PADONA /LTCN
Pennsylvania Association of Directors of Nursing Administration

DEDICATED TO SERVICE
COMMITTED TO CARING

FEBRUARY 2015

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PADONA E-News

Dear PADONA Members:

I know that many of you breathed a sigh of relief when the major snowstorm missed us this last time. It is always a challenge to care for the residents when your staff has difficulty getting to work. I sincerely applaud you for your efforts.

We have been busy preparing the new mobile app for convention. This is a learning curve for of us but I believe all of you attending convention will enjoy the end result. Remember there is still time to register for convention where you can not only get 18 CE contact hours but renew friendships with your colleagues and pamper yourself for a couple of days at the beautiful Hotel Hershey.

I was so pleased at the response we got when the call for nominations was mailed. A sincere thanks to all of you who volunteered to put your name on the ballot. In the very near future all eligible primary members will receive an email link to access the ballot and cast your vote.

As always remember PADONA is your professional organization. If there is anything I can assist you with please contact me either via phone or email. Have a good day and think spring!!

Chair, Board of Directors / Executive Director
PADONA

Five Star Quality Rating System

Article is Reprinted from Centers for Medicare and Medicaid Services (CMS)

CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which you may want to ask questions.

The Nursing Home Compare Web site now features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-star rating for each nursing home, and a separate rating for each of the following three sources of information:

- **Health Inspections** – The health inspection rating contains information from the last 3 years of onsite inspections, including both standard surveys and any complaint surveys. This information is gathered by individuals who go onsite to the nursing home and follow a specific process to determine the extent to which a nursing home has met Medicare's minimum quality requirements. The most recent survey findings are weighted more than the prior two years. More than 200,000 onsite reviews are used in the health inspection scoring nationally.

- **Staffing** – The staffing rating has information about the number of hours of care on average provided to each resident each day by nursing staff. This rating considers differences in the level of need of care of residents in different nursing homes. For example, a nursing home with residents who had more severe needs would be expected to have more nursing staff than a nursing home where the resident needs were not as high.

- **Quality Measures (QMs)** – The quality measure rating has information on 9 different physical and clinical measures for nursing home residents - for example, the prevalence of pressure sores or changes to resident's mobility. This information is collected by the nursing home for all residents. The QMs offer information about how well nursing homes are caring for their residents' physical and clinical needs. More than 12 million assessments of the conditions of nursing home residents are used in the Five-Star rating system.

On the Web site people will be able to arrange the order of the nursing homes according to any of the three aspects above, as well as an overall quality rating based on those three sources of information.

Caution: No rating system can address all of the important consideration that go into a decision about which nursing home may be best for a particular person. Examples include the extent to which specialty care is provided (such as specialized rehabilitation or dementia care) or how easy it will be for family members to visit the nursing home resident. As such visits can improve both the residents quality of life and quality of care, it may often be better to select a nursing home that is very close, compared to a higher rated nursing home that would be far away. Consumers should therefore use the Web site only together with other sources of information for the nursing homes (including a visit to the nursing home) and State or local organizations (such as local advocacy groups and the State Ombudsman program).

In the Downloads section below, the Five-Star Quality Rating System Technical Users' Guide provides in-depth descriptions of the ratings and the methods used to calculate them. Beginning with the March 2009 version, the Technical Users' Guide consists of two documents: the Five-Star Quality Rating System Technical Users' Guide and the Five Star Quality Rating System State-Level Cut Point Tables. In addition, beginning with March 2009 we have posted a data file that contains reported, expected, and adjusted staffing time values for all nursing homes on Nursing Home Compare - **Updated January 2015**.

Division of Compliance, Projects and Demonstrations

Article is Reprinted from Centers for Medicare and Medicaid Services (CMS)

Consistent with Sections 1833(e), 1842(a)(2)(B), and 1862(a)(1) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) is required to protect the Medicare Trust Funds against inappropriate payments that pose the greatest risk, and take the proper corrective actions.

The Division of Compliance, Projects and Demonstrations activities include the following:

PEPPER: The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a comparative data report that summarizes one provider's Medicare claims data statistics for services vulnerable to improper Medicare payments. PEPPER can support a hospital or facility's compliance efforts by identifying where its billing patterns are different from the majority of other providers in the nation. This data can help identify both potential overpayments as well as potential underpayments. PEPPER was created by TMF Health Quality Institute to prioritize findings

and provide guidance on areas in which a provider may want to focus auditing and monitoring efforts with the goal of preventing improper Medicare payments. PEPPER identifies areas of potential over-coding and under-coding as well as areas that may be questionable in terms of admission necessity. PEPPERs are available for Short-term (ST) and Long-term (LT) Acute Care Hospitals, Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs) and Skilled Nursing Facilities (SNFs). PEPPERs are not publicly available; they are only distributed to each individual provider. For additional information and resources, please visit the PEPPER Resources website at http://www.pepperresources.org/.

FATHOM: The First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application that allows CMS to generate reports on providers summarizing Medicare claims data for areas identified as vulnerable to improper Medicare payments. FATHOM reports can be generated for Short-term (ST) and Long-term (LT) Acute Care Hospitals, Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), Hospices, Partial Hospitalization Programs (PHPs) and Skilled Nursing Facilities (SNFs). FATHOMs are not publicly available; they are only distributed to CMS, Medicare Administrative Contractors and Recovery Auditors. FATHOM is produced and distributed by TMF Health Quality Institute.

CBRs: A Comparative Billing Report (CBR) provides comparative billing data to an individual health care provider. CBR's contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers on both a national and state level. Graphic presentations contained in these reports help to communicate a provider's billing pattern more clearly. CBR study topic (s) are selected because they are prone to improper payments. For additional information and examples of CBRs, you can access the eGlobalTech website at http://www.cbrinfo.net/.

MEDICAL REVIEW SPECIALTY STUDY: To continue to prevent and reduce improper payments, the Division of Compliance, Projects and Demonstrations in the Provider Compliance Group has contracted with StrategicHealthSolutions, LLC to conduct Medical Review Studies of Part A and B claims. These studies occur on a quarterly basis and vary in topic. The first three topics are Inpatient Psychiatric Facility Interrupted Stays, Epidural Injections, and Place-of-Service coding. For more details and contact information you can access the StrategicHealthSolutions, LLC website at http://www.strategichs.com/.

Cardiopulmonary Resuscitation (CPR) in Nursing Homes

Article is Reprinted from Centers for Medicare and Medicaid Services (CMS) and Center for Clinical Standards and Quality/Survey & Certification Group

*****Revised to include information on CPR certification and Appendix PP draft guidance revisions at F155*****

The CMS has revised surveyor guidance in Appendix PP of the State Operations Manual (SOM) under F155 to clarify CPR policies for nursing homes. The regulatory language remains unchanged.

Memorandum Summary

Revisions to Guidance - The Centers for Medicare & Medicaid Services (CMS) have revised the guidance to surveyors in Appendix PP under F155 to clarify a facility's obligation to provide CPR.

Initiation of CPR - Prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advance directives or in the absence of advance directives or a Do Not Resuscitate (DNR) order. CPR-certified staff must be available at all times.

Facility CPR Policy - Some nursing homes have implemented facility-wide no CPR policies. Facilities must not establish and implement facility-wide no CPR policies.

Surveyor Implications - Surveyors should ascertain that facility policies related to emergency response require staff to initiate CPR as appropriate and that records do not reflect instances where CPR was not initiated by staff even though the resident requested CPR or had not formulated advance directives.

CPR Certification - Staff must maintain current CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessment. Online-only certification is not acceptable.

A. Background

Federal regulations at 42 C.F.R. §483.10 provide that a resident of a skilled nursing facility or nursing facility has the "right to a dignified existence" and "self-determination" including the

right "to formulate an advance directive." The provisions of §§1819(b)(2) and (b)(4)(A) of the Social Security Act (the Act) and the regulations at 42 C.F.R. §483.20(k)(3)(i) and §483.25 further stipulate that the services provided by the facility "must meet professional standards of quality" and "the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident."

The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). These guidelines reflect global resuscitation science

and treatment recommendations from the 2010 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care with Treatment Recommendations. According to the AHA, reversal of clinical death is among the goals of ECC since brain damage

begins four to six minutes following cardiac arrest if CPR is not administered during that time.[1] In the guidelines, AHA has established evidenced-based decision-making guidelines for initiating CPR when cardiac arrest occurs in or out of the hospital. AHA urges all potential rescuers to initiate CPR unless: 1) a valid DNR order is in place; 2) obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or 3) initiating CPR could cause injury or peril to the rescuer.[2] AHA guidelines for CPR provide the standard for the American Red Cross, state EMS agencies, healthcare providers, and the general public.

B. Facility CPR Policy

One of the central tenets of person-centered, individualized care is the right to formulate an advance directive. Along with Federal regulations at 42 C.F.R. §483.10, regulations at 42 C.F.R. §489.102 require providers, including skilled nursing facilities (SNFs) and nursing facilities (NFs), to provide written information to residents about their rights to make decisions about medical care, including the right to formulate advance directives. An individual's choice to forego CPR in a medical emergency is an important aspect of advance directive decision making.

Research generally shows that CPR is ineffective in the elderly nursing home population. A 2006 research study from the Journal of the American Medical Directors Association (JAMDA) described post-CPR survival rates among nursing home residents ranged from 2 to 11 percent. This study found the survival rate was 2 percent with only 67 percent of residents receiving CPR while awaiting arrival of EMS while 33 percent of residents who wanted CPR did not receive it prior to EMS. However, the population in nursing homes is increasingly comprised of younger residents requiring medical care, residents needing short-term rehabilitation, and residents from different cultural backgrounds. The JAMDA study authors concluded that "with the increasing numbers of patients in SNF/NF for short-term rehabilitation, policymakers and nursing home administrators will need to consider the effect of limited resuscitation on these potentially more viable and younger patients."[3] The 2012 edition of the CMS Nursing Home Data Compendium shows approximately 1 in 7 nursing home residents were under age 65 in 2011, which likely reflects the increased number of short-stay residents. The Compendium also shows nursing home residents have become more ethnically diverse.[4] Cultural differences may have a significant impact on a resident's beliefs surrounding illness and their willingness to discuss end-of-life issues. The increased diversity of nursing home residents calls for decision-making regarding advance directives to be individualized, documented, and effectively implemented throughout the facility. Any limits on how a facility may implement advance directives should be applied on a case by case basis, taking into consideration a resident's preferences, medical conditions, and cultural beliefs. While some nursing homes have implemented facility-wide no CPR policies, facilities must not implement policies that prevent full implementation of advance directives and do not promote person-centered care.

C. CPR certification

Staff must maintain current CPR certification for healthcare providers through a CPR provider whose training includes hands-on practice and in-person skills assessment; online-only certification is not acceptable. Other government agencies, such as the Occupational Safety and Health Agency (OSHA),[5] institutions, and States, have also determined that online-only certification is not acceptable. Resuscitation science stresses the importance of properly delivered chest compressions to create blood flow to the heart and brain. Effective chest compressions consist of using the correct rate and depth of compression and allowing for complete recoil of the chest.[6, 7] Proper technique should be evaluated by an instructor through in-person demonstration of skills. CPR certification that includes an online knowledge component, yet still requires an in-person demonstration and skills assessment to obtain certification or recertification, is acceptable.

D. Survey Implications

When reviewing facility policies and procedures related to emergency response, surveyors should ascertain that facility policy, at a minimum, directs staff to initiate CPR as appropriate. Facility policy should specifically direct staff to initiate CPR when cardiac arrest occurs for residents who have requested CPR in their advance directives, who have not formulated an advance directive, who do not have a valid DNR order, or who do not show AHA signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC). Additionally, facility policy should not limit staff to only calling 911 when cardiac arrest occurs. Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest in accordance with that resident's advance directives or in the absence of advance directives or a DNR order. CPR-certified staff must be available at all times to provide CPR when needed. Facilities must not establish and implement facility-wide no CPR policies for their residents as this does not comply with the resident's right to formulate an advance directive under F155. The right to formulate an advance directive applies to each and every individual resident and facilities must inform residents of their option to formulate advance

directives. Therefore, a facility-wide no CPR policy violates the right of residents to formulate an advance directive.

For survey process questions on this memorandum, please contact the CMS Regional Office. Please send policy questions related to this memorandum to dnh_triageteam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

References:

http://www.nlm.nih.gov/medlineplus/ency/article/000013.htm.

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http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf

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REMINDER: Sign Up for the PADONA 27th Annual Convention in Hershey, PA from March 25-27, 2015

Speakers and Lecture Titles:

- Effective Documentation: Strategies for Success – Paula Sanders (Esq)
- Sudden Confusion in the Elderly: What Does it Mean? – Betty Robison (MSN, RN-BC)
- Balancing Your Life in the Midst of Change and Chaos – Kathleen Pagana (PhD, RN)
- Leading from Every Seat! – Leta Beam (MA)
- Pressure Ulcers: Choosing the Right Treatment – Nancy Morgan (RN, BSN, MBA, WOCN, WCC, DWC, OMS)
- Financial Mgt for Non-Financial Managers – Denise McQuown-Hatter (NHA) & Candace McMullen (RN, NHA, MHA, CLNC)
- Depart. Of Health Update – Susan Williamson (RN)
- Inappropriate Medications in the Elderly: What to Stop and Start – Emily Mallit (PharmD)
- MDS Info for DONs – Sophie Campbell (MSN, RN, CRRN, RAC-CT)
- Best Practices in Dementia Care for Successful Surveys – Alison Sprankle (BS, CMC)
- Person Centered Dining-Feeding the Body and the Soul – Ashley Baker (CDM) & Becky Weber (BS, MS, NHA)
- Recognizing & Responding to Care-Dependent Neglect: A Facility's Response-Nathan Giunta (Esq) & Suzanne Sheaffer (BSN, RN, NHA, MA)

Register and Pay today at http://www.padona.com/pennsylvania-pa-geriatric-nursing-continuing-education.html

Welcome New Members!

- Michelle Bongiovanni - Wesley Enhanced Living - Area III
- Luann Carrillo - Cambria Care Center - Area I
- Nancy Casanas - Transitions HealthCare, LLC - Area III
- Alicia Cellucci - Pocopson Home - Area III
- Mara Cloak - Sugar Creek Rest - Area I
- Margaret Clouser - Foxdale Village - Area II
- Kim Diaz - Spang Crest - Area II
- Stacey Fox - Oakwood Heights - Area I
- Lana Gordon - Area II
- Lisa Hackenberg - Juniper Village at Brookline - Area II
- Kimberly Harvey - Lutheran Soc Svcs of South Central PA - Area II
- Jennifer Heiser - Golden Living Western Reserve - | Area I
- Angela Heisey - Spang Crest - Area II
- Thresiamma John - Cathedral Village - Area III
- Marie Lang - Golden Living - Area III
- Deborah Monelli - Allied Services Skilled Nursing Center - Area III
- Dawn Montella - Beaver Elder Care and Rehabilitation Center - Area I
- Tarra Porter - Lakeview Senior Care and Living Center- Area I
- Kimberly Reinmiller - Gracedale Nursing Home - Area III
- Cheryl Ruby - Gino Merli Veterans Center - Area III
- Carol Shepherd - Cambria Care Center - Area I
- Michele Shrecengost - Sugar Creek Rest - Area I
- Kelly Swaoger - Beaver Elder Care and Rehabilitation Center - Area I
- Rick Tait - Kendal Crosslands Communities - Area III
- Karena Tripp - Beaver Elder Care and Rehabilitation Center - Area I
- Kathy Yankanich - Pocopson Home - Area III

For Members of PADONA - Free Posting of Job Opportunities

Post your company's job openings at PADONA for free for 60 days per job posting. Send the following in a Word document to info@padona.com

1. Job Title
2. Company name and address
3. Brief summary position
4. Compensation/Benefits (if known)
5. Contact information (mailing address, email address, company email)