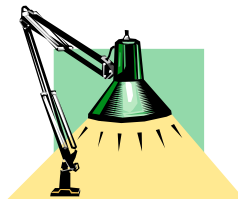


RAI Spotlight



DEPARTMENT OF
HEALTH

Susan Williamson
RAI Coordinator
1-717-787-1816
qa-mds@state.pa.us

P4 Restraints

The completion of MDS Item P4 Devices and Restraints always raises many concerns. 42 C.F.R 483.13(a) provides that “the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident’s medical symptom.” Physical restraints are defined as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.”

CMS is undertaking two separate efforts to provide guidance to facilities and surveyors on this topic. The first is the release of a Memorandum (S&C-07-22) on June 22, 2007, clarifying some phrases that appear in the instructions (www.cms.hhs.gov/SurveyCertificationGenInfor/PMSR/list.asp). According to the memo, “Proper interpretation of the physical



restraint definition is necessary in order to understand whether or not nursing homes are accurately assessing devices as physical restraints and meeting the federal requirement for restraint use.” The following are some excerpts from this Memorandum:

- **“Freedom of Movement”** means any change in place or position for the body or any part of the body that the person is physically able to control.
- **“Remove Easily”** means that the manual method, device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident’s physical condition and ability to accomplish [the] objective

(Continued on page 4)

Volume 2, Issue 1
August, 2007

Questions about the RAI?

Please submit them to
qa-mds@state.pa.us

Medicare PPS RUG Teleconference

Date: Thursday, October 11, 2007
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: Medicare PPS RUG Classification (5.20 53 Groups)
Handouts: Power Point slides will be available about October 1 on the DOH Message Board at

<http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp>

Call in number: 1-888-694-4728 or 1-973-582-2745

Conference ID Number: 9111736

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for accessing this will be posted on the DOH Message Board.

Additional questions: qa-mds@state.pa.us



Inside this issue:

Teleconference Q & As	2
K5a Parenteral/IV	2
F323 Accidents and Supervision	3
Do You “CARE”?	3
Survey	4
Special: New Facilities and the MDS	5

RAPs and Care Planning



Q & As

On July 12, 2007, a training teleconference was provided dealing with RAPs and Care Planning. The following questions were raised in the Q & A portion of the conference and the following responses developed.

Q1. What qualifications are required for personnel to complete the Resident Assessment Protocols (RAPs)?

A. Page 4-1 of the RAI Manual states “The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident’s functional status.” There are several other references in this chapter to the IDT and their role in assessing the resident and using the RAPs to develop a care plan. Beginning on page 1-17 of the RAI Manual, the section on Participants in the Assessment Process references participation of an IDT that includes facility staff with varied clinical backgrounds. “In most cases, participants in the assessment process are licensed health professionals. It is the facility’s responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.”

Q2. Why is “Identifies her own goals” a trigger for RAP review?

A. F1d Establishes own goals is a trigger for review of RAP 7 Psychosocial Well-Being. This response indicates a strength that might be used in helping the resident find satisfaction in her life in the nursing facility. Not all triggers identify deficits or problems, but certainly dealing with resident problems is usually the

main goal of the care plan. The “positive” triggers remind the facility to look at resident strengths, as well.

Q3. Please discuss responding to MDS Item E4e Resists care. Is there a difference between resisting and refusing care?

A. Resident rights in relation to resisting care has been questioned lately. Every resident has the right to refuse care, but the facility cannot simply drop the issue at that point. When a resident continually refuses care (such as medication), it is the facility’s responsibility to follow up, and care plan to assist the resident in achieving the highest practicable level of function. Find out why the resident is refusing the medication: is it making them sick to their stomach, or is it making them dizzy? Once the reason is identified, the interdisciplinary team can move forward with a different plan, e.g. providing crackers with the medication or seeing if it can be moved to nighttime.

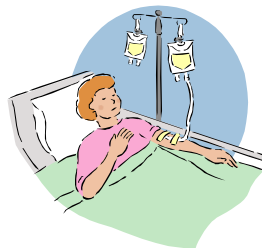
As a matter of semantics, “refusing care” might be a verbal response such as “No, I don’t think I’ll get a shower tonight.” “Resisting care” is more of a physical response such as pushing away or biting. The solution is the same: find out why the resident is resisting. Does the resident perceive the caregiver as someone they encountered in an earlier time and didn’t like? Is there untreated pain? Good detection and care planning will result in a better quality of life for both the resident and the caregivers.

K5a Parenteral/IV

CMS has changed the definition of this item in the RAI Manual several times in an effort to obtain the desired information about this therapeutic intervention. In June, 2005, the instructions were restated to “Include only fluids administered for **nutrition or hydration**,” with bolding added to give significance to those words. Since then, assessors have struggled to accurately assess residents and meet this standard.

The Data Assessment and Verification (DAVE 2) project, led by Abt Associates as a contractor for CMS, has issued an MDS Tip Sheet for this item (www.qtso.com/download/mds/DAVE_TipSheet_SectionK5_v6_2.pdf). The following information from this sheet provides some guidance for this coding requirement:

- IV Fluids: Examples of common replacement solu-



tions, mineral salts and vitamins used in IV Fluid Therapy for **nutrition and/or hydration** include D5W (5% dextrose in water); D5 ½ NS (5% dextrose in 0.45% normal saline); Normal Saline (0.9% sodium chloride); Ringers/Lactated Ringers (differing solutions of sodium, chloride, potassium, calcium); any composition of TPN; vitamins/multivitamins (Niacin, B6, B, K, Chromium, Zinc); Amino Acids; Fat emulsions.

- Coding Tip: If an IV solution contains medication, nutrients and/or fluids for reconstitution, item K5a can **only** be coded if there is supporting documentation that reflects an identified need for additional fluid intake for **nutrition and/or hydration**. This supporting docu-

(Continued on page 4)

F323 Accidents and Supervision

Revised surveyor guidance for surveying Accidents and Supervision (Tag F323) requirements in long-term care facilities became effective on August 6, 2007. The State Operations Manual has been updated at <http://www.cms.hhs.gov/transmittals/downloads/R27SOMA.pdf> to include this new guidance. This provides information not only on what the surveyors will be looking for, but on ways to provide a safer environment for NF residents.

42 C.F.R. § 483.25(h) states that the facility must ensure that

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

It is always interesting to look at the definitions provided. An “accident” refers to an unexpected or unintentional incident, which may result in injury or illness to a resident. An “avoidable accident” means that an accident occurred because the facility **failed to**:

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and/or
- Evaluate/analyze the hazards and risks; and/or

- Implement interventions, including adequate supervision, consistent with a resident’s need, goals, plan of care, and current standards of practice in order to reduce the risk of an accident; and/or
- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice.

If the accident occurred despite the facility meeting all four points listed above, the accident is considered to be “unavoidable.”

A “fall” refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

Other topics covered in this guidance include providing needed supervision, resident smoking, resident-to-resident altercations, and identifying environmental hazards and resident vulnerabilities.



Do You “CARE”?

The Deficit Reduction Act of 2005 directed CMS to develop a Post Acute Care (PAC) Payment Reform Demonstration. The demonstration is to be in place in early 2008 with a report submitted to Congress in 2011. The goal of this initiative is to standardize patient assessment information from PAC settings (SNFs, inpatient rehabilitation facilities, home health agencies and long term care hospitals) and to use these data to guide payment policy in the Medicare program.

In response to this requirement, the Medicare Continuity Assessment Record and Evaluation (CARE) Instrument has been developed through a contract with the Research Triangle Institute. This tool will be used to

- 1) standardize program information on Medicare beneficiaries’ acuity at discharge from acute hospitals,
- 2) document medical severity, functional status and other factors related to outcomes and resource utilization at admission, discharge, and interim times during post acute treatment,



and

- 3) understand the relationship between severity of illness, function status, social support factors and resource utilization.

In addition, a cost and resource use (CRU) tool has been developed which will measure staff and ancillary resources associated with different types of patients. These tools will be tested beginning in January, 2008 in ten different markets across the country. Data will be submitted through web-based data submission systems. In the testing areas, providers will continue to complete and submit MDS, OASIS, IRF-PAI or any other currently required assessment forms as well as completing the CARE. Completion of the CARE tool is currently just a demonstration project.

If you are interested in learning more about this initiative and seeing the CARE tool, go to www.cms.hhs.gov/PaperworkReductionActof1995/downloads/CMS-10243.zip

P4 Restraints

(Continued from page 1)

(e.g., transfer to a chair, get to the bathroom in time).

- “**Medical Symptom**” is defined as an indication or characteristic of a physical or psychological condition...Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident’s safety, and help the resident attain or maintain his or her highest level of physical or psychological well-being.

There must be a link between the restraint use and how it benefits the resident by addressing the medical symptom. Medical symptoms that warrant the use of restraints must be documented in the resident’s medical record, ongoing assessments, and care plans. While there must be a physician’s order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician’s order alone is not sufficient to justify restraint use.



- **Note:** Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint.
- The use of physical restraints should be limited to preventing the resident from interfering with life-sustaining procedures only, and not for routine care. A resident who is injuring himself/herself or is threatening physical harm to others may be restrained in an emergency to safeguard the resident and others.

In addition to the release of this Memorandum, CMS is also providing a series of three training sessions on Restraints on the Survey and Certification Online Course Delivery System (<http://cms.internetstreaming.com>). Topics covered include definitions, restraint reduction and restraint alternatives. Originally broadcast on August 3, 17 and 31 as Physical Restraint Use in Nursing Homes: The Exception Not the Rule Parts I, II and III, these sessions may be viewed by anyone at any time through the Archived Webcasts section on that site. There is no charge; only a registration is required.

K5a Parenteral/IV

(Continued from page 2)

mentation should be noted in the resident’s record according to State or internal facility policies.

- Coding Examples:
 - 1) Resident Mary Jones is receiving an antibiotic in 100cc of Normal Saline via IVP. She has a UTI, fever, abnormal lab results, and documented inadequate fluid intake. She is placed on the nursing home’s hydration plan to ensure adequate hydration. Documentation shows IVP fluids are being administered as part of the already identified need for additional hydration. **Code K5a for Parenteral/IV fluids. Code the IV antibiotic medication itself at item P1a(c).**
 - 2) Resident Mary Jones is receiving an antibiotic in 100cc of Normal Saline via IVP. She has a UTI, no fever, normal lab results and documented adequate fluid intake. There is no identified need for additional hydration noted. **Do NOT code item K5a. Code the IV antibiotic medication itself at item P1a(c).**



Survey: What Would You Like? Ideas?

During the last year, five issues of this newsletter and four teleconferences have been presented. We hope they have been useful to you, and we plan to continue both efforts.

We would like your input as to topics you would like to have covered in the future. Please send your suggestions to qa-mds@state.pa.us.



New Facilities and the MDS

Opening a new nursing facility that will participate in the Medicare (MC) and/or Medical Assistance (MA) programs is a complex process. Reaching the point at which MDS assessments can actually be submitted to the state database requires completion of several steps involving the Department of Health (DOH), the Department of Public Welfare (DPW), the Medicare Data Communication Network (MDCN) and Myers and Stauffer.



First, a **license** to operate a nursing facility must be obtained from the DOH, which involves meeting the standards found in PA Code Chapter 28 dealing with Long Term Care Facilities. This also includes a Life Safety Code inspection. A Facility ID number is issued and residents may be admitted.

If the facility wishes to participate in the **Medicare** program, they must admit residents and operate in compliance with certification requirements before a survey can be conducted. The MDS OBRA assessments are a condition of participation and should be performed as if the beds were already certified. The facility will be certified effective on the last day of a survey in which they are determined to be in substantial compliance with MC requirements. (RAI Manual, p. 1-16) A MC number will be issued for the facility.



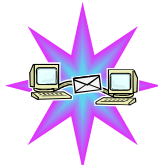
If the facility wishes to participate in the **Medical Assistance** program, DPW will first evaluate whether there is a need for MA beds in the facility's area (55 PA Code Chapter 1187.21a at www.pacode.com/secure/data/055/chapter1187/s1187.21a.html details DPW's policies concerning the addition of MA beds). If a need is identified, the licensed facility must complete an LTC Enrollment Form and an MA Provider Agreement; a PROMISE number will be assigned. The facility will want to obtain the Resident Data Reporting Manual (www.dpw.state.pa.us/omap/provinf/ltc/omaprdrm.pdf) which details the MDS reporting requirements for the MA Case Mix program.



At the facility, MDS records are accumulating. Hopefully, **software** has been obtained to allow data entry, edits and storage of this information. If the facility will be participating only in the Medicare program, they can use the free Resident Assessment Verification and Entry (RAVEN) software with PA Section S available at www.qtso.com. If the facility will be participating in the MA program, they must use other software that allows completion of the MA Change Tracking Form.



Once all surveys are complete and numbers issued, the DOH and DPW **officially notify** Myers and Stauffer that a new facility is functioning in Pennsylvania and may submit MDS records to the state database. A Password and Connectivity letter is mailed to the facility containing the information needed to submit.



As a final step in preparation for submitting MDS records, the facility must contact the **Medicare Data Communication Network** (www.qtso.com/mdcn.html) to obtain an MDCN User ID and password. Further information on the MDS submission process is available at that site as well as in the Long Term Care Facility User's Manual (www.qtso.com/mdsdownload.html).

By the time all this is accomplished, many MDS records may have been completed and may be overdue for submission according to CMS requirements. When these records are submitted, the facility may receive several **Warning** messages on their Final Verification Report, e.g., -71 Inconsistent Record sequence or -377 Record submitted late. Each Warning message should be evaluated carefully, but if the problem seems to be simply related to these start-up issues, they can be ignored. Fatal errors and other Warning messages will need to be evaluated using the Validation Report Messages and Descriptions (www.qtso.com/mdsdownload.html).