ist.asp#TopOfPage](http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/ist.asp#TopOfPage)

Survey and Certification number 07-38 is the Pre-Admission Screening and Resident Review (PASRR) and the Nursing Home Survey Process. This clarification is in response to an Office of Inspector General’s (OIG) recommendation to ensure surveyors review required PASRR documentation during the survey process. This includes pre-admission screens, resident reviews, determinations for specialized services and care plan review to ensure those services are provided.

PASRR is a Medicaid program requiring identification of those residents with serious mental illness or mental retardation (MI/MR). It requires proper placement of these individuals in a nursing facility by utilizing the Level II evaluation process. Appendix P and Appendix PP of the State Operations Manual describes the survey process related to PASRR. The Survey and Certification letter explains the various F-tags and regulations related to the PASRR process. Further information can be obtained from [www.cms.internetstreaming.com](http://www.cms.internetstreaming.com). An archived satellite broadcast from September 28, 2007 on “Mental Illness in Nursing Homes” can be viewed at no cost.

Survey and Certification number 07-39 is Nursing Homes – Medication Pass Clarification for Surveying F Tags 332 and 333 During Nursing home Surveys. F tag 332 states the facility must ensure that it is free of medication error rates of 5% or greater and F tag 333 states residents are free of any significant medication errors.

This survey and certification letter is a clarification describing what is included in the facility's 5% medication error rate during the survey process. Nutritional and dietary supplements are not included in the 5% medication error rate calculation. They are not considered medications for the purposes of the nursing home survey even though they may be recorded on the Medication Administration Record (MAR). Nutritional supplements and dietary supplements are defined in the letter. Vitamins and minerals are counted in the 5% medication error rate but are not considered a significant medication error unless the criteria at F tag 333 is met.



## End-Of-Life Dementia Care

In 2005 the Alzheimer's Association launched a campaign to improve the quality of care for residents with dementia in assisted living and nursing home settings. More than half of residents in assisted living and nursing homes have some form of dementia or cognitive impairment. Phase 1 was released with recommendations for the basics of dementia care, food and fluid consumption, pain management and social engagement. Phase 2 covers wandering, falls and physical restraints. In August 2007 they released phase 3 end-of-life care.

Phase 3 guides the health care provider through end-of-life terminology, establishing of health care documents and health care goals. Phase 3 is based on the individuality of the resident and their goals/wishes despite dementia. Key topics are:

1. Communication with resident and family with a focus on making key decisions early during care.
2. Education on disease diagnosis, progression and other community support services available and how that care will be coordinated.
3. Proper psychosocial and spiritual support of resident and family.
4. Proper training of staff in regard to dementia care.
5. Acknowledgment of death and bereavement services.

We encourage everyone to review phase 3 of the end-of-life dementia care at: [www.albany.edu/aging/lastpassages/docs/DEPRPhas e3-small.pdf](http://www.albany.edu/aging/lastpassages/docs/DEPRPhas e3-small.pdf).



## Paid Feeding Assistants

The final Guidance has come out from CMS on Paid Feeding Assistants – F 373. The

Regulation identifies that a facility may use a paid feeding assistant, if the feeding assistant has successfully completed a State-approved training course that meets the requirements before feeding residents and the use of feeding assistants is consistent with state law. The use of paid feeding assistants is to supplement C.N.A.s and not to substitute for nurse aides or licensed nursing staff. Facilities may use existing staff to assist residents to eat and drink.

The feeding assistant must work under the supervision of an RN or an LPN. In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

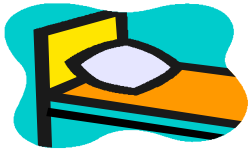
Paid feeding assistants may assist residents that have no complicated feeding problems. Complicated feeding problems include but are not limited to: difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings. Resident selection must be based on the charge nurse's assessment and the resident's latest assessment and plan of care.

The facility must maintain a record of all individuals who are paid feeding assistants. Records should include verification that the paid feeding assistant successfully completed a State approved paid feeding assistant training program.

Upon entrance conference, the surveyors will now ask if you utilize paid feeding assistants. If so, they will ask about how and where they received their training. They will also ask who successfully completed the course. They then will do observations.

Identify on the resident's plan of care if they are able to be assisted by a paid feeding assistant. Remind charge nurse's to evaluate the residents prior to meal to ensure any resident with a change in condition is assisted by a C.N.A. or nurse. They may also ask how the charge nurse is able to supervise the paid feeding assistant. Ensure that they are able to get assistance immediately whether by call light or by being in direct line supervision.

Let us know if you have questions regarding paid feeding assistants. This is really an area that can be utilized to assist us at those busy meal times.



## Other Types of Bed Rails Used

Frequent coding errors occur on MDS Section P4. Physical Restraints. This section's intent is "to record the frequency, over the last 7 days, with which the resident was restrained by any of the devices listed below at any time during the day or night". The devices include:

- P4a. Full Bed Rails
- P4b. Other Types of Bed Rails Used: any combination of partial or half rails
- P4c. Trunk Restraint
- P4d. Limb Restraint
- P4e. Chair Prevents Rising

Coding errors occur when the assessor does not understand the definition of a physical restraint. The RAI Manual, page 3-198, defines a physical restraint as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement". The assessor must observe the resident and determine if the resident can easily remove the device. The focus should be on the effect the device has on the resident. Does it restrict their freedom of movement or normal access to their body? Any device, material or equipment that meets this definition must be coded in the appropriate category. The assessor is NOT to code P4b unless the half-rails have the effect of restraining the resident. Page 3-202 states, "While bed rails may serve more than one function, the assessor should code items P4a or P4b when the bed rails meet the definition of a restraint".

what they and the resident talked about and the common interests that they had. It was the closing paragraph that really astonished me and in turn I wanted to share that we you.

Mr. L. wrote "All in all I believe the care center project was really a good thing for our religion class to do. I learned a lot about how then you get older you cherish the little things. All the stuff that you once thought was important seems to fade because your relationships with your friends, family, and God are most important. I realized that as you grow older you likely will not have very fond memories of your work or what you have done in life but more likely who you've met and loved and what you have accomplished. The care center project really gave me a different aspect on what is important and really taught me to live my life to the fullest."

The gentleman that wrote that paragraph was a junior in High School. It is so refreshing to have a younger person teach a life lesson that so many people much older than he is are never able to learn.

My reason for sharing this is simple. I think that it is good for everyone once and awhile to be reminded of what is truly important in life. Every single person who is reading this article has a tremendous amount of responsibility placed upon them to do whatever possible to improve the lives of others. What you do now for others may be the accomplishments that you hold dear to yourself now and will cherish for many years to come.



## Reflections

Each facility participates in different community relations projects. The effects of these projects are sometimes not known until you are able to see something through the eyes of others. I have been given a refresher lesson by a junior in High School and I think we all could benefit from this person's reflection.

Our facility participates with a Catholic High School in our town in which the students are assigned different resident to visit each time they come to the facility as part of a religion class. This year I was provided a copy of the reflections that the student completed. There was one in particular that stood out from the others. In this individual's reflection they wrote about



## "Weighing In" on the MDS, Section K

Coding for MDS Section K. Oral/Nutritional Status has noted several common errors related to K2 Height and Weight and K3 Weight Change. It is important to periodically review the RAI Manual utilization guidelines to ensure compliance. The guidelines for MDS Section K2 are on page 3-150 in the RAI Manual. Height, K2a, is a measure in inches and must be re-measured if the last height recorded was more than one year ago. Coding instructions are to round the height upward to the nearest whole inch. A height of 64 and 1/4 inches is rounded upward to the nearest whole inch as 65 inches. Weight, K2b, is measured in pounds and is also to be rounded upward to the nearest whole pound. Therefore, a weight of 152.2 pounds is

rounded upward to the nearest whole pound as 153 pounds.

Another common coding error occurs at MDS Section K3 Weight Change. This item records variations of the resident's weight over specific time frames. Weight change is coded regardless of cause such as planned weight loss or amputation. A RAI Manual clarification was implemented August 2003 to calculate percentage for weight loss or gain on the resident's actual weight. Do not round the actual weight. The weight recorded at K2b cannot be used to calculate the weight change at K3. The calculation for a gain or loss is described on page 3-151 in the RAI Manual. Do not round the percentages up or down.

The resident's clinical record must document weight assessment. Frequently, weight changes are only recorded as the percentage and does not state what weight measurements the assessor used. Good clinical practice can document a weight change using the following template: "Resident's current weight of \_\_\_# on (date) compared to prior weight of \_\_\_# on (date) is a loss/gain of \_\_\_# at \_\_\_% in 30/180 days." This ensures all disciplines are using the same assessment data to reflect measurable objectives, interventions and timetables for the resident's comprehensive care plan.



## **New ICD-9-CM Official Guidelines For Coding And Reporting**

New guidelines, effective October 1, 2007, have been approved by the four Cooperating Parties that review the ICD-9-CM. These four parties include the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS). The guidelines have been developed to accompany and complement the official ICD-9-CM by providing additional information for the healthcare provider and the coder.

Accurate documentation in the medical record is extremely important. The health care provider must review the medical record, identify correct diagnoses and procedures, and report them to the coder. The relationship between the healthcare provider and the coder is essential for accurate code assignment and reporting. These guidelines will assist both the healthcare provider and the coder to achieve accurate coding.

The guidelines are organized into three sections. Section I describes conventions, general coding guidelines and chapter specific guidelines. Section II describes guidelines for selection of principal diagnosis and Section III includes reporting of additional diagnoses. The guidelines also include an updated V Code Table.

A copy of the official guidelines (105 pages) can be downloaded at the following website:

[www.cdc.gov/nchs/datawh/ftp/ftp9/ftp9.htm](http://www.cdc.gov/nchs/datawh/ftp/ftp9/ftp9.htm).



## **Video Recording in Your Facility**

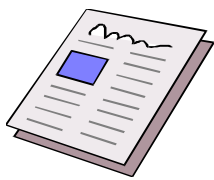
Electronic technology advances daily and with it an increasing opportunity for resident and staff confidentiality to be breached.

The use and purpose of video (including camera phones), audio or audio/video equipment varies by the occasion and the user. The purpose may be as innocent as recording grandma on her 100<sup>th</sup> birthday or as questionable as hiding a video camera in a resident's floral arrangement.

The Iowa Code 2001, Section 727.8 states "Any person, having no right or authority to do so, who tap s into or connects a listening or recording device to any telephone or other communication wire, or who by any electronic or mechanical means listens to, records, or otherwise intercepts a conversation or communication of any kind, commits a serious misdemeanor; provided, that the sender or recipient of a message or one who is openly present and participating in or listening to a communication shall not be prohibited hereby from recording such a message or communication; and further provided, that nothing herein shall restrict the use of any radio or television receiver to receive any communication transmitted by radio or wireless signal."

It is almost always illegal to record a conversation of which you are not a participant, of which you do not have consent to record and of which you could not naturally overhear.

While we do not want to think that any of our residents or their family members would be a party to secreting a video camera or audio transmitter into our facility, it is becoming a matter of preparedness to include a policy in the facility admission packet that prohibits the use of hidden cameras, listening devices, etc. unless approved by the facility administration and in the nature of an official investigation.



## Newsletters-A Marketing Resource

If you're looking to increase the awareness and enhance the image of your health care facility, Newsletters may be what you're looking for.

They can be used as an external or internal marketing tool and will be valuable in meeting your overall marketing objectives.

What are the Advantages to a Newsletter?

- \*It will provide information and be a major communication tool to inform residents, families, employees and other interested persons of facility happenings.
- \*It can be a public relations tool.
- \*It can also be used to help sell the services you offer at your facility

Suggested ways to enhance your readership:

- Provide information that will focus on the reader's interest
- Develop appropriate content
- Use the right format
- Increase your mailing list over time
- Always publish and mail your newsletter on a regular basis

Here are the possible disadvantages:

- It can be costly
- Article contents/substance may decrease
- It becomes difficult to stay on a publishing schedule
- It may not be read
- It may possibly get thrown away

Newsletters are a form of 'flexible' marketing. They can get out messages that are current and relevant. They also may provide the reader with a sense of community, family and connection.

## OSHA



Have you ever received a flyer in the mail that invited you to attend an OSHA training? Did you look at the flyer and then file it in the trash can thinking OSHA will probably never come to your facility to do an inspection? If this is the case then this information may interest you. OSHA inspectors are coming into care centers in Iowa.

These are just a few examples of some of the things that they are looking at. For further information visit [www.osha.gov](http://www.osha.gov).

Needle stick Injuries: You must record all work-related needle stick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material. You must enter the case on the OSHA 300 Log as an injury. To protect the employee's privacy, you may not enter the employee's name on the OSHA 300 Log, but enter "privacy case" instead.

You must establish and maintain a sharps injury log for the recording of injuries from contaminated sharps. The information in the sharps injury log shall be recorded and maintained in such a manner as to protect the confidentiality of the injured employee. The sharps injury log shall contain, at a minimum:

- A. The type and brand of device involved in the incident,
- B. the department or work area where the exposure incident occurred, and
- C. an explanation of how the incident occurred.

Lock-Out/Tag-Out Program: Your lock-out/tag-out program must be assessed and reviewed annually by someone other than the person who is in charge of the program in your facility. The yearly review needs to be documented.

Eyewash Station: If you are using a chemical in your facility that is labeled a "corrosive" (either on the bottle or on the MSDS sheet) you must have an adequate eyewash station that is in an accessible location and requires no more than 10 seconds to reach. For example if you are using de-limer in the dishwasher in the kitchen then you need to have adequate eyewash within 10 seconds travel time of the dishwasher.

What is adequate eyewash?

\*It shall be located on the same level as the hazard and the path of travel shall be free of obstructions that may inhibit the immediate use of the equipment.

\*The controls on the eyewash must cause flushing fluid flow within one second. Stay open valves are specified to ensure continuous flow while freeing up the hands to hold the eyelids open.

\*Each eyewash location shall be identified with a highly visible sign positioned so the sign shall be visible within the area served by the eyewash.

\*The eyewash must provide enough water for a continuous flush for 15 minutes @ 0.4 gallons per minute. The water that is being used for the flush must be tepid, between 78 degrees Fahrenheit and 92 degrees Fahrenheit per the ANSI standards.



## Common Life Safety Deficiencies

- Hazardous Rooms not equipped with a self-closing door device.
- Smoke barrier penetrations on corridor smoke doors and in the attics
- Failure to test battery emergency light units. (Requires a documented monthly Test of 30 seconds)
- Failure to conduct sensitivity testing of the facility smoke detectors.
- Required self-closing metal containers for disposal of cigarette ashes & butts from ash trays.
- Hood and Duct extinguishing system not tied to fire alarm system.
- Quarterly testing of sprinkler systems not completed
- Automatic dialer did not send audible or visual alarm when set to trouble code.
- Absence of battery emergency light located at generator transfer switch location.
- Absence of specifications on wood paneling and carpet

- Fire alarm panels are not supervised shall be protected by smoke detection
- Lint, corrosion and paint on sprinkler heads
- Absence of emergency lighting outside the building to the public way
- Absence of 2 sources of light (bulbs) in fixtures in exit discharge areas
- Canopies and overhangs (combustible and over 4 feet) not sprinklered
- Absence of exit signs in required areas
- Blinds draperies not being tagged as flame retardant
- Attic access panels constructed of plywood and not sheet rocked
- Fire drills being conducted within timeframes that show a pattern. Example: All 2<sup>nd</sup> shift fire drills being conducted between 2:30 and 3:00 p.m.)



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