March 2009 Vol. 12, No. 3

An Integrated Approach to the LTC Industry

PPS ALERT FOR LONG-TERM CARE

MDS 3.0 update

CMS revising 3.0 timeline

Agency aiming for October 1 implementation

At the January SNF/Long-Term Care Open Door Forum, amid industry rumors that this year's planned MDS 3.0 implementation would be delayed, a CMS official said the agency is still pursuing an October 1 implementation. However, officials also stated that CMS will revise its original MDS 3.0 timeline.

The agency is "working aggressively toward" the October 1 implementation date, **Mary Pratt,** director of the division of postacute and chronic care at CMS, said at the forum.

"That being said, it is also important to mention that stakeholders have been expressing concern about the implementation of the MDS 3.0, which is currently scheduled for October 1, 2009," Pratt said. "We acknowledge that the time frame is ambitious, and your comments and issues related to the implementation are under consideration."

HCPro

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New 3.0 timeline in the works

Although officials said CMS planned to stick to the October 1 deadline for the new assessment system, it will change the original timeline, which had a March release date of the final MDS 3.0 form and *RAI Users' Manual*.

In January, many long-term care providers noticed that CMS had removed its MDS 3.0 implementation timeline from its Web site.

> **"One of the things we're doing is looking at all of the moving parts, and I'm making sure that our work plans and timeline take everything into account."**
>
> *—Sheila Lambowitz*

CMS identified some inaccuracies with the timeline and is planning to revise it, agency officials said at the forum.

"We're evaluating the whole process, and we'll let you know as soon as we can," **Sheila Lambowitz,** director of the division of institutional postacute care at CMS, said when asked whether the agency still planned to release the final MDS 3.0 form in March.

"Right now, we're still moving forward," Lambowitz said. "We just want to make sure we cover all the bases and we address all the issues before we put a revised timeline back up there."

CMS will also reschedule some of the MDS 3.0 train-the-trainer events originally planned for this spring, she said.

MDS 3.0 and RUG-IV

Long-term care providers still don't have an answer as to when CMS will release the next iteration of the resource utilization group (RUG) system, often referred to as RUG-IV, or how a new RUG system would interact with the MDS 3.0.

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MDS 3.0

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When asked by a caller whether CMS had an estimated time of arrival for RUG-IV, Lambowitz said changes to the RUG system will roll out in the SNF PPS regulation, which would require proposed and final rules to be published in the *Federal Register.*

Since the proposed rule requires a 60-day comment period before the final rule can be issued, officials will aim to release the proposed rule in April in order to issue the final rule by July 31, she said.

"But we do have to do significant work to do briefings through a whole series of internal and external stakeholders, including [Office of Management and Budget], so we can't you give you an exact date," said Lambowitz.

Officials were also asked whether the MDS 3.0 would be moved or whether CMS would revert to using the current RUG system if it couldn't meet its date for the final rule.

CMS officials will evaluate that situation when they have a better idea of when the proposed rule will be released, Lambowitz said. "Basically, I can't tell you without my crystal ball … exactly what date it will go out, but we watch these things very carefully," she said, adding that she also couldn't answer questions about how interrelated the MDS 3.0 and RUG-IV would be or how the 3.0 would affect state case-mix payment systems.

"One of the things we're doing is looking at all of the moving parts, and I'm making sure that our work plans and timeline take everything into account," Lambowitz said. "So we will be giving answers to those questions fairly soon, but not today."

New administration, new rules

Providers may have heard that President Barack Obama's administration has established a moratorium on regulations put in place toward the end of former President George W. Bush's administration and regulations CMS put in place during the latter half of 2008, Lambowitz said. The new administration will reevaluate those regulations.

"In terms of how they affect the nursing home industry and your operations, we really haven't had any SNF or long-term care regulations that were moving through

Online extra

As the long-term care industry awaits the MDS 3.0, we know you have plenty of questions about the new assessment system. We're tracking MDS 3.0 developments at *www.mdscentralonline.com* to keep you updated as soon as CMS releases news.

If you have a specific MDS 3.0 question, visit *www.mdscentralonline.com* and click on the Ask Diane icon to submit your question. We'll notify you as soon as CMS releases the information you're looking for.

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the system that were caught in this freeze," Lambowitz said, adding that the last payment regulation for SNFs was made in July 2008.

"We have been moving forward on competitive bidding for [durable medical equipment], and there is a regulation that is on hold pending a reevaluation. But other than that, we're not aware of anything that affects you directly," Lambowitz said.

Dispelling 3.0 rumors

CMS is working with the intention of giving providers updates on the MDS 3.0 and disseminating information to all stakeholders, Pratt said. The updates will be delivered through the open door forum listserv or posted at *www.cms.hhs.gov*.

"If you hear any other information, please use those sites to verify any other announcements because those will be the official vehicles by which we send out the word on any updates on implementation," Pratt said. ■

Still waiting for pain tag

Long-term care providers are still waiting for revised guidance on F309, Quality of Care, pain management.

A caller to the January 29 CMS SNF/Long-Term Care Open Door Forum asked CMS officials when the revised guidance on F309, the pain tag, would be posted on the CMS Web site and whether the general investigative and pain management protocols would be effective March 31.

CMS sent long-term care surveyors a memo dated January 23 containing revised guidance on F309, including new general and pain management investigative protocols, with an effective date of March 31. The caller asked whether providers should observe the effective date or wait until CMS posts the materials.

Sheila Lambowitz, director of the division of institutional postacute care at CMS, didn't have an immediate answer to the question.

"I know the pain material is out for review, but we don't have a date," Lambowitz said, adding that providers should wait until CMS officially posts information.

Telling your facility's story in a five-star era

Now that consumers can access star ratings for nursing facilities on the Internet, telling the public about your facility's special programs and unique benefits is more important than ever.

If your facility has tried to get your local newspaper or television station to cover a special event, you know the challenges of getting media coverage: fewer writers and reporters at many media outlets, press releases that disappear in the newsroom, and staff members at your facility who are too busy to deal with the media.

Working with the media can help you tell your community about your nursing facility's award-winning staff or creative activities program. A long-term care consultant and the director of marketing, communications, and PR for a long-term care organization explain strategies for building relationships with the media, relaying your facility's message, and responding to negative coverage.

Building relationships with the media

Establishing relationships with members of the media is important, says **Carol Marshall, MA,** a long-term care consultant in Fort Worth, TX, and author of an upcoming HCPro book about customer satisfaction in long-term care.

If you have a relationship with a reporter, you'll have a friend when you want coverage of a special event or achievement and when you must respond to a bad survey, an elopement, or a lawsuit, Marshall says.

You can establish a good relationship with the media by pitching feature stories, sending quality news releases and photos, and responding to media inquiries in a timely way, says **Sarah Soden,** director of marketing, communications, and PR at United Methodist Homes, a nonprofit organization that operates several nursing

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Five-star

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and long-term care facilities in New York and Pennsylvania. Establishing your facility as a helpful resource will give members of the media confidence that you will provide them with honest information in a timely manner, Soden says.

Marshall suggests keeping in touch with members of the media about long-term care industry news and making your staff members available as expert sources. This can help you build relationships with reporters, and reporters may appreciate getting a lead on a story, she says.

Working with the media

In 2008, Soden helped United Methodist Homes get television news coverage for a vow-renewal ceremony for residents, a gallery opening for art created by young children in a United Methodist Homes day care, and a certified nursing assistant who received an Excellence in Caregiving award from the Central New York chapter of the Alzheimer's Association.

One of Soden's rules about working with the media is never invite reporters to events that aren't truly unique or interesting. If you invite members of the media to dull or routine events, they may not show up when you have a great one.

When you invite the media to your facility, make it as easy as possible for reporters to get the information they need, Soden says.

She takes the following steps when enlisting media coverage for special events:

1. Send out a press release well in advance of the event with basic information (e.g., who will be there, the contact information of your facility's media representative, and the event's purpose, importance, and date and time). Also, tell the press whether they can get photographs or video footage.
2. Ask members of the media to let you know whether they'll be coming. If you don't hear from anyone, follow up with a phone call.
3. Attend the event and identify residents who are willing to be interviewed. Make sure you have signed consent forms on file for any residents who are interviewed or photographed.
4. Give reporters a more detailed press release (e.g., one containing the history behind an event) and your contact information in case they have additional questions after the event.
5. Soden also takes photos, interviews residents, and writes her own story for her facility's newsletter or Web site.

When you invite members of the media to your facility, remember that you are inviting them into your residents' home.

Your residents have the same expectation of privacy as you do at your home. Don't volunteer residents for interviews without their permission, and make sure any residents who are interviewed have the required mental capacity, Soden says.

Responding to bad news

At times, your facility may have to respond to negative news coverage, such as a story about a bad survey, a lawsuit, or a poor rating under the five-star system.

Your facility or corporate organization should appoint one person as a media representative or spokesperson. If you don't have a PR director, your administrator might be the appropriate spokesperson.

Train staff members not to speak to the media and to refer any inquiries to the designated spokesperson, says Marshall. She suggests that the spokesperson tell the media you are investigating a problem rather than refusing to comment.

"If you slam the door on the media, they'll run away with the story," Marshall says.

Develop strong internal communication and anticipate negative coverage so you can prepare a response, Soden says.

"Be honest and up front about the situation. 'No comment' just prolongs the life of an issue in a news cycle," she says.

Answering five-star questions

With all the attention the five-star rating system has received, nursing facilities may already be fielding calls from the media about their star ratings.

When the rating system was unveiled in December, United Methodist Homes explained how the ratings were calculated, why the organization's facilities received their ratings, and what they are doing to improve, Soden says.

"We also explained our organization's take on the rating system and why the star ratings don't make for a complete picture of our facilities and services," she says.

You can read an article United Methodist Homes posted on its Web site about the rating system at *www.unitedmethodisthomes.org/news/viewarticle.asp?a=3079.*

The American Health Care Association (AHCA) has posted information about the five-star rating system on its Web site at *www.ahcancal.org,* including quality talking points and myths and realities about the rating system.

When the five-star rating system was released, some nursing facilities were contacted by members of the media before they had seen their ratings, says **Lyn Bentley, MSW,** director of regulatory services at AHCA. One reason AHCA posted the information was to help nursing facility staff members who may not be experienced in dealing with the media.

"A director of nursing or administrator's business is getting people to care for people," says **Donna Doneski,** director of public affairs at AHCA, who helped assemble some of the information posted on the Web site. Doneski says she hopes the information will also be useful to consumers who may be trying to evaluate information about a nursing facility.

CMS says consumers should visit nursing facilities in person, but that suggestion may be difficult to find among the other information about nursing home ratings on the agency's Web site. Doneski also recommends that consumers visit *www.longtermcareliving.com* for information about selecting a nursing home.

For more details about AHCA's efforts to work with CMS to improve the five-star rating system, see "Five-star update" on p. 6.

Talking about satisfied customers

One way to respond to questions about your facility's star rating—especially if you didn't get five stars—is with your customer satisfaction survey, says Marshall.

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What CMS says about five-star

CMS gave long-term care providers a preview of their rating under the five-star quality rating system one week before the ratings were refreshed with the past two months of data on the Nursing Home Compare Web site in late January, CMS officials said at the January SNF/Long-Term Care Open Door Forum.

Since the ratings have been refreshed with new data in February and March, providers should have been able to preview their ratings before they were posted on Nursing Home Compare. CMS also plans to open a Nursing Home Compare hotline the week before and after the ratings are updated so providers can ask questions about how their ratings were calculated, officials said.

The hotline number is 800/839-9290, and providers can see their star ratings at *www.medicare.gov/nhcompare.* At the open door forum, CMS officials said they expected to refresh the data February 26.

Agency officials also confirmed that they have been speaking with stakeholder groups regarding the five-star quality rating system.

Questions? Comments? Ideas?

Contact Associate Editor
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Five-star

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You can survey your customers with commercially produced surveys or create a survey program. When you receive the results, make an effort to work on areas your customers were unhappy with, then survey your customers again, Marshall says.

After you conduct a strong customer satisfaction survey, include the results in:

- Your facility newsletter or Web site
- Newspaper ads
- Flyers or handouts
- Presentations your staff members give during local speaking engagements
- Your facility brochure

Changing perceptions about long-term care

Working with the media gives your facility an opportunity to educate the community about long-term care.

"Many people still hold ideas about nursing homes that are 20 years or more out of date," Soden explains, adding that she always has positive and timely stories to tell about events at United Methodist Homes facilities.

By telling their stories, your staff members can be your best advocates in helping the public understand the value and role of long-term care in your community, she says.

Working with members of the media can help nursing facilities change the perception that nursing home residents are recipients of the community, not givers to it, says Marshall.

If any of your residents knit caps to donate to homeless shelters or send care packages for troops overseas, telling their story can show the public that your residents are still vibrant members of the community. ■

Five-star update

Members of three long-term care industry associations met with CMS in January to discuss their concerns about the five-star rating system released in December 2008.

The American Health Care Association (AHCA), the American Association of Homes and Services for the Aging, and the Alliance for Quality Nursing Home Care met with Thomas Hamilton, director of the survey and certification group at CMS.

Hamilton was willing to clear the agenda to listen to the industry groups' concerns, says **Lyn Bentley, MSW,** director of regulatory services at AHCA, who was involved in the meeting.

CMS plans to form four work groups, which will include some industry advocates, to identify ways to improve the rating system, Bentley says. The groups will focus on quality measures (QM), staffing, surveys, and consumer satisfaction. CMS will determine which issues can be resolved quickly, and which must be addressed over the long term, she says.

One major problem is that the rating system uses information from QMs to rank facilities, something QMs were never intended for, Bentley says. As a result, a facility that admits many postsurgical patients may be penalized under the rating system because its QMs show a high incidence of pain.

However, it may be expected for residents to experience pain after surgery and doesn't necessarily indicate wrongdoing on the facility's part.

Bruce Yarwood, president and CEO of AHCA, wrote CMS two detailed letters during summer 2008 expressing concerns about problems in the rating system.

The rating system is having a broad effect on the long-term care community, Bentley says. Many providers are struggling to explain their ratings to families, and staff members feel demoralized by poor star ratings. One administrator who called Bentley said she lost two admissions because of her star rating, even though the administrator believed her facility was excellent.

AHCA is encouraging providers to monitor their star ratings and ensure that the information used to arrive at the rating is accurate, Bentley says. Providers should also ask CMS questions, such as why a recent survey wasn't included.

PPS Q&A

Editor's note: "PPS Q&A" is written by ***Rena R. Shephard, MHA, RN, RAC-MT, C-NE,*** *founding chair and executive editor of the American Association of Nurse Assessment Coordinators and president of RRS Healthcare Consulting Services in San Diego. To submit a question, contact Associate Editor Emily Beaver at* ebeaver@hcpro.com.

Q A resident had horrible/excruciating pain once during the observation period. She was given a medication, and the pain was relieved without recurrence during the observation period. Does the result of the intervention affect the coding of the pain in J2a, pain frequency, and J2b, pain intensity? Would it be coded 0, no pain, because it was relieved promptly?

A No, the result of the intervention does not affect the coding of pain. The question you must answer is whether there was pain during the observation period. If the answer is yes, code the frequency in J2a and the highest intensity the pain reached in J2b, even if it reached that intensity only once during the observation period.

The *RAI User's Manual* states, "Code the highest intensity of pain that occurred during the observation period in J2b. Code for the presence or absence of pain, regardless of pain management efforts" (p. 3-141). In the example provided, J2a would be coded 1, pain less than daily, and J2b would be coded 3, times when horrible or excruciating.

Q If a person ambulates in the hall only once in the seven-day lookback period for G1, activities of daily living (ADL), is it coded as 8, activity did not occur, since it didn't occur the three or more times necessary to assign a code?

A No. If it happened even once, it occurred, and 8 is not the correct code. If the activity occurred only once or twice in the observation period, the instructions are to code it 0, independent, regardless of the level of assistance required. A higher level cannot be coded until the ADL occurred at least three times. See the definitions in Chapter 3 of the *RAI User's Manual*.

Q We are having a debate about how to calculate MDS minutes for group therapy. The regulations say no more than 25% of therapy time can be in group therapy, so we make sure that the number of therapy minutes doesn't exceed the number we get when we divide the total number of minutes in P1b by four. Now we're told we're doing it incorrectly. Please explain the process.

A To calculate the allowable 25% for group treatments, simply multiplying the total number of minutes by 25% is incorrect. The following formula, which must be calculated separately for each therapy discipline (i.e., physical therapy, occupational therapy, and speech-language pathology), can be used to calculate the allowable 25% for group treatments that can be counted on the MDS:

1. Individual minutes divided by 0.75 = total allowable minutes (individual plus group minutes)
2. Subtract individual minutes from total allowable minutes to determine the maximum number of group minutes available to the resident for the MDS

The following are two examples of these calculations:

- 250 individual minutes divided by 0.75 = 333 allowable minutes. 333 allowable minutes minus the 250 individual minutes = maximum of 83 minutes permitted for group treatments for this resident.
- 300 individual minutes divided by 0.75 = 400 allowable minutes. 400 allowable minutes minus 300

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Correction

A question in the January **PPSA** Q&A incorrectly stated that a resident was admitted to the emergency room November 20. The question should have listed the date the resident was admitted to the emergency room as November 29.

Q&A

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individual minutes = maximum of 100 minutes permitted for group treatments for this resident.

The *RAI User's Manual* states:

For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time. ***Note:*** *The 25% rule applies only to Medicare A residents. (p. 3-188).*

Q I have a resident who was in the facility on Part A for 12 days and converted to Medicaid on day 13, which was yesterday.

No one realized that the assessment reference date (ARD) hadn't been set for the five-day assessment. I'm confused about how to handle this.

Illustration by David Harbaugh

"She just coded all the residents' ADLs and forgot all the subtasks."

A Because the resident has been discharged from Part A, you cannot do the assessment now, and you cannot bill the default rate in this situation. In other words, the facility will receive no payment for the stay.

The 2009 PPS final rule made this clear and reiterated the following five circumstances under which a facility may bill the default rate in the absence of a required RAI, as outlined in the *Provider Reimbursement Manual:*

- The stay is less than eight days within a spell of illness
- The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial
- The SNF is notified on an untimely basis of the revocation of a payment ban
- The beneficiary requests a demand bill
- The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan

If the resident had not been discharged from Part A and was still in your facility on Part A, a late assessment could be completed with a current ARD, and the default rate would be billed for all of the days out of compliance.

In this case, the ARD would be set for today, day 14, and the resource utilization group calculated by the assessment would be effective today.

Thus, the facility would bill the default rate for days one through 13.

You can read about these regulations in the final rule at *http://edocket.access.gpo.gov/2008/pdf/e8-17948.pdf.*

Editor's note: Due to a production error in the February **PPSA** *Q&A, part of Shephard's answer was omitted. The question and complete answer are reprinted below.*

Q I am trying to understand the projection in section T. How can it be okay to bill for a category if the minutes haven't been provided? Also, if the projection shows that the resident will get enough minutes to reach the

Rehab Very High category, why does the facility get paid at the Rehab High level?

A The projection, which covers the first 15 days of the Part A stay, allows the facility to be paid for the level of services the resident is expected to receive, even though that level of rehab might not be delivered during the seven-day observation period of section P1b.

The limitation is that the resident cannot classify into the highest rehab resource utilization groups—Rehab Very High and Rehab Ultra High—using this projection, regardless of the number of minutes projected. The only way to classify into these two categories is by delivering the actual days or minutes required for the categories as entered in item P1.

The instructions for completing section T are in Chapter 3 of the *RAI User's Manual*. It explains the process for projecting therapy days and minutes for the first 15 days of the Medicare stay. The projection must be based on the treatment plan resulting from the evaluation. The process is as follows:

1. Look at the number of minutes/days of therapy documented in section P
2. Based on the treatment plan, project how much more therapy the resident is expected to receive from the day after the assessment reference date through day 15
3. Add the two together; that's your projection

Facilities should routinely audit the accuracy of projections by comparing them to the amount of therapy actually provided. At times, projected days/minutes will not be delivered because the resident was too tired or got sick. Most of the time, the projection should be fairly accurate or it probably isn't being done correctly. ■

Case study

Taking away restraints, one resident at a time

Continuing Education | Learning Objectives

After reading this article, you will be able to:

- State the definition of a restraint according to the *State Operations Manual*
- Name the regulation limiting restraint use in long-term care facilities
- Explain why reducing restraints in long-term care is important for resident care
- Discuss strategies for reducing restraint use

Operating a restraint-free nursing facility may seem like an unattainable goal, but it has been a reality at one Pennsylvania nursing facility in recent years.

The Partridge-Tippett Nursing Facility, which is part of the United Methodist Homes' Wesley Village Campus in Pittston, PA, has been restraint-free for the past seven years, according to staff members. As a result, the facility has experienced fewer falls and residents have a better overall quality of life, says **Patt Vitale, RN,** director of nursing services at Partridge-Tippett.

Reducing restraints has been one of the great success stories in long-term care during the past two decades, according to a CMS report issued in November 2008. The percentage of nursing home residents physically restrained daily declined from 21.1% in 1991 to 5% in 2007, according to the report.

However, many long-term care facilities are still using some physical restraints, believing restraints are necessary for resident safety.

Restraints can endanger residents and are not proven to reduce falls, according to CMS. Using unnecessary physical and chemical restraints can result in poor survey results for nursing facilities.

Partridge-Tippett now serves as a training site for other area nursing facilities that want to reduce restraints. Understanding Partridge-Tippett's approach to eliminating

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Restraints

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restraints by creating a restraint reduction task force and adopting an interdisciplinary approach may help your facility reduce restraints.

Reasons to reduce restraints

The 1987 Nursing Home Reform Act established residents' right to be free from chemical and physical restraints imposed for discipline or convenience and not required to treat the resident's medical symptoms.

Long-term care facilities that are found to use physical restraints not required to treat the resident's medical symptoms may be cited with F221 or with F222 for chemical restraints not required to treat medical symptoms.

Beyond regulatory compliance, there are several important reasons to reduce restraints, including the serious risks physical restraints can pose for residents.

"There are inherent dangers, and people can die," says **Janie Krechting, RN, C, BSN, MGS, LNHA,** adjunct professor at the College of Mount St. Joseph in Cincinnati. Restraints can become dangerous if residents get trapped or tangled in them, Krechting says.

Physical restraints can lead to strangulation and death from asphyxiation, loss of muscle tone and decreased bone density, and loss of dignity, among other problems, according to CMS' November 2008 report on restraints.

Falls that occur when residents are restrained often result in more serious injuries, the report states.

Staff members at Partridge-Tippett found that eliminating restraints decreased falls, Vitale says, noting that the number of falls at Partridge-Tippett is lower than the 1.5 falls per bed per year benchmark.

Eliminating restraints also improves residents' well-being in other ways. **Mary Lou Langdon, RN,** who is now a unit manager at Partridge-Tippett, says she remembers working as a night shift nurse at a time when restraints were more common in nursing homes.

Some residents would stay awake all night trying to get out of their restraints, Langdon says.

When residents are not restrained, they are more comfortable, sleep better, and have a better quality of life, she adds.

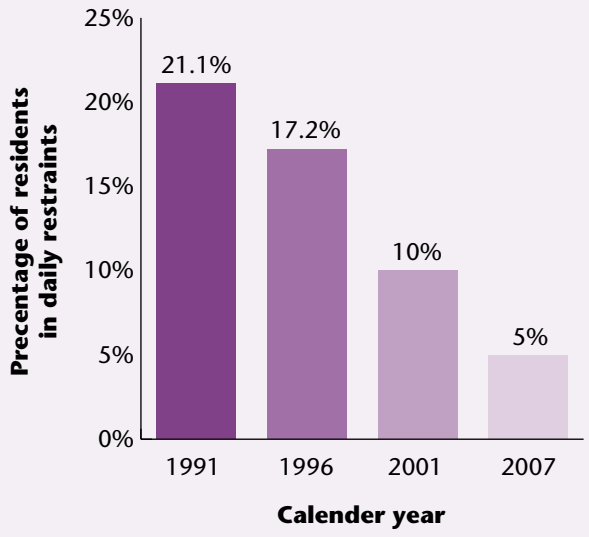
MDS 3.0 question of the month

Q My automation vendor recently contacted me and told me the company will not be going forward with producing new software for the MDS 3.0. What should I do?

To read Regulatory Specialist Diane Brown's answer to this question, visit *www.mdscentralonline.com.* Click on the Ask Diane icon and then on the Diane Brown link above her picture. Diane answered this question on January 26. If you don't see the answer on the page, click on the Next Page link until you find January 26.

Editor's note: Do you have an MDS 3.0 question that you'd like to submit? Ask your question on the Ask Diane page at www.mdscentralonline.com.

Trends in nursing home restraint use



Source: CMS.

Steps to restraint reduction

One of Partridge-Tippett's first steps toward becoming restraint-free was to create a restraint reduction task force. The task force, which began 12 years ago, included members of the nursing staff, social services, and therapy and activities departments.

Each week, members of the task force would identify a resident who had restraints, review his or her medical record, and work together to identify ways to eliminate the restraints, Langdon says.

Every member of the team is important, say Partridge-Tippett staff members.

Therapy department members evaluate the resident's movement and find chairs the resident can sit in without being restrained.

The activities department finds appropriate activities for residents because when they are engaged in an activity they enjoy, they aren't focusing on trying to get out of their chair, which may result in a fall.

One benefit to Partridge-Tippett's approach was that many of the steps were inexpensive, Vitale says. The facility had to evaluate staffing time and purchase some equipment, but it was able to eliminate many restraints by thinking of creative interventions.

Evaluating residents as individuals

A key to identifying restraints and reducing their use is recognizing that what may restrain one individual (e.g., a half bedside rail) may not restrict another. This requires evaluating individual residents, says Krechting.

The *Long-Term Care State Operations Manual* defines physical restraints 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." The manual defines chemical restraints as "drugs used for discipline or convenience and not required to treat medical symptoms."

"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, according to a June 2007 CMS memo issued to state survey agency directors. "Remove easily" means that the manual method, device,

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Tips for reducing restraints

Even if your facility doesn't have a restraint reduction program, the following tips will help you reduce the use of restraints at your facility:

- **Start at the top.** Get your nursing facility's administration to commit to reducing restraints at your facility, says **Patt Vitale, RN,** director of nursing services at the Partridge-Tippett Nursing Facility in Pittston, PA. After you have support from the top levels of your organization, you can work on getting the entire staff to buy in.
- **Go less restrictive.** If your facility must use a restraint, use the least restrictive method possible. For example, remove a restraint during meals or activities when direct supervision is available, says **Janie Krechting, RN, C, BSN, MGS, LNHA,** adjunct professor at the College of Mount St. Joseph in Cincinnati.
- **Make a team.** Forming a restraint reduction task force was one of the first steps Partridge-Tippett took toward eliminating restraints. The facility involved members of its nursing staff, social services, and therapy and activities departments in the task force.
- **Take it slowly.** Partridge-Tippett eliminated restraints by evaluating one resident at a time and brainstorming ways to remove restraints.
- **Look for alternatives.** A low bed may work as an alternative to a bedside rail, Krechting says.
- **Learn from other facilities.** Partridge-Tippett was identified as a training site for facilities that want to reduce restraints. Look for nursing facilities with strong restraint reduction programs in your area. Also, your state may have a restraint reduction task force that can provide you with resources.

Restraints

< *continued from p. 11*

material, or equipment can be removed intentionally by the resident the same way it was applied by staff members (e.g., the resident puts down bedside rails rather than climbing over them). The memo's clarifications of those terms were meant to be used in conjunction with the definition of physical restraints.

Creating individualized plans for each resident was a top priority in Partridge-Tippett's restraint reduction program, says **Danielle Janeski, NHA,** assistant administrator at the facility.

The facility didn't take what Janeski calls a "cookie-cutter approach" to eliminating restraints: simply removing a restraint and not following up with individualized interventions. Instead, staff members would track residents' patterns and formulate initial, individualized plans or interventions congruent with the patterns.

For example, the team would track a resident's toileting for a few weeks, establish a pattern, and then toilet the resident prior to the usual time, Janeski says. This might help a resident avoid falling when traveling to the bathroom and allow the facility not to restrain the resident.

Educating families and staff members

Many nursing facilities are reluctant to eliminate restraints because they are afraid of lawsuits from residents' family members, Krechting says.

Educating residents' families was one of the biggest challenges Partridge-Tippett faced when implementing its restraint reduction program, Janeski says.

Many families were concerned that their loved one wouldn't be safe. Some residents had come to the nursing facility from a hospital, where they were confined to a bed during treatment, and families weren't aware their loved ones could be treated without restraints.

The facility met with family members and educated them about the benefits of removing restraints. Eventually, families began to like the idea that their loved ones could live free of restraints, Janeski says.

Getting the entire staff to buy into the program is also important to the success of a restraint reduction program, and buy-in needs to start at the top, Vitale says. "The commitment needs to begin at the administrative level, where we're deciding this is the right thing do for our residents," she says. ■

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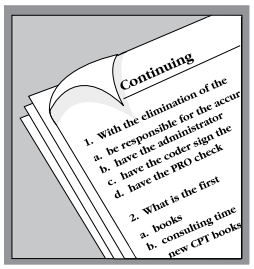

Nursing Continuing Education Exam

January–March 2009

A service of **PPS Alert for Long-Term Care**

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January

1. **Nursing facilities must be able to immediately identify delirium in residents because _____.**
   a. delirium is over-detected among nursing home residents
   b. the condition cannot be reversed
   c. delirium is a manifestation of a more serious condition, such as dehydration or an adverse reaction to medication
   d. delirium is easy to detect

2. **Under the MDS 2.0, nursing facilities assessed residents for delirium by what means?**
   a. Structured cognitive assessments
   b. Unstructured observations
   c. Resident interviews
   d. Nursing facilities did not complete delirium assessments under the MDS 2.0

3. **Under draft versions of the MDS 3.0, how will nursing facilities assess for delirium?**
   a. Using structured cognitive assessments
   b. Interviewing residents
   c. Reviewing residents' medical records
   d. All of the above

4. **What kind of assessment must be conducted so nursing facility staff members can complete the confusion assessment method (CAM) under the MDS 3.0?**
   a. Unstructured staff observations
   b. Family member interviews
   c. Structured cognitive assessments
   d. The Mini-Mental Status Exam

5. How will assessors get the information they need to complete the CAM under the MDS 3.0?
a. By interviewing residents, using clinical judgment, and reviewing medical records
b. From the resident's doctor
c. From the resident's family members
d. From nursing facility staff members' observations

6. How will assessors get the information they need to complete the CAM for residents who cannot be interviewed?
a. By using old MDS 2.0 assessments, staff interviews, and chart review
b. From the resident's doctor
c. From the resident's family members
d. Nursing facilities do not have to complete the CAM for residents who cannot be interviewed

7. Negative pressure wound therapy is a _____.
a. traditional wound care technique
b. wound care technique that uses a pump to apply a vacuum-like pressure to heal wounds
c. wound care technique that requires frequent dressing changes
d. wound care technique that leaves wounds exposed to the open air

8. A nursing facility should use negative pressure wound therapy _____.
a. after traditional wound care techniques have been unsuccessful
b. for any wound
c. for prolonged periods
d. on wounds with stable black eschar

9. Under the most recent drafts of the MDS 3.0, negative pressure wound therapy _____.
a. is not considered a skilled service
b. cannot be reimbursed by any payer
c. can be recorded under skin treatments
d. is not included under skin treatments

10. Under Medicare, negative pressure wound therapy _____.
a. is not considered a skilled service
b. can be reimbursed in addition to the daily rate
c. is not reimbursed in addition to the daily rate
d. can only be reimbursed if the resident is receiving another skilled service

February 2009

11. Which of the following beneficiary notifications is not mandatory for SNFs under any circumstance?
a. SNF Advance Beneficiary Notice (ABN)
b. Notice of Exclusion from Medicare Benefits (NEMB)
c. ABN for Medicare Part B services
d. A generic notice (CMS 10123)

12. Issuing an ABN gives a resident the right to _____.
a. appeal to a fiscal intermediary (FI) for the demand bill process
b. an expedited review through a Quality Improvement Organization (QIO)
c. continue to receive skilled care covered by Medicare
d. remain in the nursing facility

13. Issuing an expedited determination notice (EDN) gives a resident the right to _____.
a. appeal to an FI for the demand bill process
b. an expedited review through a QIO
c. continue to receive skilled care covered by Medicare
d. remain in the nursing facility

14. When Medicare Part A services are ending, but the beneficiary will remain in the facility for custodial care or therapy, which of the following notices would a facility issue?
a. ABN (or ABN-G)
b. SNF ABN/denial letters and EDN
c. NEMB
d. The SNF is not required to issue any notices

15. When therapy is no longer medically necessary for a resident, but the resident's family wants to continue therapy under private pay, which of the following notices would a facility issue?
a. SNF ABN/denial letters
b. ABN (or ABN-G) and EDN
c. ABN only
d. NEMB

16. Under which of the following circumstances might an NEMB be issued?
a. Part A services are ending, but the beneficiary will remain in the facility for custodial care
b. Part B services are ending because they are no longer medically necessary or reasonable
c. All Part A and Part B services are ending
d. The beneficiary did not have a three-day qualifying hospital stay

17. *Transmittal 1106* states that Medicare contractors shall advise providers to use the _____ to inform beneficiaries about the therapy caps.
a. NEMB, or a similar form of their own design
b. ABN/ABN-G
c. SNF ABN/denial letter
d. EDN

18. Which of the following beneficiary notifications are issued for the expedited review process?
a. SNF ABN/denial letters and ABN (or ABN-G)
b. SNF ABN/denial letters and NEMB
c. SNF ABN/denial letters only
d. A generic notice (CMS 10123) and a detailed notice (CMS 10124)

19. Beneficiaries enrolled in the Medicare Advantage program _____.
a. receive all of the same beneficiary notifications as those in the Medicare fee-for-service program
b. receive different notifications under the ABN process
c. receive different notifications under the expedited review process
d. are exempt from the beneficiary notification process

20. Which of the following is not one of the steps facilities should take to ensure that all beneficiary notices are issued properly?
a. Determining which staff members are responsible for issuing specific beneficiary notifications
b. Assigning responsibility for the beneficiary notification process to one person
c. Training more than one staff member to issue notifications
d. Inviting the staff members responsible for beneficiary notifications to daily Medicare meetings

March 2009

21. The *Long-Term Care State Operations Manual* defines a physical restraint as _____.
a. clothing or material that restricts freedom of movement or normal access to one's body
b. 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
c. bedside rails, chairs, or lap belts that restrict freedom of movement or normal access to one's body
d. any device restricting freedom of movement imposed for the nursing facility's convenience

22. The *Long-Term Care State Operations Manual* defines a chemical restraint as _____.
a. drugs used for discipline or convenience and not required to treat medical symptoms
b. any antipsychotic drug
c. any sedative drug
d. drugs used in excessive dosage

23. The 1987 Nursing Home Reform Act established _____.
a. residents' right to be free from chemical and physical restraints imposed for discipline or convenience and not required to treat the residents' medical symptoms
b. residents' right to be safe from harm caused by falls
c. nursing homes' right to use physical and chemical restraints at their discretion
d. the right for family members to decide whether their loved one should be restrained

24. According to a 2008 CMS report on restraint use in nursing facilities, nursing facilities _____.
a. use more daily physical restraints than they did 15 years ago
b. use more daily chemical restraints than they did 15 years ago
c. use fewer daily physical restraints than they did 15 years ago
d. have completely eliminated restraint use

25. According to CMS, restraints have not been proven to lead to _____.
a. strangulation/asphyxiation
b. decreased muscle tone
c. loss of dignity
d. decreased risk for falls

26. Staff members at the Partridge-Tippett Nursing Facility in Pittston, PA, found that after eliminating restraints, falls at the facility _____.

a. increased in number
b. increased in severity
c. decreased in number
d. did not change in number or severity

27. According to staff members at Partridge-Tippett, families should _____.

a. dictate whether nursing facilities should restrain residents
b. receive education from the nursing facility about the benefits of not restraining residents
c. not be involved in care planning decisions
d. immediately accept a facility's decision not to use restraints

28. Mary Lou Langdon, RN, a unit manager at Partridge-Tippett, says removing restraints improved the quality of life for residents by _____.

a. allowing them to be more comfortable and sleep better
b. permitting them to move about the facility freely
c. giving them more dignity
d. giving them the ability to socialize with other residents

29. Which was the first step Partridge-Tippett took toward eliminating restraints?

a. Asking family members whether they approved of eliminating restraints
b. Asking residents whether they would like the facility to eliminate restraints
c. Conducting a customer satisfaction survey
d. Forming a restraint reduction task force that included members of the nursing staff, social services, and therapy and activities departments

30. Which of the following was not a strategy Partridge-Tippett used to eliminate restraints?

a. Finding meaningful activities for residents to engage in
b. Educating family members about the benefits of eliminating restraints
c. Removing restraints without following up with appropriate interventions
d. Tracking residents' toileting patterns and toileting residents at appropriate times

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