NAB REVIEW MATERIAL

PREPARED BY

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Test Make-up	Core	LOS
Domains of Practice	# of Questions	
Care, Services, and Supports	39	27
Operations	37	17
Environment and Quality	13	16
Leadership and Strategy	11	0
Total	100	60
Unscored Pilot Items	25	15

Types of Questions

From the NAB website: nabweb.org:

1. Knowledge — This type of question involves remembering and understanding previously learned material. It may also require the candidate to demonstrate the interrelationship among given facts.

2. Interpretation — These questions require that the candidate understand and make use of information presented, as opposed to recalling a fact or definition.

3. Problem solving and evaluation — This type of question requires that the candidate organize facts, interpret data, assess the situation and choose the best alternative or course of action.

How long do I have to complete the test?

Please note that once you start your test you will have 2.5 hours to complete the Core exam and 1.5 hours to complete the Line of Service. You do not have to take both exams the same day. If for some reason you pass one of the exams and not the other, you are only required to re-take the one you failed.

Things to note:

1. This is a multiple choice, best answer exam.
2. There will be four choices to select from; none of which are "none of the above" or "all of the above."
3. You can change answers.
4. You can skip questions and go back to them.
5. Please note that a no response is a wrong response. An absolute guess is better than a non-response.
6. Even though we break down the course in the Domains of Practice that you will be tested on, the questions on your test will be intermingled.

PLEASE REFER *TO NABWEB.ORG FOR ALL TESTING DETAILS.*

Acronyms for Care, Services, and Supports

AED	Automatic Electronic Defibrillator
AIDS	Acquired Immunodeficiency Syndrome
ADL	Activities of Daily Living
AMD	Age-related Macular Degeneration
BAA	Business Associate Agreement
BHS	Behavioral Health Services
CAA	Care Area Assessment
CDM	Certified Dietary Manager
CMS	Centers for Medicare and Medicaid Services
CNS	Certified Nurse Specialist
CPR	Cardiopulmonary Resuscitation
CNA	Certified Nurse Aide
CVA	Stroke
DEA	Drug Enforcement Administration
DMP	Disease Management Programs
DO	Doctor of Osteopathic Medicine
DON	Director of Nursing
EDK/EMK	Emergency Drug Kit/Emergency Medication Kit
EHR/EMR	Electronic Health Record/Electronic Medical Records
FICA	Social Security
GDR	Gradual Drug Reduction

HAI	Health Care Associated Infections
HACCP	Hazard Analysis and Critical Control Point
HIPAA	Health Insurance Portability and Accountability Act
IDD	Intellectual and Developmentally Disabled
IP	Infection Preventionist
IPCP	Infection Prevention and Control Program
LPN/LVN	Licensed Practical Nurse/Licensed Vocational Nurse
MD	Medical Doctor
MDS	Minimum Data Set
MI	Mental Illness
MRSA	Methicillin Resistant Staphylococcus Aureus
NF	Nursing Facility
NP	Nurse Practitioner
NPP	Non-Nurse Practitioner
OIG	Office of Inspector General
OT	Occupational Therapist
PA	Physician Assistant
PASSAR	Preadmission Screening and Resident Review
PBJ	Payroll Based Journal
PEG	Percutaneous Endoscopic Gastrostomy
PFA	Paid Feeding Assistants
PHF	Potentially Hazardous Foods
PHI	Protected Health Information
PPS	Prospective Pay System

PRN	as needed
PT	Physical Therapist
PTSD	Post Traumatic Stress Disorder
QAA	Quality Assurance and Assessment
QAPI	Quality Assurance and Performance Improvement
RLS	Restless Legs Syndrome
RN	Registered Nurse
ROM	Range of Motion
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility
TIA	Transient Ischemic Attack

I. Care, Services, and Supports

(Core: 39; LOS 27)

Aging Process

1. Physical—Normal Changes include muscle loss, skin texture changes, bruise easily, lose taste buds, sense of smell lessens, problems with balance.

   Abnormal—Parkinson's, Alzheimer's, strokes (CVA), glaucoma, incontinence, arthritis, macular degeneration, and prostate diseases

2. Psychological—Normal—Slowed memory retrieval (senior moments), problems handling change, resistance to change, forgetfulness, depression when admitted.
3. Psychological—Adnormal—Hallucinations, Delusions, dementia

4. F**ailure** to distinguish between normal and abnormal characteristics the staff tends to infantilize residents, which leads to regression.

Stereotyping Not possible; aged too different.

5. **Misconception** Aged normally decrease in intellectual functioning; normally cannot care for selves. May lead to being treated as infantile-*to be avoided*.

Plan, Implement, Evaluate Nursing Services

1. Purpose To maximize residents' health potential, eliminate excess disability.

Administrator's role

Though it isn't necessary for the administrator to have a medical background, it is essential for him/her to have a sound understanding of the processes involved in the care of the residents. He/she must ensure that the newest geriatric knowledge is available to properly trained staff, and there is suitable environment.

2. Nurse Staff Requirements:

See Human Resources under Operations

3. Preadmission Screening (may be referred to as the PASSAR) **(F645)**

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disabled (ID); 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

Mentally Ill (MI) Definition for mental illness is a person who has a serious mental illness and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder),

Intellectually Disabled (ID) A person is considered mentally disabled if he has been diagnosed as intellectually disabled.

Purpose is to prevent inappropriate placement. Specifically, facilities are prohibited from admitted a person with a diagnosis of mental illness or intellectual disabled unless they physical condition requires skilled care.

4 **Admission Orders:** At the time of each resident's admission, the facility must have physician orders for the resident's immediate care.

5. Resident Assessment (F636) Must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Assessment areas include an assessment of the resident's ability to perform ADL's, communications skills, vision, psychological well-being, among others.

6. Interdisciplinary Team **(F657)** does assessment. Make-up of team depends on resident's overall condition-RN, MD/DO, Social Worker, Activities Director, Rehab therapist, dietitian, CNA. Each must sign and certify accuracy.

7. **Uniform (minimum) data set (MDS)** use instrument specified by state and approved by CMS, describe resident's present level of functioning in four activities of daily living (ADL's) and potential for improvement or regression.

8. **Care Area Assessments:** Additional assessment information is gathered using Care Area Assessments (CAA) Summary. These identify the physical

and/or psycho-social problems the resident is suffering from and are *triggered* when completing the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The assessment nurse will determine which of these problems will be care planned.

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. (F639)

9. **Electronic reporting**: Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System.

   A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month.

10. Coordinated by RN, commonly referred to as the RNAC (Registered Nurse Assessment Coordinator). No waiver. Must certify completeness.

11. Content Shown on form provided by state.

12. Frequency for long-stay, non-skilled:

a. No later than 14 days after admission

b. After significant change

c. Annually

d. Quarterly reviews

13. Frequency for Short-stay, Medicare under PDPM

a. Only one assessment is required—the five (5) day, which sets the reimbursement rate for the nursing component for the entire skilled stay.

14. Significant Change (F637)

CMS defines a significant change as: *a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or review of the care plan or both.*

15. Insignificant (short term) decline that does not require reassessment as drug effect, re-dosage level, colds, symptoms associated with previous diagnosis, steady progress requiring assessment when stabilized.

16. Baseline care plans (F655) Within 48 of admission, the facility **must** develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and **person-centered care** of the resident that meet professional standards of quality of care. Typically completed by an assessment nurse.

17. **Comprehensive plan of care (F656)** is developed from the assessment, reviewed and revised as indicated. Care Plan (PCP) includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

    a. **Resident and family participate** Promotes cooperation
    b. **Contents: Objectives** for highest functioning level a resident is expected to attain-**measurable.** Plans for attaining goals must be written.
    c. **Timing** complete **in seven days** after assessment. (Maximum is 21 days after admission.)

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Nursing practices and principles

Administrator needs to know something of these, especially those that could result in problems for the facility.

Scope Nurses perform only duties within scope of nursing practice-defined by nurse practice act and board of examiners.

Ethics Practice according to professional ethics established by licensing boards, and code for nurses. Administrator should report unethical practice to appropriate board.

Late Lost ADL Activities of daily living:

i. Transfer
ii. Bed Mobility
iii. Toileting
iv. Eating

These four ADL's impact a facility's Quality Measures the most and are used to help set Medicaid rates in those states that Case Mix Index reimbursement.

Instrumental ADLs require more physical and mental abilities.

a. Telephone
b. Shopping
c. Food preparation
d. Housekeeping
e. Laundry
f. Public transportation
g. Medications
h. Finance

Acute and Chronic Diseases

Acute: Rapid onset, curable with proper treatment, e.g. flu, Pneumonia, UTI, and Acute Myocardial Infarction
Chronic: Develop over time, can be treated but not cured, e.g. Alzheimer's Disease, Diabetes, COPD, Hypertension

Adverse Events

An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Examples include 1) falls, 2) medication errors, 3) spread of disease due to errors in infection and prevention 4) pressure ulcers due to inappropriate care, 5) injuries from abuse or neglect 6) failure to identify acute changes in condition.

Fall Prevention

Prevention of falls is a top priority in all nursing facilities. Medical treatment, rehabilitation, and environmental changes may be considered to help prevent falls. CDC recommend some interventions:

- Assess a resident's risk factors related to falls and to have a program in place to reduce falls within the nursing home.
- Educate the staff about fall risk factors and prevention strategies.
- Review resident's medication regimen to assess potential risk and benefits.
- Analysis the physical plant to ensure the safest possible environment possible.
- Provide resident with hip pads that may help prevent hip fractures when a fall occurs.

- CMS defines falls as:
    1. An episode where a resident lost his balance and would have fallen, if not for staff intervention.
    2. A fall without injury is still a fall.
    3. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall has occurred.
    4. **CMS** gives residents the "right to fall."

Pharmaceutical services—

Must have policies and procedures covering all aspects of drugs

- Medication control is primarily for protection of resident-also to

prevent illicit use, meet government regulations.

- **Pharmacist** Two roles:

1. review each drug regimen at least monthly
2. consult on overall medications program.

May be the same person**. Reports irregularity to the attending physician, Medical Director, and DON**

Common Abbreviations:

B.I.D.	twice daily
T.I.D.	three times daily
Q.I.D.	four times daily
PRN	as needed (or necessary)
ROM	Range of Motion
STAT	Immediately
UTI	Urinary Tract Infection

- **Prescribing** Who prescribes: MD, DO, NP, PA, typically. Registered Dietitians can prescribe therapeutic diet orders if the attending physician deems it and if the State permits. Who can receive: MD, RN, LPN, RPh. Physician signs as determined by State. FAX may be used by physician for all telephone orders except Schedule II drugs.

- **Dispensing-- Pharmacist only** (placing two or more doses in separate container and labeling)
- **Nurses** can place one dose in container
- **Labeling** marred labels return to pharmacy
- **Storage** externals/internals-separate areas
- **Scheduled drugs**-fewer people have access to keys, separately locked, firmly affixed compartments. Original containers. Inventorying.
- **Administration** as ordered. Administered by MD, licensed physician extender (NP, PA) RN, LPN, Medication Aide**. Steps**: Check MD order, identify drug, resident, dosage. Pharmacists sometimes make errors. Example: Rx Xanax, dispenses Zantac.
- **Self-administration** Decided by interdisciplinary team, including the PCP.
- **Automatic Stop Order** Required on drugs not limited to time and number of doses. Nurse call MD before last dose. Not recommended practice in nursing homes.
- **Standing order** Procedure staff follows under specific circumstances. Differs from PRN which usually refers to individual.
- **Taking medication home-only** by MD order May take home when discharged.
- **Destruction of DC'd** Scheduled drugs regulated by DEA; Non-scheduled by RN

- **Medication Error** Must not have 5% or more, and residents free of significant medical errors**. Significant-**causes resident discomfort or jeopardizes health and safety.

Error Rate = # of errors X 100 5 = .05 X 100 =5%

# of opportunities 100

Opportunities are defined as the number of doses given plus doses ordered but not given.

Best way of reducing errors is using **unit dose system**.

- **Unnecessary drug** Excessive dose; excessive duration, inadequate monitoring; inadequate indication for use; adverse consequences (reduce or discontinue)

- **Psychotropic** drugs are those that affect brain activity associated with mental processes and behaviors. The following are in the psychotropic drug family:
  - Anti-psychotic
  - Anti-depressant
  - Anti-anxiety
  - Stimulants
  - Mood Stabilizers

- **Anti-psychotic drugs** Give only for specific diagnosis, documented diagnosis. **Administrator** should know symptoms-head jerking, loss of control tongue—this is **Tardive Dyskinesia**--results from prolonged use of anti-psychotic drugs. Report it to DON. Anti-psychotic medication reduction is a major CMS focus area. You will see the acronym **GDR** in your practice—stands for **Gradual Drug Reduction** in relation to the use of anti-psychotic medications. GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dos or medication can be discontinued. The goal is to discontinue the medication.

Psychotropic drugs prescribed on an as-needed basis (PRN) are limited to 14 days. These orders cannot be renewed unless the attending physician or prescribing practitioner evaluate the resident to determine whether or not a renewal is necessary.

- **Drug categories and Terminology:**

  Have some knowledge of categories and examples. Medicaid usually pays only for generic drugs.

  Generic substitution Different brand or unbranded drug substituted for a trade name drug. Must be same chemically, dosage form, but distributed by different drug company. Brand name is usually capitalized.

Brand (trade names)	**Generic**
Valium	diazepam
Coumadin	warfarin sodium
Quinidex Extentabs	quinidine sulfate
Seldane	teterfendine
Xanax	alprazolam
Thorazene	chlorpromazine

- **Effects of Aging** More sensitive to drugs. Discharge from body changes-urine, perspiration, feces, breathing. (Affect longer and more intensely.)

- **Drug Enforcement Administration (DEA**)

Created by Comprehensive Drug Abuse Prevention and Control Act of 1970:

a. Purpose-classify and set standards for use and control of substances with abuse potential.

b. Five schedules (I-V)-I is illegal, II, III, IV are controlled substances. V sold over the counter.
c. Stored and destroyed according to DEA
d. Cautionary statement on all sold by pharmacist (II, III, IV)- no transfer

Infection Prevention and Control Program (F880)

Facility required to: (1) to have a system in place for preventing, reporting, investigating, and controlling infections and communicable diseases for all residents, employees, volunteers, and the general public; (2) have procedures for isolation, etc.: (3) record incidents and corrective measures: (4) be prepared to accept AIDS residents; (5) care for high risk (immobilized, intrusive devices, altered immune systems, recently discharged from hospital)

a. **Methicillin Resistant Staphylococcus Aureus (MRSA)**
b. C-Dif—becoming common place in hospitals and nursing homes. Resident's with c-dif must be isolated and treated accordingly. Staff providing care must wash hands with soap and water. Symptoms include diarrhea. Many afflicted after undergoing antibiotic therapy for a different infection.
c. Infection Prevention and Control Program—Incorporates the following components:

- Policies and procedures which promote consistent adherence to evidenced-based infection control practices
- Program oversight that includes planning, organizing, implementing, operating, monitoring, and maintaining all the elements of the program and ensuring that the facility's interdisciplinary team is involved in infection control and prevention.
- Have an ***Infections Preventionist,*** who is a person designated to serve as the coordinator of the infection prevention and control program
- Surveillance, including process and outcome surveillance, monitoring, data analysis, documentation and communicable disease reporting as required
- Education of staff to ensure compliance with facility, State, and Federal regulations
- Antibiotic review including reviewing of data to monitor appropriate antibiotics in the resident population.

Infection Preventionist: (F882)

Facilities must designate one or more individuals as the infection preventionist (IP) who are responsible for the facility's Infection Prevention Control Program. (IPCP). The IP must:

- Have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field;
- Be qualified by education training, experience or certification;
- Work at least part time at the facility;
- *Have completed specialized training in infection prevention and control.*
- Be a member of the Quality Assessment and Assurance Committee.

Infection Control Training (F945) A facility must include a part of its infection and control program mandatory training that includes the written standards, policies, and procedures for the program

Isolation—may be referred to as "Transmission-based precautions-purpose is to protect **others; reverse isolation:**

cytotoxic therapies and AIDS when there is an outbreak of

communicable disease.

Two major causes of the spread of infections: 1. Improper hand hygiene and 2. Mishandling of soiled linen.

Reverse Isolation Used when protecting individual

Depressed Immune Response among the elderly is a major reason for an Infection Control program that includes

immunization for *everyone.*

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Skin Care

diseases of skin—shingles, cellulitis, etc.
Reactions to medications—hives, blisters, burning.
Proper hydration—strong relation to skin condition. Pressure sore (decubitus ulcer)

- Eroded tissue due to lack of blood flow.
- Cause—lack of care of pressure points, turning, changing wet bed or clothing.
- Admission, if present, note size, document, take pictures
- Transfer to hospital—make color pictures when possible.
- Kennedy Ulcer

AIDS Cannot refuse to admit. Isolate only when bleeding or bloody discharge, or when has other contagious disease. Must follow universal/standard precautions; **then fully able** to care for AIDS residents.

Bladder/bowel problems Physical and emotional. Three effective practices (1) prompted voiding, (2) physical exercise-pelvic floor exercises, walking, calisthenics, and (3) Kegel exercise by which sphincters are strengthened. Proper hydration. Must provide needed assistive devices.

Care of deceased Actions to be taken:

- Contact the resident's family
- Follow facility protocol in pronouncing death.

- Complete forms and documents for the release of the body.
- Preparation of the body for the family to view and release to the mortuary.
- Conferring with family before release.

Cerebrovascular accidents (CVA or stroke) Post-acute phase need rehabilitation and restorative nursing-PT, OT, ST. **Goal** Attain fullest potential of physical, mental, psychosocial well-being.

Change in Condition-physical or mental. Notify physician and family or legal representative. **Reassessment required if significant**.

Contracture-Shortening or shrinkage of muscles, tendons, etc., by persistent flexion or distortion of a joint-especially in arthritis and tendonitis. Preferred treatment is ROM. Splint if flexed.

Dental Services (F791)

Provide or obtain from outside service

- 24-hour emergency care-acute pain, damaged tooth.
- Routine inspection, cleaning, filling.
- Prompt referral, appointment, transportation
- Poor dentition a major factor in malnourishment
- Charges may be made to Medicare, private pay residents. Medicaid requires facility provide emergency and routine care—not required to pay for services not reimbursed

Behavioral Health Services (F740)

Behavioral disorders can be brought on by a number of physical, emotional, and/or psychological factors, ranging from UTI's to depression to physical pain. *The facility **must** provide the necessary behavioral health care and interventions to attain or maintain the highest practical, physical, mental, and psychosocial well-being for their residents. The ultimate goal is the prevention and treatment of mental and substance abuse disorders which in turn allows that person to enjoy the highest quality of life practical for him/her.* CMS stresses the care and services

provided for those who are suffering from PTSD. Per regulations, the *facility must ensure that residents who are trauma survivors receive culturally-competent**, trauma-informed care** in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.* The services provided or arranged by the facility, as outlined in the comprehensive care plan must be *culturally-competent and trauma-informed.* According to the United States Department of Health and Human Services, "individual trauma results from an even, series of events, or set of circumstances that is experienced by an individually as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Psychosocial problems the facility must ensure that a resident who displays mental and psychosocial adjustment problems receives appropriate treatment and services to achieve as much re-motivation and reorientation as possible.

a. Manifestations—sad, withdraws, mask-like expressions, crying, etc.
b. Treatment-reality orientation, validation therapy, sensory training, re-motivation, promote community and family contact, Social Worker counseling, psychotherapy-latter through outside resources
c. Sudden changes in mood or behavior, (loss of social judgment, sexual activity, etc.) Notify physician and family. Reassess before taking action if significant.
d. Mental confusion from medication—closely monitor all taking four or more medications.

Resident Adjustment Programs

- Crisis Intervention
- Individual, group, and family psychotherapy
- Music therapy
- Training in drug-therapy management
- Structural socialization activities
- Maintenance of daily living skills
- Development of appropriate personal support networks

Dementia Alzheimer's, others. ½ of residents diagnosed with dementia.

Often have behavioral problems—Dementia training for staff is mandated.

Depression Know symptoms, treatment programs. Most new admits experience some depression. **Clinical:** 1. Medications: Lexapro, Celexa, Zoloft, Cymbalta , Remeron. 2. Counseling, psychotherapy, and 3. Activities.

Discharge Planning (F622, F 623, F624, F660, F661)

Begins upon admission. Discharge summaries must include:

a) A recapitulation of the resident's entire stay.
b) A final summary of the resident's status.
c) Contain a post-discharge plan of care, developed with the participation of the resident***, and with the resident's consent, the resident representative(s)***, which will assist the resident to adjust to his/her new living environment.
d) The resident's disease diagnosis and health conditions, course of illness/treatment or therapy, medications, and pertinent lab, radiology, consultation results, and instructions or precautions for ongoing care.
e) The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services.

Emergency Care Have plans posted at nurses' station-regular physician, back-up physician, transfer to emergency room. Special plans for cardiac cases. Review procedures regularly. **Emergency Medication Kit** (or perhaps referred to as the **Emergency Drug Kit—EDK)** contains material nurses' use

EDK typically belongs to pharmacist. (Approved by State Board of Pharmacy)

a. **Crash Cart** contains materials both nurses and MDs use.
b. **Medical Director, DON, and pharmacist** collaborate to determine

which medications are to be in the EDK.

Hearing deficit & balance

Must have proper treatment and assistive devices, appointments, and transportation to specialists.

Facility does not provide services and hearing aids, but ensures availability.

a. Trauma may be greater than loss of sight or an ADL loss

b. Vertigo is a major cause of dizziness and is one of the major causes of falls.

c. BDA—Benign Disequilibrium of Aging

Tube feeding If admitted feeding self or with assistance, not fed by tube unless documented cause - now unavoidable. Watch for complications: aspiration, pneumonia, diarrhea, vomiting, dehydration, etc.

1. Nasogastric
2. PEG tube—better tolerated.
3. For d/c planning, facility provides family with training on the PEG; care plan it.

Quality of Life Promoted by care and environment that enhance dignity, self-determination, participation, notice before roommate change, other. Must strive to help elders avoid the plagues of the elderly:

Atmosphere

1. Physical—pleasant buildings, rooms, surroundings, change colors.
2. Social—make eye contact every time see a person and call name and smile. Never ignore any person you pass in the facility.
3. Be friendly, show warmth, interest in individual.
4. Eden Alternative Loneliness, Helplessness, boredom

Rehabilitative (restorative) nursing Identify daily needs of residents for range of motion, ambulation, breathing exercises (in care plan). Specific MD approval not required

Restless legs syndrome (nightwalkers) Unknown origin

a. Treatment very diverse—medications, exercise, hot showers, heating pads, etc. Difficult to control.

Restraints Physical and chemical-psychoactive drugs. What is a restraint? A physical restraint is 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. Cannot release self-leg, arm, hand mitts, safety ties, or vests, wheelchair safety belts, bed rails…(limits access to body and environment.)

- Use only to control harmful behavior, never for convenience, discipline, or when necessary for **treatment**
- Physician orders. If resident chooses restraint it is considered therapeutic intervention-bed rail, belt for chair-Informed consent (legal representative if incapable)
- Monitoring. Every 30 minutes, release for 10 minutes every two hours-a standard of practice.
- CMS's goal: restraint free.
- Alternatives: Remove from group, walk, talk with someone, physical

activity, environmental change

Visually impaired (same services as hearing impaired)

Environmental considerations: no glare, indirect lights, use of color. *Age Related Macular Degeneration (ARMD)*-one in three (3) over 75 has it. Regular screening. Glaucoma - pressure too high

Wanders and elopement Facility must plan, due to liability **Assess** possibilities before and at admission. Plan includes notifying doctor and family, setting up monitoring program, installing door alarms, advising all staff. Document.

a. **Wrist bands** that trigger door alarms are not restraints (Wanderguard, Code Alert, magnetic locking doors, etc.)

Sexuality resident right to privacy. Consensual nature. Same-sex spouses and same-sex domestic partners included.

D. Social Service

1. Goal Help maintain or improve each resident's ability to meet every day physical, mental, and psychosocial needs.

2. Duties Not specified by CMS; standards of practice include:

a. Member of interdisciplinary team
b. Social history
c. Community resources-have complete file
d. Family counseling-especially at admission (not psychotherapy)

e. **Discharge planning**-Must begin at admission

f. **Advance medical directives** (living will)-at or before admission-know wishes of resident (means for making health related decisions). Most widely used means to lessen conflict between professional ethic and resident wishes.

g. **Auditing** regular reports from SW (conference or written). Include number or residents being counseled. Review community file. **Effective SS program** when links social supports, physical care and environment with resident needs. Administrator knows social work program is productive when resources are being utilized.

E. Dietary Management

Staffing

a. A qualified dietitian full-time or as consultant-needs knowledge of administration-**Duties** Number 1 is to ensure residents' nutritional needs are met
b. If a qualified dietitian is not employed full time, the facility must designate a person to serve as the director of food and nutrition services
c. If not a qualified dietitian, the designed dietary manager must receive frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

Menus must meet nutritional needs according to Food and Nutrition Board of Research Council, NRC (National Academy of Sciences)> State determines retention.

RDA'S Recommended dietary allowances of vitamins, minerals, calories proteins, etc.

Food Classes that provide RDAs (daily)

1. 4 oz meat
2. 2 cups fruit/vegetables
3. 4 servings of bread/cereal
4. 2 cups milk

(a class not eaten-alternative means to meet needs: nutritional supplements)

Inventory on hand-Three (3) days supply of perishables; seven (7) days supply of staples

These are standards of practice. An administrator should anticipate the type of catastrophe his/her facility may suffer and plan accordingly. ***The 3 and 7 day SOP MAY not be sufficient. Please check your state requirements for state-specific regulations.***

Allergies Dairy products most frequent; seafood. Odor of some foods may cause anaphylaxis within 60 seconds. Dietary personnel must know about food allergies-check tray cards and servings carefully.

Food preparation. Unacceptable practices.

a. Prolonged storage
b. Too much exposure to light.
c. Prolong cooking in large volume of water.
d. Precooking to attain soft texture.

Weight Loss Surveyors measure by these parameters for unplanned weight loss:

Interval	Significant loss	Severe loss
1 month	5%	Greater than 5%

3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

% loss = Usual weight less actual X 100 $\frac{110 - 100}{110}$ X 100 = 9%

usual weight

Meals 3 daily - no longer than 14 hrs. between evening meal and breakfast-16 hours with substantial snacks and o.k. from resident's council. (Snacks must meet RDA's)

Therapeutic Diets: Prescribed by physician. The attending physician may delegate to a qualified Dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.

Assistive devices to maintain or improve ability to eat. Provided by facility.

Feeding Residents Only health care professionals may feed patients who need assistance with eating. States have the option to utilize Paid Feeding Assistants (PFA). These professionals must complete a state mandated program before working as a feeding assistant and must work under the supervision of an RN or LPN. The PFA is not to assist residents with complicated feeding problems, e.g. swallowing difficulties and aspiration potentials.

Food temperature

a. Storage-Potential Hazardous Foods (PHF) 41 degrees F or below. Frozen must be kept frozen "solidly" according to regulations.
b. Serving-Hot foods leave kitchen or steam table at 135 degrees F or above. Cold foods 41 degrees F or below when leave kitchen.
c. Cooking temps:

Poultry and Stuffed Foods	165 F
Ground Meat (beef, pork)	155 F

Fin Fish	145 F
Port and Ham	145 F

Dishwashing-High temperature dishwasher wash cycle 150-165 degrees F or mfg. recommendation; Rinse cycle 180 degrees F.

Low Temperature Dishwasher (chemical sanitization) wash 120 degrees F and final rinse 50 ppm (parts per million) hypochlorite (chlorine) on dish service in final rinse

Sanitation: Hazards Analysis Critical Control Point (HACCP) is effective means of preventing food borne illness. Traces how, when, where contamination can occur. Not yet required by CMS.

Poisons never stored in food service.

Dining-Encourage all who can to eat in dining room.

a. Getting out of room

b. Socializing

a. Administrator visits
b. Assigned table for certain groups
c. Need at least one licensed staff member in case of aspiration or other problems.

Cost of Raw Food-figured by dividing total cost by # of resident days: 100 residents X 30 days = 3,000 divided <u>into</u> $15,000 = $5.00 ppd.

Food Needs of elderly-- Value, choices, taste changes, dentures.

F. Medical Services:

Terminology: A few terms relating to geriatrics.

a. communicable
b. cytotoxic-radiation, chemotherapy, immuno-suppressants

c. degenerative-deterioration of tissue or organ, loses vitality

d. delusion and hallucination

e. hematoma

f. hepatitis B

g. malignant/benign

h. nosocomial-infections that occur after admission (now referred to as Healthcare-associated infections (HAI)

i. Community-acquired infections—aka as *present on admission*—infections that are present or incubating at the time of admission and which generally develop within 72 hours of admission

j. diagnosis-organs or system affected, characteristics.

- Alzheimer-pre-senile dementia due to atrophy of frontal and occipital lobes, progressive deterioration, chronic, interferes with social and emotional function.
- Arteriosclerosis-most frequent metabolic deficiency

- CVA-cerebrovascular accident (stroke) may lead to paralysis
- Dementia --- Impairment of mental powers due to organic causes
- Glaucoma-eye pressure 16 to 18, cannot cure, can control
- Multiple Sclerosis-chronic, progressive, involves central nervous system
- Parkinson's
- Syndrome

k. Transmission-based precautions—formerly Isolation Precautions

Physician Service (F 711) Every resident has own physician-M.D. or D.O. only can admit and serve as attending physician. Back-up physician.

a. Role in admission and assessment.

b. Responsible for total programs of care

c. Visits (same for SNF and NF) -once every 30 days/first 90, every 60 days thereafter. Up to 10 days late o.k. Next visit must be counted from regularly scheduled date.

- At the option of the physician, required visits in SNF's after the initial visit, may alternate between personal visits by the physician and visits by a *non-physician practitioner (NPP)*. A NPP is either a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA).
- Physician must write, sign, and date progress notes at each visit and sign and date all orders (with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician approved facility policy after an assessment for contraindications.

d. Medical Director Duties (F841)
Implementation and coordination of resident care policies, supervise medical care, policies on accidents/incidents, lab, radiology, pharmacy, quality of care

e. Communication of regs to MDs, between staff and MD

f. MD orders, recording, electronic signatures, FAX
Controlled drug order may be FAXED to pharmacist only.

g. Rubber stamp—when authorized by facility management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. **Medicare regulations prohibit the use of stamped signatures for SNF patients.**

h. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.

i. Changing MDs - supposed to do new history, new orders, written release from prior MD

Physician/Resident relationships-to be promoted by staff. How to talk with doctor.

Hospice Care (F849) In 2013 federal regulations were enacted that requires nursing homes to either contract with at least one hospice company, allowing residents in the facility to opt for hospice care if they chose to and if they qualify for hospice services, or to assist those residents to transfer to a facility that had a hospice contract.

1. Hospice care is for people with a life expectancy of six months or less (if the diseases run it normal course).
2. If resident lives more than the six months, he/she can still receive hospice services if the Medical Director of the hospice company or other hospice physician *recertifies* the patient's prognosis is terminal and life expectancy is six months or less.
3. After the initial six-month certification, Medicare stipulate that the patient can get hospice care for two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. Each benefit period must be "recertified" by an aforementioned physician.

Telehealth： Provision of health-related services (clinical and nonclinical remotely by electronic communications.

Telemedicine: A subset of telehealth; specific to remote provision of clinical services.

F. Resident Activity Program - a resident right

1. Definition Social, recreational, religious, and other activities that promote quality of life. Over and above activities related to activities of daily living.

2. Based on individual needs, interests of each resident as identified in assessment.

3. Calendar of events posted

4. Useful service Only if part of care plan-if does not volunteer, facility must pay them (at least minimum wage).

5. Handicapped Provide needed adaptive equipment so can participate.

6. Volunteers Have PPRs to cover work

7. Community Programs-Take residents out to community activities, as well as bring community groups in.

8. Facility newsletter best means of interesting residents in each other. AHCA study determined this.

9. Resident/Family Council Administrator role is to:

a. Provide space
b. Provide material
c. Provide a resource person - meeting by invitation only.
d. Implement recommendations when possible.

G. Medical (clinical) records (F573, F583, F842)

A nursing home must maintain its medical records and its Health Management processes in accordance to the Health Insurance Portability and Accountability Act of 1996. (HIPAA). Key components of HIPAA include:

- **Access to Medical Records**—Residents have the right to review their medical records and purchase them at a reasonable charge.
- **Notice of Privacy Practices**—Facilities are required to provide a notice to the resident about their rights as identified by HIPAA. This is typically done upon admission and is included in the admission packet.
- **Limit on the Use of Personal Health Information**—Facility must have written authorization from the resident and/or legal responsible party prior to releasing any information to such entities as banks, marketing firms, or life insurance companies. Medical and nursing staff may share vital medical information needed to treat the resident.
- **Must limit** who has access to the computer software

Must be complete, accurate, accessible, and organized.

Content and format-CMS requires;

- Identification data-social history, SSN, doctor, family ...
- Assessments

- Plan of care and services provided
- Preadmission screening results
- Progress notes
- Closing data when discharged (checked by surveyors)
- Correcting charting error: mark through, correct, date, initial; by person who made error.
- Discharge summary includes:
    - Recap of resident's stay
    - Final summary of status
    - Post D/C plan
    - Must be completed 90 days after discharge

Frequency of documentation of progress determined by the facility. Have reporting schedule to chart progress in maintaining or improving function. Physician records after each visit. Medication pass recorded as completed.

Confidentiality: No release without consent except:

a. transfer
b. court order
c. third-party agreement (surveyors)
d. payment purposes e.g., managed care utilization reviews
e. Public health activities such as reporting abuse, neglect, domestic violence health oversight activities.
f. Business Associate Agreements (BAA)—Protective Health Information (PHI) As a part of the HIPAA privacy rule, formal business agreements must exist between the facility and any entity in which PHI must be reviewed and/or transmitted for the purpose of protecting the individually identifiable health information.
g. HIPAA Breach Notification Rule—Requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information.
h. Encryption—PHI that is transmitted electronically musts be encrypted.

Ownership and accessibility *Belongs to facility*. New owner must keep as state requires.

a. Accessible to resident to read in 24 hours, excluding weekends and

holidays; copy in two working days.

b. Legal liability of record borne by MD

Security Proper storage (lock and key), limit access procedures.

Retention State determines. If not, CMS says five years. Juvenile record kept according to state law-usually three years after attaining age of accountability.

H. Rehabilitation Program

Needs of elderly-may require special services as PT., OT, ST, mental health, mental retardation-especially due to CVA's, falls, structural surgery...

Goal Help each person live at fullest potential possible for that individual-walk again, feed self, toilet, etc.

Services-Facility must provide or arrange for through outside resources.

Specialist:

a. Physical therapist-trained (usually registered) through degree program. Works with all types. Rehab-ambulation; heat, hydro, sound-wave and other treatments; special exercise; manipulation...

b. Occupational therapist-trained (registered). Works primarily with extremities, eye/hand coordination, strength, dexterity, range of motion...

c. Speech/language-(Speech Language Pathologist (SLP)) Improve auditory comprehension, speech production, expressive behavior.

d. Mental health specialist-psychiatrist, psychologist, SW, etc.

Counseling, psychotherapy.

Program Carried out on written order of physician. Team role.

a. First step is to assess-part of team role
b. Identify needs, set goals
c. Select treatment modalities, implement
d. Record results, report to nursing staff and physician.
e. Certain resident activities are rehabilitative, though done by **activity director**.
f. Facility must provide space and equipment when outside resources do not furnish.

I. Monitor and evaluate resident satisfaction (Quality of care and life)

Numerous methods involving both staff and outside resources.

1. Administrator-visit each unit regularly, observing work being done and the environment. Require regular reports from each unit of the facility.

a. Nursing-incidents/accidents, number in restraints, PRN orders, number of complaints
b. Dietary-number and type of meals, cost; obtain weekly reports on # of meals, types, income, etc.
c. Other Departments

J. Grievances

a. Document-helps determine frequency, patterns.
b. Reasons for complaints—most resident want to go home. Also, most family member have not resolved feelings about placement.
c. Action-act only after know what situation is. May need reassessment (mild CVA's and dementia)

Counseling residents/family:

1. LIFE

Listen—Let them get it off their chest

Investigate—No snap judgments, threats, early recommendations

Feedback

Evaluate

1. Keep feeling under control—use low affect, soft voice, little emotions—no anger, impatience, or irritation.
2. Use Crisis Intervention—everyone loses emotional equilibrium at times and cannot think straight due to irritation, anger, or other.
    a. Keep quiet and let them explode.
    b. When get it off their chest they usually sigh and relax
    c. Then can problem solve

K. Resident Rights ***(F-Tags 550-586)*** Facility must practice and promote rights in many areas. **Purpose** is for residents to have autonomy and choice, to the extent possible, over how they wish to live and receive care.

Exercising rights Free of interference, coercion, discrimination, or reprisal. Facility can encourage to participate in documented care plan program.

Notice Prior to or at admission must notify (and document) residents of their rights (Federal and State) in language they understand. Also, eligibility for Medicare or Medicaid and basic rates.

1. **Records**-has right to inspect and purchase copy of all records
2. **Medical care and treatment**-has right to refuse to be admitted to facility. Choose own physician.
    a. Refuse treatment—discuss alternatives first.
    b. Inform in advance of care and treatment—total health status.
    c. Informed consent.

3. **Research—**may refuse to participate

4. Advanced directive May refuse to sign

5. Notification of change Within 24 hours must:

a. consult with resident
b. consult with physician
c. notify family (legal representative) when:

- Accident occurs that has potential need of MD
- Significant change in status
- Decision to alter treatment
- Decision to transfer

6. Reasonable accommodations Changes that maintain unassisted functioning (furniture, adaptive equipment, grab bars, safeguard for wanderers, measure to reorient and re-motivate)

7. Resident Funds-right to manage own financial affairs, to deposit funds with facility. Request in writing.

8. Privacy and confidentiality of self and records-Privacy with whomever wishes-private room not necessary. Visual privacy at least by curtains. Privacy of body during care and treatment.

9. Grievance and complaints-Allowed to voice complaints regarding care and treatment. No discrimination or reprisal. Promptly investigate and resolve all complaints. Post names, telephone numbers, etc. of advocacy groups. Surveyors will ask residents how staff responds.

10. Survey Results-Allowed to examine survey results and plan of care. Have readily available.

11. Work- May refuse to perform useful service, or may do so if

a. **Facility** documents need or desire in plan of care
b. **Plan specifies** nature of services and if volunteer or paid
c. **Compensation paid** when do not volunteer-at prevailing wage
d. **Resident agrees** to work described in plan.

12. Mail- right to uncensored, unopened mail-sending and receiving.

a. **Access** to stationery and stamps
b. **Prompt mailing**-within 24 hours-and receiving-the day it is delivered to facility.

13. Access and visitation- (F564) Facility provide immediate access 24 hours per day to:

a. **Representative of CMS or state,** resident's physician, ombudsman, and advocacy reps. Immediate family and other relatives may visit as resident desires.
b. **Facility may establish** guidelines for "reasonable access" by assigning location of visit, not allowing disturbance of other residents-make these available to resident and family in writing.

14. Telephone – Access to private use of telephone-both auditory and visual in-so-far as possible.

Telephones in occupied offices and nurses' station do not qualify.

Equipment required to accommodate hearing impaired and wheelchair bound residents

Cordless and cell phone sometimes valuable

15. Personal Property Retain and use personal possessions so long as it does not hinder staff function; infringe on rights of other residents; or threaten health and safety.

Value to residents. Something to share.

Losses be documented and fully investigated

Labeled, proper storage provided

16. F-559 a. Married Couple Share room if both consent.

b. Roommate of choice when practical.

17. Transfer and discharge-may refuse transfer from one distinct part of a facility to another distinct part in order to be eligible for Medicare. No move solely for purpose of becoming eligible for Medicare. May do so if resident requests it.

Transfer or discharge possible when resident's:

- needs cannot be met
- health is improved so s/he no longer needs facility care
- continued stay endangers safety of others
- continued stay endangers health of others
- has failed to pay for care after reasonable and appropriate notice, or
- facility goes out of business
- Documentation Needs that cannot be me and health improvement is entered in record by resident's physician. Any physician can document dangers to self or others in

record. Staff fully document all transfers/discharges.

Notice Facility must notify resident and family member before hand in writing. Include in notice and in clinical record:

- Reason
- Effective date
- Location to which transferred/discharged
- Right to appeal
- Full information to Medicaid agency, ombudsman, and proper advocacy agency

Timing Notice given 30 days before transfer/discharge unless:

- Safety of residents endangered
- Health of residents endangered
- Resident has urgent needs for immediate transfer
- Not resided in facility for 30 days

Orientation Transfer/discharge a planned event; resident oriented to plan for change so it is orderly/safe. Trial visit to new location, family assistance, attention to personal belongings, orienting new staff to resident's needs lessens anxiety.

Bed-hold policy (F625) Before transfer to hospital (24-hours in case of an emergency transfer)*, or granting therapeutic leave, explain:

- Duration of stay under state plan
- Facility policy on bed-hold periods
- Written notice covering these standards

*Must maintain document multiple attempts to contact the resident's representative in those cases where the facility was unable to notify the representative.

Readmission Must have written policy. Must readmit to first available semi-private room shared by a member of same sex.

18. Restraints-Free from restraints used for discipline or convenience. Must be for treatment. Discipline means to punish behavior; convenience means to control behavior or maintain residents with least staff effort.

19. Abuse-Free of verbal, sexual, physical, or mental abuse, corporal punishment, involuntary seclusion, exploitation, misappropriation of personal items **(F600 through F610)**

Verbal oral, written gesture that is disparaging, demeaning, derogatory- in hearing of resident or family

Sexual harassment, coercion, assault

Physical slapping, hitting, pinching, kicking, pushing, pulling hair, handling in rough, angry manner

Mental humiliation, harassment, threats, deprivation

Involuntary seclusion Separation from others, or from rooms

Reporting/investigating every incident. Documentation must include: Who, nature of abuse, where, when, whether addressed immediately.

Report to State Agency and to one or more local law enforcement agencies.

Must report within 2 hours after forming the suspicion, if the events that cause the suspicion result in serious body injuries or not later than 24 hours if the alleged abuse did not result in serious bodily injuries. Results of the investigation must be reported to the State agency within 5 working days.

The facility **must develop and operationalize policies** and procedures for the purpose of assuring that the facility is doing all that is within its control to prevent abuse and neglect.

There are seven components that are mandatorily addressed:

Screening

Training

Prevention

Identification

Investigation

Protection

Reporting/response

20. Activities- Self-determination and participation. Can choose activities, schedules, and health care consistent with interests, assessments, and plan of care. Includes sleep, being awakened at night, eating schedule, clothes, grooming, visitation, short leaves, free time.

a. **Involve community** in and out of facility
b. **Participation-**may refuse
c. **Groups-**Free to organize residents, families, resident/family groups.
d. **Work** must be part of plan of care.

II. **Operations**

(37 Core; 17 LOS)

Acronyms for Finance

ACO	Accountable Care Organizations
ADR	Additional Development Request
AP	Accounts Payable
AR	Accounts Receivable
BAA	Business Associate Agreement
BBA	Balanced Budget Act
DHHS	Department of Health and Human Services
CD	Certificate of Deposit
CPA	Certified Public Accountant
DEERS	Defense Enrollment Eligibility Reporting System
DENC	Detailed Explanation of Non-Coverage
DMERC	Durable Medical Equipment Regional Carrier
DOJ	Department of Justice
DOL	Department of Labor
ECR	Electronic Cost Reports
EOQ	Economic Order Quantity
FCA	False Claims Act
FI	Fiscal Intermediary
FICA	Federal Contributions Act (Social Security Tax)
FIFO	First In First Out

FWT	Federal Withholding Tax
GAAP	Generally Accepted Accounting Principles
ICD-10	International Classification of Diseases, Tenth Revision
IPA	Interim Payment Assessment
HCBS	Home and Community Based Services
HCFAC	Health Care Fraud and Abuse Control
HMO	Health Maintenance Organization
IGT	Intergovernmental Transfer
LIFO	Last In Last Out
LLC	Limited Liability Company
MAC	Medicare Administrative Contractor
MAP	Medical Assistance Program
MIC	Medicaid Integrity Contractors
MIP	Medicaid Integrity Program
MMA	Medicare Prescription Drug, Improvement and Modernization Act
MOA	Memorandum of Agreement
NF	Nursing Facility
NPI	National Provider Identifier
NTA	Non-Therapy Ancillary
NOMNC	Notice of Medicare Non-Coverage
PAMA	Protecting Access to Medicare Act of 2014
PBJ	Payroll Based Journal
P & L	Profit and Loss Statement

PDPM	Patient Driven Payment Model
PDGM	Patient Grouping Payment Model
PFFS	Private Fee-for-Service
PHO	Physician Hospital Organization
PO	Purchase Order
PPD	Per Patient Day
PPO	Preferred Provider Organization
OIG	Office of Inspector General
QIO	Quality Improvement Organization
PCP	Primary Care Physician
RAC	Recovery Audit Program
ROI	Return on Investment
RUGs	Resource Utilization Groups
SNF	Skilled Nursing Facility
SNP	Special Needs Plans
SS	Social Security
VBP	Value-Based Purchasing

A. **Financial management (10 Core; 4 LOS)**

1. **Process** of ensuring materials and other resources are bought and used efficiently and economically; attain goals.
2. **Value** Administrator has information to make decisions and manage facility. Control device-measure performance against original plans.
3. **Administrator's Role** Owners hold administrator responsible for proper financial management of facility. Varies according to type of ownership. Chain organizations may do budgeting, payroll, group purchasing - administrator may have little input. Smaller organizations usually have CPA to supervise accounting, make financial reports, handle payroll, etc.

B. **Accounting Terminology** —Terms you need to know.

Asset A thing of value, things owned, such as cash, equipment, real estate.

Current asset Cash or other short-lived asset, e.g. A.R. and C.D.'s that are used up usually within one year. **Fixed or non-current assets** will not be used up within a year, e.g. building, equipment, etc.

Tangible Assets have physical characteristics, they can be seen and touched.

Intangible assets are non-physical, as copyrights, patents and goodwill

Book Value is cost of a depreciable asset less accumulated depreciation.

Capital is a term meaning funds to be used in business. Real estate, buildings and certain equipment can be included under certain conditions.

Investment Capital is cash used to purchase real estate and equipment, and to build—used to produce operational revenues.

Working Capital Excess of current assets over current liabilities. A measure of company's ability to pay bills.

Capital Expenditure—Expenses of increasing book value of facility assets.

Contract for personal services involves the offer of money, consideration, acceptance. Spell out duties, authority, time, remuneration, escape clause, other terms.

Earnings refers to generated revenues, or income. Gross earnings are total revenues or income.

Gross Profit—Net sales less cost of goods.

Operating Profit—Gross profit less operating expenses.

Net earnings (or net profit) equal revenues minus expenses.

Dividends—Earnings distributed to owners.

Retained Earnings—Earnings not distributed to stockholders, limited, or IRS will tax.

Equities—Interest in or claims upon assets by the owners—equals capital stock plus retained earnings.

Fixed expense Fixed expense remains constant without regard to volume of business, e.g. mortgage payments, leases, taxes.

Variable expense change with volume of business, e.g. Food, medical supplies, utilities, etc. Often shown graphically.

Semi-variable expense May see this term in reference to Certified Nurse Aide wages. For example, if a facility's census drops by 5 from one day to the next, the administrator may send an aide home to keep within budgeted HPPD numbers, thus that employee's wage may be described as a semi-variable expense.

Gross Income—Total income from all services. Also, capital gains, interest on bonds, workers' compensation insurance benefits.

Operating expense—Those incurred in normal operations of business—salaries, benefits, utilities, materials, rents, etc.

Liabilities are debts or obligations owed. **Current liabilities** are debts usually due within one year, such as FICA taxes, FWT, notes payable

and dividends**. Long-term liabilities** are debts not due for a period usually more than one year, such as mortgages, bonds, and property liens.

Lien—claim or charge on property for payment of obligations.

Liquidity denotes how quickly an asset can be converted to cash without appreciable loss.

Marginal Return—Point at which revenues equal expenses, the break-even point.

Mortgage—conditional transfer of title on property by a borrower to a lender to secure payment of a debt or loan.

Net Worth is total assets less total liabilities.

Note—Written promise to pay definite sum of money on a certain date usually with interest.

C Forms of Business Organizations

1. **Sole Proprietorship-**legally liable for business debts

   Is a business operated by one individual; the business is considered part of the individual, not a separate entity. The business profits and losses are included on the individual's personal tax returns, and the individual retains personal liability for the business debts and lawsuits.

2. **Partnership-**legally liable for business debts
3. **Corporation-**not generally liable for business debts, except payroll

taxes. Best for owner's protection against liabilities of business

4. S Corporation-no corporate tax, except some long-term capital gains. Profits or losses claimed on individual tax returns.

Limited Liability Corporation (LLC)—Combines characteristics of corporations and partnerships. More flexible management. Profit and losses can be allocated regardless of *how* stockholders are invested in the company.

For Profit v. Not-for-Profit (Nonprofit)—For Profits differ from Not-for-profits in the fact that profits go back to the owners in forms of dividends, whereas the profits in the not-for-profit organizations go back into the operations of the organization.

D. Fiscal year and budgeting

Corporations choose any 12 months. Partnerships *generally*

use calendar year. Sole proprietorships use calendar year.

Budget Plan expressed in numerical terms that is a forecast revenues/expenditures for fiscal year. Also budget other resources--allocating staff, space, equipment, supplies.

Formats:

- **Master Budget** includes cash budget, capital budget, liquidity ratios, pro-forma financial statement.
- **Capital Budget** includes real estate, buildings, equipment, usually limiting factor as re-coverage from expenses takes long time. *Medicare* counts $5000 or more as capital if item has useful life in excess of one year (previously $500 or more).
- **Cash Budget** Forecast of all cash receipts and disbursements. Considers schedule of cash inflows and payments of obligations. Shows availability of cash.
- **Value:** Makes possible plans to invest surplus and for periods when

expenses exceed income.

- **Operating Budget** includes details of anticipated revenues (income) by service, and anticipated expenditures by category. **Value**: Helps to continuously study and control finances.

- **Integrated Budget** A document that projects all capital and operating costs, as well as all revenues, and consolidates this information.

Methods: Most chain organizations have computerized financial management. Local facility computers linked with mainframe computer in central office. **Advantage:** easier to access computer data, make comparisons, etc. **Most budgets** now prepared by central office in chain organizations, may ask for administrator input. Some have administrator develop budget, send to central office, which negotiates with administrator. Family-owned facilities still depend on administrator to develop budget.

Timing-Begin well before beginning of fiscal year-biggest error is waiting too late

Basis-on past years' experience, historical trends, and future expectations.

Forecasting-Begin with overall facility utilization forecasts-average daily census, resident days by payer, anticipated changes in needs, trends in economy, employment rates.

Reason-Determine reasonable costs and plan cost control

Departments-Involve department heads in budgeting for own units. Promotes cooperation.

Keep revenue cost in balance-no deficit budgeting.

Zero-based-Evaluated costs and benefits of all activities in comparison to alternative expenditures, rank and chose from alternatives in terms of how they fit overall priorities.

Value of budget

a. It expresses in financial terms the goals and programs
b. It provides criteria for evaluation of performance
c. It serves as a control device.

E. Accounting Standards established by accountants and boards-Generally Accepted Accounting Principles (GAAP). Nearly all facilities now use computerized accounting.

Definitions

- **Accounting** includes bookkeeping, budgeting, reports, specials studies, auditing, designing systems.
- **Bookkeeping** is very mechanical, recording of business transactions.
- **Double-entry accounting** Each transaction has equal debits, equal credits.
- **Cash Basis-**revenues/expenditures recorded when actually received or paid out, except for depreciation expense.
- **Accrual Basis-**revenue/expenses recorded when incurred. Medicare requires.

Accounting Records

- **Account** Summary of changes in assets, liabilities, stockholders equity, revenue, expense. Each account given title that describes nature of item included (equipment; utilities, auto expense...)
- **Chart of Accounts** Complete list of all categories in the ledger-may include number-receivables and payables-like table of contents.
- **Journal** Book of original **entry. Contains** all financial transactions in chronological order. Tells where to post debits and credits.
- **Ledger** Complete listing of all accounts and their balances, payable and receivable.

Financial Statements

a. **Trial Balance** List of all accounts and their balances, except account with zero balance. Made at any time, used in preparing other statements.
b. **Balance Sheet** Summarizes assets, liabilities, and stock holders' equity. Reflects **solvency.** Made up at **any time**.
c. Earning statement Compares revenues with expenses incurred to produce income. Reflects **profitability. Also called Profit and Loss Statement.**
d. Retained earnings Explains changes in retained earning that occur between balance sheet dates.
e. Statement of changes in Financial Position Shows flows of funds into and out of the business. Derived from and ties together b,c, and d in single report.
f. Bank Statement Lists balances at beginning of month, deposits, checks paid, bank charges, interest, daily balances, and ending balance. **Reconcile** immediately upon receipt monthly.
g. Cash flow statement Sometimes used to show cash receipts and disbursements leading to net change in cash in a given period. Provides information to plan for short range, cash needs or able to pay obligations promptly.

Three Basic Steps in Accounting:

- **Entries-**Transactions recorded as they occur in the journal. Tells where to post.
- **Posting-**Transfer of debits and credits from journal to ledger which is charts of accounts-payables and receivables.
- **Tabulate** account balances periodically.

Amortization and Depreciation

Amortization Allocation of costs of non-current, intangible assets over a specified period of time. Also, of debt-monthly payments

Depreciation All assets costing $5000 or more and used more than one year are depreciated. Allocation of costs of tangible assets over a specified period of time. Cause of depreciation is decrease in value due to use, obsolescence, action of elements...

- Straight-line depreciation method distributes the same dollar amount of depreciation to expenses each year during the asset's assigned life. **Required by Medicare.**
- **Accumulated** depreciation is the total depreciation taken to date on a depreciable asset.
- **Salvage value-**If there is a salvage value, subtract from cost before depreciating.

Adjusting entries Done by accountant if administration is concerned with **profitability.** Also done for discounts on purchasing, for uncollectable bills, and at the end of the year.

a. Adjustment in basic bookkeeping is done in journal
b. Error noted in audit is adjusted in ledger.

Break-even analysis Determining break-even point when income equals expense-**marginal return**. Analyze variable and fixed expenses.

Value Can study volume of service and expenses in integrated manner; expenses more closely controlled; decisions on expansion can be carefully considered; easy-to-read report summarizing data contained in various income statements.

Lower break-even--Do four things: 1. Reduce fixed cost, 2. Increase prices where possible, 3. Lower variable cost and 4. Work case-mix.

Percent Occupancy Determined by dividing the number of possible patient days into the number of actual patient days, multiplied by 100.

Example: 120 beds X 30 days = 3600 possible days

$$\frac{\textbf{3240 actual days}}{\textbf{3600}} = .90 \times 100 = 90\%$$

Payback period for capital investments Divide original cost by saving per year:

$$\frac{\$10{,}000}{\$1{,}600} = 6.3 \text{ years}$$

Auditing Checking accounting records for accuracy. Can have compliance audit.

Nursing Costs Cost of drugs $0.60 ppd. 100 beds with 90% occupancy. How much do you expect to spend in a 30 day month?

100 beds

x 90% occupancy

90 pts.

x $0.60 cost ppd

$54.00 total cost/day

x 30 days

$1620.00

F. Ratio Analysis

Ratio Analysis Analyzes strength and profitability, and efficiency of operations. Done by determining relationships between certain items in balance sheet and earnings statement, and pairs of items of different statements (173)

1. **Current or working capital** shows excess of current assets over current liabilities. Expressed as 1.5:1. Creditors interested in this ratio. $25,000 / $50,000 = 1:2
2. **Quick or acid test** Relates quick assets (cash, AR) to current liabilities. (Creditors and owners interested in this.)

$$\text{Acid test ratio} = \frac{\text{quick assets}}{\text{Current liabilities}} \qquad \frac{\$37,500}{\$25,000} = 1.5:1$$

3. ***Note:*** *A current ratio of 1:1 indicates the facility can pay its debts and perhaps have a surplus. At first glance a ratio of 2:1 appears much better. However, there may be too much money tied up in current assets that are not liquid. In this case, a quick or acid test may be better. A quick ratio of 2:1 means the facility has adequate assets to meet its obligations with a surplus than can be possibly invested until needed*

G. Accounts Receivable

1. Reimbursement sources
    a. Medicaid **
    b. Medicare **
    c. Private pay
    d. Managed Care
    e. Long-term care insurance

Medicaid—Title XIX program for medical assistance to the medically indigent—based on medical need.

a. Eligibility—Possess no more than a home, car, and other resources up to an amount set by state and approved by CMS. Spousal Impoverishment provisions allow the spouse of a nursing home resident to maintain more assets so that they may continue to live at home without undue financial hardships.

b. State has official state Medicaid agency that administers program with CMS approval.

c. Services include in-patient and outpatient hospital care, lab, x-ray, SNF and NF, home health, private duty nursing, dental, PT and OT, prescribed generic drugs and some other. Varies by state.

d. Not covered are materials for personal care—toothpaste, tooth brushes, OTC's, etc. State provides full list of what NH must furnish residents on Medicaid.

e. Billing NH bills a fiscal intermediary chosen by the state. Nursing Homes bill electronically on Form UB04. Failure to bill timely may result in forfeiture of that payment.

Medicare Insurance program, PPS

4 parts:
Medicare Part A—In-patient hospital services, SNF, Home Health, Hospice,
Medicare Part B—Outpatient services, Physician services, DMEs
Medicare Part C—Managed Care
Medicare Part D--Medications

Eligibility—Anyone over 65 who is eligible for social security is eligible for Part A. Others over 65 may join and pay a premium. Certain disabled also eligible without regard to age. Everyone pays premium for *Part B.*

Prospective Pay System (PPS) SNF's are reimbursed on a prospective pay system commonly referred to by its acronym "PPS".

Services PPS for SNF

Part A covers hospital in-patient, SNF, patient teaching (self-administration of medications, ostomy care, diabetic management, and rehabilitation—PT, OT, ST. It does not cover Respiratory Therapy.

Therapies must be given 5 times weekly; can be a combination of the therapies.

Length of Stay in SNF up to 100 days—as long as making progress. Must have had 3-day hospital stay within 30 days of discharge if it is continued care for conditions that arose in original stay. *Be careful of observation days—they do not count!!*

Re-qualify—for another 100 days if there is a 60-day break in skilled services. This does not mean the person has to be discharged from the nursing home, nor does it mean just because they were discharged from the nursing home that the spell of service has been broken.

Payment in SNF Part A pays 100 percent of charges during first 20 days; resident pays co-payment from day 21 through 100th day. Co-payment amount adjusted each January

Patient Driven Payment Model: The reimbursement program for Medicare Part A patients.

- **Payment rate is based on the 5-day MDS for the entire stay by combining five different case mix components.**
  - Physical therapy payment
  - Occupational therapy payment
  - Non-therapy Ancillary
  - Speech Language Pathology
  - Nursing Payment

Key provisions under PDPM

Nursing Component

- Section GG of the MDS determines the nursing functional score
- Must be done on the first 3 days of admission for all admissions
- 5 day assessment must be completed within the first 8 days of admission
- Reimbursement rate remains the same throughout the benefit stay unless there is a condition or service change

Interim Payment Assessment

- Optional
- Completed in order to report a change in patient's PDPM classification rather than discharge
- Typically submitted when a change in condition requires services that increase the cost of care and thus results in a higher reimbursement rate.

Physical and Occupational Therapy

- PT and OT rates will be reduced by 2 percent every 7 days after day 20 of admission.
- The 4 categories of PT and OT:
  - Major joint replacement
  - Non-orthopedic surgery and acute neurologic
  - Other orthopedic
  - Medical management
  - Group and Concurrent Therapy (PDPM allows therapy to perform up to 25%)
  - Group therapy: 2-6 patients who are performing similar activities that are part of their plans of care regardless of payer source
  - Concurrent is the treatment of 2 patients at the same time, who are performing different activities

Speech Language Pathology

- **SLP rates payment remains constant throughout the participant's stay**
  SLP rates are impacted by:

- Acute and non-acute neurologic
- SLP-related co-morbidities
- Cognitive impairments
- Mechanically altered diet
- Swallowing disorders

Non-therapy Ancillary (NTA)

- Based on the presence of certain comorbidities or use of certain extensive services.
- CMS understands the cost impact of medications at the time of admission is extensive.
- A patient with more comorbidities will likely require more medications.
- 50 conditions that were related to increases in NTA cost.
- The reimbursement for the NTA component will be **reduced after the third day of admission up to 67%.** (Emphasizes the need to capture everything possible on the initial admission)

Non-case Mix Group

- A fixed cost based on geographic area an includes costs incurred regardless of resident characteristics**.** This is a flat rate that covers room and board, capital expenses, and administrative overhead.

Interim Stay

- Determines how payments will be made when residents are discharged and readmitted during a benefit period
- Interruption window is 3 days, day of discharge is day 1.
- If a patient is re-admitted during the *interruption window,* the Medicare payment continues where it left off under the variable payment rate.
- If the interruption window is exceeded, or the resident is admitted to a different SNF, the per diem payment is rest to day one and a new 5-day admission assessment is required.

Triple Check

- Ensures that billing codes are consistent throughout the process.
- Includes professions from the billing department, therapy department, and MDS coordinator

Consolidate billing SNF's bills a fiscal intermediary selected by CMS. SNF bills for all ordered services given to residents, except for:

a) Physician services
b) Professional component of diagnostic test, but not the technical aspect itself
c) Physician assistants and nurse practitioners
d) Hospice care
e) Qualified psychologists

Payroll Based Journal

Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to report on the level of staff in each nursing home, as well as employee turnover and tenure, which can impact the quality of care delivered.

Therefore, CMS has developed a system for facilities to submit staffing information – Payroll Based Journal (PBJ). This system allows staffing information to be collected on a regular and more frequent basis than previously collected. It is auditable to ensure accuracy.

MEDICAID/MEDICARE COVERAGE/LIABILITY NOTICE (NOMNC ANDSNFABN)

The facility must:

Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—

The items and services that are included in nursing facility services under the State plan for which the resident may not be charged; and

those other items and services that the facility offers and for which the resident may be charged and the amount of charges for those services.

NOTICE OF MEDICARE NON-COVERAGE/DENIAL LETTER: If a SNF believes upon admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the SNF believes that an otherwise covered item or service may be denied as not being reasonable and necessary, facility staff musts inform the resident or his/her legal responsible representative in writing why these specific services may not be covered and of the beneficiary's potential\al liability for payment for the non-covered services. Regulations mandate that a 2-day notice is given to the resident/legal representative prior to discharging from Medicare Part A. The *Notice of Medicare non-coverage* (CMS form 10123) is the form used by SNF's. The NOMNC is issued when all covered services end for coverage reasons. It informs the beneficiary of his or her right to an expedited review of a service's termination. The form used for Part B notices is CMS-R-131. It must be provided far enough in advance to allow time for the resident/legal responsible party to consider all available options

Recovery Audit Program—Its mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries. These audits are conducted by accounting firms contracted by CMS. RAC stands for ***recovery audit contractors***. They are reimbursed a percentage of the monies recouped by CMS as a result of the RAC audit.

Accountable Care Organizations--Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

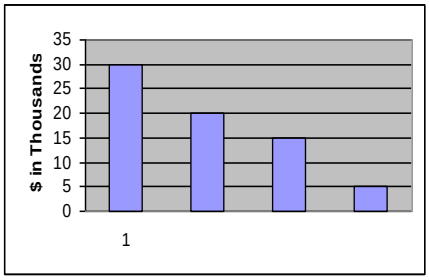
The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.

Aging accounts Value of aging accounts is twofold: (a) reminds resident his account is in arrears and needs attention, and (b) it helps you estimate actual amounts you can expect to collect. Accountants have determined collection rate by days delinquent as:

1-30 days	lose 5%
31-60	lose 10%
61-90	lose 25%
91-120	lose 50%

Days Past Due Amount % Uncollectable



1-30	$30,000
31-60	$20,000
61-90	$15,000
91-120	$5,000

Deliquent accounts NHA should take active role—letters, phone calls, personal visits. The longer it takes, the less you will collect. When all else fails, may need to turn account over to collection agency or an attorney. Before you do, suggest family take out loan and pay you—pay loan monthly.

NPI numbers for physicians providing services must be included on the UBO4—

H. Banking

1. Receipts All funds received should be receipted and immediately recorded in proper accounts—first opportunity to lose money.

2. Deposits All funds received should be deposited the same day they are received. Person receiving funds should not make up bank deposit slip—second chance to lose funds.

3. Statement Bank statement should be reconciled immediately after receipt—third chance to lose funds. Do not allow person who makes deposit to reconcile statement. Due to limited staff some facilities have one person to receive funds and reconcile statement—another makes deposit.

4. Savings Keep as much money in savings as possible—make your money work for you. Maintain only enough in checking to cover day-to-day cost. This is usually determined by corporate financial persons.

5. Investment Funds not used for as much as 20 to 30 days may earn most by keeping them in money market funds—they are still liquid.

I. Accounts payable

1. Internal financial controls Whatever is spent must be tightly controlled, the same as for funds you receive. Purpose if such controls are fourfold:

a. Protect assets against theft and waste (safeguarding assets)—(main purpose)

b. Ensure compliance with policy and procedure and Fed. Laws.

c. Evaluate performance and efficiency

d. Ensure accurate, reliable data and accounting reports.

Examples: requisitions, purchase orders, receiving reports matched to PO's. Each voucher paid by check, proper authorization for purchasing.

Purchasing

Consolidate purchasing by (a) standardize both products and vendors well before purchasing, (b) centralize purchasing so all department heads do not purchase, and (c) minimizing number of staff who can purchase. Have strict purchasing procedures, and negotiate with vendors.

Statement contains balance from last statement date, dates, and amounts of payments, dates and amounts of new purchases, and new balance. Also contains age of amounts due. *Do not pay by statement*.

Payment by numbered invoice. Every check should be backed by invoice(s).

Use discounts and full credit period-helps with cash flow.

J. Inventory Control --- maintain proper levels to reduce working capital needs (182)

1. **Economic Order Quantity (EOQ)** Method helps on when and how much to order. Balances cost of reordering and carrying cost, and risk of running out. Must consider shrinkage, spoilage, and theft.
2. **Frequent reports** to administrator on amounts on hand.
3. **Perpetual inventory** best. Know amount on hand and cost based on use at all times. Tighter control.
4. **End of Year** All inventories are valued. Supposed to use cost when purchased or current cost, whichever is less.
5. **Turn-over rate** number of times an item is replaced during the year.
6. **FIFO-**older stock used first. Inflation results in older stock being of higher value. Also reduces spoilage.
7. **LIFO**-New stock used first. Inflation makes value of remaining goods less than those just used.
8. **Storage**—freezers and storage rooms locked.
9. **Spoilage**—milk and others—make sure to rotate—FIFO

10. **Sudden increase in cost**—Compare to same dates in prior years, see if cyclical.

11. **Energy** cost appear too high, best to hire maintenance engineer to do energy audit, set up program for **one** person to audit-save enough first year to cover fees

K. Cost management involves sensitivity analysis-purpose is to anticipate changes in variable costs and to plan containment.

Due to: increased competition, changes in reimbursement, more regulations**.** **Employees biggest problem in cost management. Only solution.**

1. Do not buy miracle items.
2. Request free trial on new items.
3. Consider what you <u>can afford</u>.
4. Analyze cost effectiveness—product may be good, but too expensive for what you get.
5. Teach staff cost control starting with budgeting.
6. Manage cash flow—use discounts, full credit period, work resident accounts (best way to increase cash flow), keep inventories down, sale of stock.
7. Lag-time—If receipts late, use line of credit, pledge accounts receivable, borrow from retained earnings, bank loan.
8. Regularly compare expenditures to see if within budget.

Payroll accounting:

1. **Records** (attendance and payroll) Wage & Hour says keep at least 3 years. May keep employee earning record.
2. **Check Stubs** Show gross pay, Medicare, SS, FWT (other authorized withholdings),amount of check, totals year-to-date.
3. **Remitting Withholdings**
   To IRS Medicare, SS, FWT via bank deposits
   1. **Look back period** 4 quarter previous year- if paid $50,000 or more, must deposit via Electronic Federal Tax Deposit System (EFTDS). Advantage of EFTDS: reduces errors, makes corrections easier, acknowledges receipt in 48 hours.
   2. If deposit less than $50,000,must deposit in bank by 15th of next month, unless total is less than $2500—then can remit to IRS quarterly. May use electronic or hardcopy depositing.
4. **FUTA** depositing quarterly with state workers' comp. agency & with IRS at end of year. If amount exceeds $500 for year, Federal part must deposit quarterly.
5. **Basis of Workers' Comp. Premium:** total payroll, claims experience, risk class, & some other legal requirements
6. **Garnishments** Do not fire unless it meets federal standards.
7. **Overtime—**Make sure you have employees properly classified—exempt vs. non-exempt. If in doubt, contract Department of Labor.

Resident funds Keep all who request it (in writing) **(F567, F568, F570)**

Clerk Only one person should handle. Have policies and procedures to provide financial controls.

Documentation All received, all withdrawn documented with receipts and/or signature.

Charges No charges to personal account for items paid by Medicare/Medicaid

Deposits under $50 may keep in petty cash, interest earning account, or non-interest earning acct.

1. **Over $50** in interest earning account(s), interest to each individual.
2. **Total funds within $200** of SSI (may be referred to as resource limit)-notify resident in writing.

NOTE: For Medicare Part A recipients in the nursing home the regulations states for those patients the dollar amount to the interest-bearing accounts is $100. It gives the facility the leverage to use the "$50 rule" however.

Surety Bond Facility bond or assurance approved by DHHS, at least to cover all resident funds. May have alternative assurance.

Conveyance at death Within 30 days funds and accounting to person or probate administering estate.

Co-mingling Residents' funds must never be included with or in any way used as facility funds.

Procedures carefully followed and documented for funds and **personal valuables**; otherwise facility may be responsible.

Petty cash fund

1. Established on **imprest** basis when is periodically reimbursed from general cash.
2. Reconcile when run out of cash-group receipts and post to correct account, total groups of receipts and write check for that amount.
3. **Value**-convenience on things like postage due and small purchases, and reduces check writing.

Auditing The checking, reviewing, testing, and verifying, the accuracy of accounting records, usually by a CPA.

1. Annual audits are required.
2. Compliance audit is one that includes accuracy and that determines

   Whether all business procedures were followed.
3. Annual cost report is required of every Medicaid agency.

Acronyms for Risk Management

ADA	Americans with Disability Act
EEOC	Equal Employment Opportunity Commission
LSC	Life Safety Codes
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PSDA	Patient Self-Determination Act
PCP	Primary Care Physician
QAPI	Quality Assurance and Performance Improvement
WHO	World Health Organization

Risk Management (Core 13; LOS 7)

Risk Management- Program to reduce occurrences (incidents) that may lead to action damaging to facility and its reputation. Economic loss through tort action-civil suit. Primarily to protect facility, but also to protect residents, staff, and visitors.

Risk factors- first, Identify and enumerate risk factors in each department; second, a program for each department should be established and employees educated to recognize risks and to handle them with care and judgment.

1. **Administration-**PPR's, staff qualification, follow-up of complaints, accidents, insurance.....
2. **Nursing-**Restraints, PRN orders, medications, lack of proper assessment and care plan. *Number one* area of concern.
3. **Environment-**LSC, ANSI, ADA, OSHA-poor security and preventive maintenance, inadequate safety and infection control. Housekeeping safety.
4. **Dietary-**Infection control, spoilage, food taste and appearance, garbage disposal.
5. **Tools** for developing good program:
    - Proper plans for each department
    - Adequate insurance
    - Training
    - Documentation
    - Quality Assurance and Assessment (key)
    - Monitored by NHA (MBWA)

All incidents and accidents must be documented and a follow-up completed.

Legal Management

An administrator's goal should be that no law suits are filed against his/her operations. The old adage of *an ounce of prevention is worth a pound cure* is so true when it comes to legal management. Law suits from residents/family members and EEOC suits from disgruntled former employees make up the preponderance of tort actions lodged against health care facilities. Things to remember in an attempt to prevent law suits include:

- Develop relationships with residents and their responsible party
- Follow up on all concerns
- Proper charting *"The faintest ink is better than the clearest memory…"*
- Understand and follow facility Risk Management Program
- Completed **Incident Report** (Administrator should review)

Legal liability

Respondeat Superior-Er responsible for work errors of Ee's when on duty. Vicarious Liability-may be responsible for non-contract workers while performing duties in facility.

- Properly trained Never allow Ee on job until fully trained. General Liability Insurance, Malpractice Insurance.

Quality Assessment and Assurance Committee: (F868) (Required)

a. **Make-up-**DON, Medical Director or his/her designee, and at least three other staff members, at least one who must be the administrator, owner, a board member, or other individual in a leadership role. ***The Infection Preventionist must be a member.***
b. **Duties-**Identify issues that negatively affect resident care, develop and implement plan of correction. May oversee safety and infection control

plans, pharmaceutical service.

c. **Reports** to the facility's governing body, or designated person (s) functioning as a governing body regarding its activities, including implementation of the QAPI program.
d. **Meeting-**at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.
e. **Keep records-**must document actions, continuing record. DHHS and State-no required disclosure-just ensure they are kept (compliance)

Quality Assurance and Performance Improvement (QAPI) (F865)

Introduced as a part of the Affordable Care Act, or Obama Care. Five strategic Areas of QAPI:

- Design and Scope
- Governance and Leadership
- Feedback, Data Systems and Monitoring
- Performance Improvement Projects
- Systematic Analysis and Systemic Action

Plan that investigates all resident/family complaints, decides on course of action, implements, gives feedback

Compliance and Ethics Program are mandated in nursing homes by CMS.

Should be designed implemented, and enforced so that they will be effective in preventing and detecting criminal, civil, and administrative violations, and in promoting quality of care.

Eight (8) components:

- Written compliance and ethics standards, policies, and procedures
- A committee comprised of high-ranking employees, i.e., CEO, department leaders, board members, etc.
- Committee with the requisite authority to assure organizational compliance

- Prohibition of delegating substantial authority to those who have had a propensity to engage in criminal, civil, and administrative violations
- Education for staff, volunteers, contract workers with regard to organization's corporate compliance and ethics standards
- A plan outlining reasonable steps to achieve compliance with program standards, policies, and procedures
- Consistent enforcement of the operating organization's standards through appropriate disciplinary actions
- Responds appropriately when violations are detected

Patient Self-Determination Act requires all health care facilities accepting Medicare and/or Medicaid to recognize a person's living will or power of attorney for health care decisions (Advanced Directives).

Fraud Control

1. False Claims Act (Civil War-time law) To prevent false claims for services not rendered, double-billed, and not necessary.

2. Penalties FCA includes mandatory penalties from $5000 to $10,000 per false or fraudulent claim, plus triple the amount of false claim and the cost of investigating and prosecuting for claim.

3. Health Care Fraud and Abuse Control (HCFAC) created as part of HIPAA in 1996. The office of Inspector General (OIG) and Department of Justice (DOJ) authorized to fight fraud. Resulted in significant saving already

4. **Safe Harbor Rules** Get regulations from OIG. Governs reimbursement under Medicare/Medicaid. Not violate Anti-kickback Statute. Involves investors, space and equipment rentals, personal services, management contracts, referral sources-no compensation to anyone for referral of residents.

The federal Anti-Kickback Statute ("Anti-Kickback Statute") is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. *See* 42 U.S.C. § 1320a-7b. The Anti-Kickback Statute is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment for up to five (5) years. *See* 42 U.S.C. § 1320a-7b(b). In addition, conviction results in mandatory exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7(a). Absent a conviction, individuals who violate the Anti-Kickback Statute may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. 42 U.S.C. § 1320a-7(b). The government may also assess civil money penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Statute. 42 U.S.C §

Acronyms for Human Resources

ADA	Americans with Disability Act
ADL	Activities of Daily Living
CEU	Continuing Education Unit
CDM	Certified Dietary Manager
CMS	Centers for Medicare and Medicaid
CNA	Certified Nurse Aid
COBRA	Consolidated Omnibus Reconciliation Act
DEA	Drug Enforcement Administration
DON	Director of Nursing
Ee	Employee
Er	Employer
EEOC	Equal Employment Opportunity Commission
FDA	Food and Drug Administration
FLSA	Fair Labor Standards Act
FMLA	Family Medical Leave Act
FTE	Full Time Equivalents
HIPAA	Health Insurance Portability and Accountability Act
INS	Immigration and Naturalization Service
IRS	Internal Revenue Service
MBWA	Management By Walking Around
MSD	Musculoskeletal Disorders
NLRA	National Labor Relations Act

OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
OT	Occupational Therapist
OTA	Occupational Therapist Assistant
OSHA	Occupational Safety and Health Administration
PFA	Paid Feeding Assistant
PPR	Policies, Procedures, Rules
PTO	Paid Time Off
QAPI	Quality Assurance and Performance Improvement
NLRB	National Labor Relations Board
RAD	Resident Activities Director
RD	Registered Dietitian
Sr	Supervisor
SSA	Social Security Administration
TQM	Total Quality Management
TRS	Therapeutic Recreational Specialist

Human Resources (Core 13; LOS 6)

Purpose To provide quality resident care (24/7/365) with efficiency and economy. To do so, must:

- **Employ** qualified person for each position

- **Create** a positive work environment to promote quality performance-three factors promote job satisfaction and enhance communication between staff and management:
  a. **Policies and procedures** Clear guidelines for Ee's to work by. Know what to do, and how-I like the way they let me do my work.
  b. **Social Environment** People like to work with others (few hermits)-I like the people I work with: pleasant, congenial, cooperative.
  c. **Work itself** Interesting, challenging, satisfying, fulfilling-I like what I do.

Governmental Oversight

CMS Centers for Medicare and Medicaid

EEOC Equal Employment Opportunity Commission

OSHA Occupational Safety and Health Administration

IRS Internal Revenue Service

INS Immigration and Naturalization Service

SSA Social Security Administration

United States Department of Labor

FDA Food and Drug Administration

DEA Drug Enforcement Administration

OIG Office of Inspector General

Policies, Procedures, and Rules (PPR's)

1. First step in human resource management.
2. Purpose Provide information on what management expects of employees and what employees expect from management.
3. Definitions
4. Employee Handbook Simply written PPR's on personnel management. Copy for each employee.

Staffing requirements

Administrator licensed by the state.

Nurse Staff Requirements:

a) Federal regulations do not set a specific staffing ratio for nursing homes.

b) The 2016 regulations require a facility to have "sufficient nursing staff to meet the needs of the residents. (**F725)**

c) Staff must demonstrate appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident, as determined by the resident's assessments and individual care plans.

d) Facility must have a competency-based staffing approach that requires the facility to evaluate the resident population and its resources, and base its staffing plans and assignments accordingly.

e) Facilities must have RN coverage at least 8 consecutive hours per day, seven days per week. **(727)**

f) Director of Nursing must be an RN. **(F727)**

g) A licensed nurse must serve as a **charge nurse** on each work shift. A charge nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care. The DON may serve as the charge nurse only if the facility has 60 or fewer residents.

h) **Certified Nurse Aide (F728, F729, F730)** Each state must maintain a registry which includes name, address, SS number, date of birth, record of training and competency evaluation completed, (name and date of program), documentation of any act of neglect, abuse, or misappropriation of property**. Facility cannot use any individual working as a nurse aide for more than 4 months, on a full-time basis unless:**

- **That individual is competent to provide nursing and nursing related services, and**
- **Has completed a training and competency evaluation program approved by the State.**
- **Nursing Home must verify that CNA is registered and is in good standing before hiring.**

- **The facility must compete a performance review of every nurse aide every 12 months, and must provide regular in-service education based on the outcome of these reviews.**

- Discipline If CNA is reported to have committed any violations of concerning abuse, neglect, or misappropriation of property, the Administrator must:

    i. Ensure that it cannot happen again until the case is completed
    ii. Report incident to the state Medicaid complaints office.

iii. Do a full investigation and document.
iv. Never hire a CNA found guilty of one of these 3 violations.

Social Worker (F850) More than 120 bed facility, SW must have at least bachelor's degree in social work or in human services field (sociology, special ed., rehab, counseling, psychology, etc.) **plus** one-year supervised SW experience working with individuals in health care facility.

- 120 beds or less; state sets requirement.

Resident activity director (RAD): (F680)Therapeutic Recreation Specialist preferred: licensed or registered, if applicable, or eligible for certification as a TRS or an activities professional by a recognized accrediting body; or is OT or OTA; or complete state approved course. May also qualify by having 2- years' experience in a social or recreational program within the past 5 years, 1 of which was full time in a patient activities program in a health care setting.

Dietitian A qualified dietitian or other clinically qualified nutrition professional is one who:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or equivalent foreign degree) with completion of the academic requirements of a program in nutritional services or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
- Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed.

Director of Food and Nutrition Services (F801)

i) is a Certified Dietary Manager or

ii) A certified food service manager, or

iii) has similar national certification for food service management and safety from a national certifying body, or d) has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management from an accredited institution of higher learning.

Consultants, professionals Administrator must ensure all outside resources used are qualified to provide service

a. Pharmacists
b. Rehabilitation therapist.

Support staff—No CMS specifications for workers in dietary, housekeeping, laundry and maintenance. A director of environmental services preferred to be over the last three departments.

Job terminology

1. **Job-**Collection of tasks that can be performed by an employee.
2. **Job classification-**Titles of jobs, nurse, aide, secretary.
3. **Job analysis-**First step is to identify (1) tasks, then (2) knowledge, skill, behaviors needed. Best person to help determine is the employee. Use to develop job description.
4. **Job assignment-**Specific assignment of duties (usually written).
5. **Job evaluation-**Appraisal of a job by application of standards in order to rank or rate jobs. Used to determine pay levels.
6. **Job description** - List of duties, level of authority, distinguishing features of work, special requirements as standing, stooping, lifting, and qualifications-required license, training, etc.
7. **Job specifications** - Usually same as job description

Professional ethics Administrator must know ethics of practice of all staff. Hold professional staff to their code

- **Report** unethical practice to proper Board and/or agency.
- **Ethics** in practice as relates to residents—Ethics Committee

Employment practices (Free of discrimination-Wage and Hour, EEOC, ADA)

- Advertising (external recruitment)
- Job Posting (internal recruitment)
- Staff one of the best sources of applicants

  CNA Registry

  Labor Pool/Agency-disadvantages: affects care, decreases morale, increase cost

  - Employment agency (Head hunters)-advantages: screens for basic job requirements.

Application form May not ask birthday, gender, marital status, nationality, children, (*arrest records),* birthplace, physical size, etc.

Fill out alone in facility to test reading

Include permission to contact references

A provision in the Affordable Care Act (ACA) requires criminal background check on all non-licensed personnel

Employment history Always check two references-good indicator of success is length of time on prior jobs.

Verify employment dates

Ask if would reemploy

Interviewing

Methods

- Non-directive-open ended questions; give problem and ask how handled.
- In-depth (directed)-ask specific questions.
- Patterned-use list of sequential, detailed questions (some think it is more reliable).
- Know job requirements ahead of time
- Things cannot ask as may be discriminating
- Do not discuss job itself until you have information on applicant-will tailor answers to what job requirements are.
- Interview all applicants-major error is hiring first one who is well qualified.
- Applicant with **disability**-must interview differently (see next section on ADA).

Pre-employment tests Personality, interest, ability, work sample-must be done by qualified examiners**. Reading** test by use of application.

No test given that has **adverse impact** on minorities or women. (Title VII)

Construct Validity Measures traits or behaviors of people you need for the job.

Content Validity-Measures skills, knowledge, and performance requirements.

Medical exams Pre-employment physicals only after job offer.

Physician only gives findings, not recommendation or decision on employment.

Drug and Alcohol Testing generally permissible. Obtain written consent of applicant. Paid for by facility.

Dress requirements If uniform required, Er must pay if cost places Ee below minimum wage. **Can be told what not to wear**.

Employing supervisors-Resumes done by professionals, don't

oversell job; tell some of problems, give scenarios and ask how would handle; first impression not always best

Agencies regulating employment practices

Wage and Hour Division (Department of Labor)-Fair Labor Standards Act

1. Standard work week-40 hours, and 8/80.

Value of 8/80-helps in scheduling, payroll, etc. Scheduling—holidays, leave, week-end, etc. may require much thought and innovative ideas in order to prevent overtime

2. Minimum wages
3. Overtime pay

Professional, administrative, executive-exempt

4. Child labor-work permit required. If hire, get birth certificate.
   a. hours when under 17.
   b. No hazardous equipment when under 17, e.g. buffer, meat slicer, no laundry work, lawnmowers, etc.
   c. 16 and 17 year old children can work as a CNA with conditions
      - Cannot independently operate a power lift device, whether floor-based or celling-mounted
   d. Not drive unless 18 or over

e. Penalties - fine up to $10,000 and up to 6 mos. in prison

5. Payroll records-WH recommends keeping at least 3 years

Full time equivalents- FTE's are budgetary numbers used to determine the number of individual employees are need to fully staff the facility without putting it in an overtime situation. Today, these numbers are typically calculated by using software programs. However, either of the following formulas can be used for determination:

# of positions X # of days/week X 20% = FTE's

3 LPN's X 7 days X 20% = 4.2 FTE's

# of positions X 1.4 [This formula assumes the positions are scheduled for 7 days each week.

Equal Employment Opportunity Commission (EEOC)

Purpose No discrimination in employment and use of facilities
Title VI-race, religion, sex, national origin
Sex-substantially equal work, equal pay

- **Sexual harassment-**Ee comes to NHA, s/he should investigate, take action, document. Tort action frequent.
- **Age-**over 40
- **Pregnancy-**same benefits as all other Ees. Sick leave.
- **Disabled Vietnam veterans**

Handicapped -- Rehabilitation Act of 1973 - no discrimination if employer receives federal funds; no discrimination in hiring or use of facilities by handicapped in programs using federal funds. Also, requires Affirmative Action in federally-funded programs.

Americans with Disabilities Act Job description set up to **show essential and marginal tasks**-may not ask if have handicap

Who is covered-physical, mental or psychological disability, obese, AIDS victims, and others.

Classify tasks as essential-ask how they would do
Reasonable accommodations
Penalties-Depend on number of employees (legal form of all-purpose extortion).

Immigration and Naturalization Form I-9 since Nov. 1989 Every employee must have one on file.

Employee compensation Pay scales related to level of authority, training required, supervisory duties, skill. **Key** to good pay system is to start with fair wage standard-prevailing wage paid by other facilities.

Increment pay plan Beginning pay with regular increases-

1. Seniority, merit, mixed, job-based
2. Shift differentials

Employee benefits SS. Medicare, workers comp., unemployment insurance and Family and Medical Leave are required.

1. Other (not required)—vacation, sick, breaks, holidays, PTO etc. (may be referred to as "**Fringe Benefits**."

2. Most costly—usually vacation leave

3. Total cost of benefits may be 25 to 40 percent of base pay

Factors in setting up employee compensation programs are:

- Supervisory duties
- Level of authority
- Knowledge required
- Necessary skills

Family and Medical Leave Act of February 1993:

Provisions-leave **without pay** must be granted. leave must be granted to fathers in case of newborn child;
leave granted for placement of child for adoption;
leave granted to care for spouse, child, or parent with serious health condition.

- Up to 12 weeks per year; does not have to be all at once.
- **Eligibility-**Must have worked 1, 250 hours during the past twelve months, includes person working part-time (at least 60%).
- Regulated and enforced by Wage and Hour Division, U.S. Dept. of Labor. **Value** Help recruit and maintain staff, may help morale, *not motivate*.
- Employer qualifies if it employees at least 50 people for at least 20 weeks per year.

Staff Development

Orientation Facility, staff, personnel policies and procedures (handbook). Documentation.

Training Depends on duties-aides train in lifting, ambulating, falling, communication with residents (one of the biggest problems for CNA's).

1. Program not required by CMS-except for CNAs (must have 12 hours CE per year)--will look for if staff is not knowledgeable.

Facility-wide program Planned, have responsible person or committee, supported by administrator; provide space, time, materials, trainers, and monitor results.

Content

1. Fire prevention-number one for all
2. Infection control-A top priority in dietary services where certain diseases can be spread so easily through food handling
3. Residents' rights
4. Safety-accident prevention
5. Work attitudes-team, cooperation, (TQM, Quality Assessment)
6. Individual job skills
7. CNAs, communication with residents.
8. Cultural Diversity
9. False Claims Act as mandated by the Deficit Reduction Act of 2005

Dietary In-services-Fire control and infection control are required programs. Other programs taught but not mandated include food portioning, food preparation, and temperatures.

Effective When Ee's are capable of learning and motivated; and when **administrator support** program.

Absenteeism and Turnover

Absenteeism Temporarily absent

Turnover permanent-

1. **Costs** of recruiting, hiring, orienting, training can be extremely high. Promotes research studies.
2. **Other negative factors**-Supervisors tire of training, residents affected, poor or inadequate care.
3. **Major reason** Do not feel appreciated, job dissatisfaction.
4. **Rule** If 35 % or more, in trouble. How to figure: number leaving divided by number of positions:

   38 leaving = .38 X 100 = 38%

   100 positions

5. **Exit** interview-Help pinpoint problem areas, why leaving
6. **Solutions-** Supervision, more input, training, and advancement, pay.

Discipline and Counseling Rules of behavior must be clear and understood; penalties must be equally clear

Purpose change Ee behavior to acceptable and improve work performance

Types of discipline - oral, written, suspension, docking pay

Fairness and consistency—same penalty for same error.

Most severe When abuse, under influence, fighting. First offense may be terminated.

Documentation is imperative.

Discharge Just cause according to state employment security is misconduct. Absenteeism is not considered misconduct.

Ee counseling-low affect (soft voice), be specific, listen, no hasty decisions, accept feelings, no criticism. Non-directive; draw out information.

Problem solving approach- With supervisor let him/her ventilate, then engage in problem solving. How have you handled this? What went wrong? What else can you do? Set time to follow up.

Grievances Must have or employees feel no one cares. Explore all employee complaints, give feedback. Invites organized labor without it.

Key person in handling Ee problems and grievances is immediate supervisor. Can squelch, distort ...

Negotiating Use of give and take in solving problems. Not a win/win situation. Get Ee ideas and build on them. Useful for contracts with HMO's, consultants, and labor unions.

Staff Recognition Promotes job satisfaction and **motivates.** Stimulated by own needs and rewards:

- **Organizational** Pay increases, benefits, recognition, praise, awards, promotion. Controlled by facility.

- **Social Recognition** from fellow worker-not controlled by facility.

Monitoring performance Use MBWA. **Accountability** holds Ee responsible for work assigned. Should be **regular**-frequency depends on job itself. **Infrequent** monitoring tends to promote feeling high performance not necessary.

1. Ee needs to know *what, who, and how* will be monitored-not **when**.

Performance Evaluations

Job or performance based Evaluate on basis of goals and procedures for individual Ee's job. Do not compare with each other.

1. **Purpose** is to help (a) employee improve work performance, (b) evaluate effectiveness of policies and procedures.
2. **Objective/subjective** techniques used: (a) attendance records, work completion, write-ups (objective), (b) supervisor's observations and opinions. (subjective)
3. **Technique** (a) Supervisor complete form and interview Ee, (b) both supervisor and Ee complete form then interview. Ee's tend to under rate self.
4. Do not overemphasize **negative** features. Cover positive, too.
5. **Documentation** Signatures and dates

Personnel Records Purpose-To provide factual information for making objective

personnel decisions Not required by CMS, but by Wage & Hours, EEOC, INS, state, etc.

1. **Content** (Standard of Practice)
    a. Personal data-name, birth, sex, SS#, etc.
    b. Recruitment date-application, references, etc.
    c. Work experience date-prior jobs
    d. Compensation data
    e. Attendance records
    f. Health/safety/accidents (separate file)
    g. Evaluations
    h. Leave records
    i. Orientation and in-service
    j. Discipline

2. **COBRA** - Health Insurance—protects health insurance coverage when workers change or lose job. To qualify must:

    - Can continue coverage for up to 18 months, but must pay premium.
    - Most recent insurance must have been under a group plan.
    - Not eligible for Medicare or Medicaid or have coverage under another insurance plan.

3. **HIPAA** (Health Insurance Portability and Accountability Act) ensures the confidentiality of medical records. It still being implemented and changed.

4. **Documentation** available to Medicare/Medicaid and other government agencies. No Federal law that Ee see record; most states have such laws.

Union activities

NLRA purpose-(1) define and protect employee and employer rights, (2) encourage bargaining, (3) eliminate harmful practice.

Things to do when Union comes in:

1. contact labor relations specialists and develop plan. (Number 1)
2. conduct meeting and quote union promises
3. discipline on the job union activities
4. describe collective bargaining
5. union representation—speaks for Ee, cannot represent self.
6. strikes-can lay off if strike is for pay/benefits
7. card signing does not mean must join
8. tell them disadvantages of unions.

Things cannot— SPIT

1. Threaten to fire, demote
2. Interrogate-question if for or against, attend meetings, or sign card and
3. Promise raise, promotion or other benefit
4. Surveillance-may not watch to see who attends meetings, discusses union and passes out literature on his own time.
5. Administrator cannot attend union meetings
6. Sr speaks for union-do not fire. Clarify facility stand on unionizing.

Election NLRB may call election when 30% sign cards. 50% plus one who vote determine outcome of election

Unions seek to become the bargaining agent. They cannot approach employees on job; can when not on duty.

Cannot pass out literature in patient areas; can in non-patient areas.

If Unionized, determine in advance the essential demands and what you will do before **contract negotiations**. Must tell employees that the Union is their "bargaining voice." Have written plan.

Mediation-Third party tries to get parties to agree.

Arbitration-Opposing parties agree to abide by decision of the arbiter.

Decertification-If dissatisfied with union, members of union may petition NLRB for decertification election at end of contract.

Employee health and safety CMS mandates safe and healthy environment for staff, residents, and public. OSHA mandates safe, healthy workplace, for employees to work in.

- Studies show lower back injury and job dissatisfaction have significant correlation.
- Programs include (OSHA)
  - Identify and correct safety hazards
  - Investigate each accident, document
- Record and report by OSHA standards
- Deal with job dissatisfaction
  - Use TQM
  - Provide supervisory training
  - Give Ee's more control over how their work is done
  - Job and skill training for Ees to improve self
  - Reward work performance and dedication
  - Wellness
  - Smoking regulations
  - Substance Abuse policies

Acronyms for Environment and Quality

ADA	Americans with Disability Act Accessibility Guidelines
AIDS	Acquired Immune Deficiency Syndrome
ANSI	American National Standards Institute
BBP	Blood borne pathogen
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
EID	Emerging Infectious Diseases
EWSP	Emergency Water Supply Plans
FDA	Food and Drug Administration
HAI	Healthcare-Associated Infections
HBV	Hepatitis B Virus
HCP	Hazard Communication Program
HCS	Hazard Communication Standards
HIV	Human Immunodeficiency Virus
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disability
IP	Infection Preventionist
IPCP	Infection Prevention and Control Program
LSC	Life Safety Code
LTCF	Long-term Care Facilities
MRSA	Methicillin-Resistant Staphylococcus Aureus
NEP	National Emphasis Program
NFPA	National Fire Protection Association

NHSN	National Health Safety Network
NPP	Non-Physician Practioner
OEP	Office of Emergency Preparedness
OPIM	Other Potentially Infectious Diseases
OSHA	Occupational Safety and Health Administration
PPE	Personal Protective Equipment
QAPI	Quality Assurance and Performance Improvement
SDS	Safety Data Sheets
SMDA	Safe Medical Device Act of 1990
USPHS	United States Public Health Service
VRE	Vancomycin-Resistant Enterococcus

III. **Environment and Quality**
(Core 13; LOS 16)

The physical plant (Regulations governing the physical plant come from various agencies. The ones that CMS specifies can be found in F906 through 926 inclusive. The Life Safety Codes, ANSI and ADAAG regulations must be adhered to as well.)

- Buildings, equipment**,** grounds-- All designed, constructed, equipped, and maintained to protect health and safety of residents, personnel, public

Life Safety Code (LSC) Entire construction plan and materials meet LSC standards. CMS requires unless have waiver or exception. CMS grants waivers on SNF's; states on NF's. Facilities are now under the *2012 edition of the National Fire Protection Association's Life Safety Codes*. Deficiencies noted in a LSC survey will cited as "K" tags, and as in health care inspections, a Plan of Correction must be submitted and approved by the designated State Agency.

National Fire Protection Association (NFPA) established code.

Purpose is to ensure reasonable degree of safety from fire.

Waivers If CMS finds a state fire and safety code adequately protects residents and personnel then Life Safety Code does not apply. Facilities erected prior to 2012 may obtain a waiver if they are and have been in compliance with an older addition of Life Safety Code as specified by CMS.

Before a nursing home may be built it must present architectural plan to State Medicaid or designated agency that approves construction. All major renovations, such as additional beds, change in utilization of space, and so on must receive approval. The state provides guidelines on what must be approved. Upkeep and repairs do not require prior approval.

Blue prints—keep as-built plans available for surveyors who do LSC inspection as well as for repair persons who may need prints for big jobs.

Life Safety and other standards Building and content standards are set by LSC, CMS, ANSI or ADAAG—(dependent on which the state chooses)and state and local codes.

Life Safety Code accepts ANSI and ADAAG standards so they are essentially all LSC standards. Administrator does not need to know *every* standard, but **must** keep a copy of the "LSC Handbook" as reference. The architect who designs the facility must know and incorporate all LSC and other standards, but it is advisable for the NHA to check his building to ensure compliance. Following are some LSC, ANSI/ADAAG, and CMS standards

- **Building Materials** Fire-rate according to number of stories. Two-hour and one-hour rating.

- **Sprinklers** All buildings have automatically activated by smoke or heat.

- **Exits** No room more than 100 feet from exit. Lighted exit signs of specific size. These signs **must** be connected to an emergency energy source.

- **Walls** Extend continuously to roof deck of next floor. Wall finish

must meet flame-spread requirements (have certificate of this.

- **Furnishings** Curtains and carpet must meet fire-rating.

- **Rooms—**CMS rules approved in 2016 stipulate that resident rooms in those health care facilities certified after the effective rule date must accommodate **no more than 2 residents.** Each resident room must have an adjoining bathroom equipped minimally with a toilet, sink, and shower. Semi-private rooms must have at least 80 sq. ft/resident, 100 sq. ft. for single occupancy.

  --Direct access to corridor

  --Outside window (CMS) or door (LSC)

  --Privacy (cubicle curtains, appropriate window coverage doors that close and latch, and so on)

  --Furnishing

  Separate bed, proper size and height

  Bedding appropriate to climate

  Individual closet space

  Functional furniture appropriate to the weather and climate

  Sufficient electrical outlets to accommodate the resident's need to safely use electronic items such as an electric razor.

  Enough over-bed tables to meet needs of residents

  --Toilets (CMS, ANSI, ADA)

  --Bathing facilities (CMS)

  --Resident call system (CMS) (LSC)

--Temperature range 71-81 degrees F (three (3) feet above floor),

states set actual, A/C not required

- **Furnishing—**Must be structural sound and functional. Chairs must be of varying size and some must be movable by residents. **Wheelchairs** must fit under the dining room tables. The **ADA** require dining room tables have a minimum of a 27-inch clearance from floor to the dining room table frame, and a 28 to 34 inch span between the floor and the eating surface. There must be a minimum of 30 inches between the legs of the table.

- **Doors** All 44" or more in new construction (41.5 opening); outside doors open egress. No locks on resident door except staff has key (LSC). **Bathroom door** 32" (ANSI/ADAAG) **Fire Doors** with automatic hold-open devices required in corridors.

- **Corridors** No dead-ends (LSC) 8 feet wide (CMS)

- **Floors** At or above ground level. (LSC). Fire rating if carpeted (LSC). Non-slip bath/toilet (ANSI, LSC).

- **Fire alarms** Flashing and audible. Connect with local fire dept. if possible. Must have NFPA 71 certification of fire alarm service.

- **Smoke detectors** Approved detectors required

- **Smoking** Written regulations, enforced. Smoking areas with non-combustible ashtrays, metal containers with self-closing lids. Prohibited areas include resident rooms and beds, oxygen, flammable liquid storage. Proper signs posted. Supervise non-responsible.

- **ANSI/ADAAG (Americans with Disabilities Act Accessibility Guidelines** Make building available to and usable by physically handicapped, not mental (blind, deaf, non-ambulatory, semi-ambulatory, uncoordinated). ADAAG make buildings available to ADA's. State decides whether to apply ANSI or ADAAG standards to nursing homes.

  Wheelchair passage 32" bathroom doors, 36" elsewhere

  Parking 13 feet; cannot block sidewalk; alley for two cars The number of handicap parking places is determined from a grid issued by ANSI. It must be noted that for every 8 handicap parking slots, one must be van accessible. If the facility only has one handicapped place, it must be van accessible.

  Ramps Maximum rise 30" Slope not more than 1:12

  Water fountains, telephones (non-Braille), light switches accessible to wheelchair residents

  Toilets (also ADA for staff) seat 17" to 19" height; handrails, 33" to 36". 5% or more meet standards as determined by state and CMS

  Handrails outside ramp, stairwell, bathroom required by ANSI, and specific height. CMS requires in corridors. ADAAG specifies all 34" to 38" in public buildings. On stairwell must be 32" and **extend 12" beyond last step**. (ANSI)

  Monitored Nationally the Office of Civil Rights monitors ANSI. States may assign to Fire Marshall, Medicaid Agency, other. ADAAG is monitored by State Agency handling LSC and ANSI.

  Alarms flashing alarms for deaf, sound alarms for blind, tactile warnings for blind to identify danger areas.

  Grating No greater than one-half inch; openings perpendicular to travel route, if elongated.

Threshold—No more than ½ inch on entrance and exit doors, except exterior sliding door can be ¾ inch in height.

- **Grounds** and parking. Maintenance cost-mowing biggest. State decides on number of parking spaces per bed.

- **Water** Must have backup source of supply. Temperature established by the state. Automatic Control Valves

- **Ventilation** All areas ventilated to outside-window, mechanical ventilation, or combination.

- **Pest control** Prevention program best; use contractor and staff. No traps, poisons, sticky fly paper. **Advantage** to use pest control service: **licensed and trained** in use of all pesticides, how to rotate chemicals to prevent buildup of resistance.

- **Space and equipment**
  Facility must provide sufficient space and equipment for

  dining, healthcare services, recreation and rehabilitation.

  Sufficient means enough to enable staff to provide residents

  with needed services as identified in the plan of care.

  - Space large enough to accommodate usual number that use it; must be accessible.
  - Accommodate wheelchairs, walkers, other ambulatory devices.
  - Rehab areas have exercise equipment, storage for supplies and equipment.

Alcohol-based Hand-Rub Dispensers—All employees, with some exceptions, are required to use the alcohol-based rubs for hand-hygiene and the strategic locations of these dispenses are important. CMS requires:

- Where these dispensers are placed in corridors, the corridor must have a minimum width of six (6) feet.
- Dispensers installed directly over a carpeted area are permitted only in smoke compartments equipped with a sprinkler head.
- A dispenser cannot be placed within one inch above, beneath, or to the side of an ignition source, e.g. an electrical outlet.

Monitoring States decide who will monitor LSC and ANSI/ADAAG standards. The monitor may be the State Medicaid Agency, State Fire Marshall, or other. If it is an agency other than State Medicaid, the monitoring agency must coordinate its findings with the Medicaid agency.

Preventive Maintenance Definition: checking all systems, including roof, on regular basis and documenting. Roof protects all other assets**.**

1. Value:

- Everything safe and operative for resident care (number one)
- Saves downtime
- Small repairs cost less than complete breakdown
- Equipment and systems last longer.

2. **Personnel**—Major error in hiring
3. **Work orders**

Environmental Quality Clean, attractive, home-like

Housekeeping Procedures for floors, rooms, aseptic cleaning, storage of materials, **odor control**, role in infection control, equipment care, safety

Homelike Resident brings own belongings as long as it does not interfere with staff work or infringe on other residents' rights. De-emphasize institutional look.

a. **Sound** Comfortable, does not interfere with hearing. Background noise under resident control. Level not require staff to raise voices. Consider differences in room assignments.
b. **Lighting** Adequate for resident/staff to perform. Comfortable-minimize glare, **give resident control**. Ambient light levels are minimum averages measured at 30 inches above the floor in a horizontal plane.

Environmental design Now part of all new construction. Must be designed to provide most attractive, comfortable, usable environment.

a. Landscaping—all grounds, Nursing home sign.
b. Choice of colors.
c. room size—too small?, adequately designed?
d. Medical records storage
e. Parking—inconspicuous
f. Functional equipment—not just fancy.

Linen supply and laundry Clean linens in good condition, not ragged, stained. What resident clothing will launder?

a. **Monitoring costs-** temperatures, overloading/under loading, over drying, filters **Guideline-**after 10 years use, maintenance cost usually justify replacement of equipment

Occupational Safety and Health Administration (OSHA)

OSHA falls under U.S. Department of Labor

Mission: To assure so far as possible that every worker has a safe and healthful work environment.

Focused Hazards:

1. **Musculoskeletal disorders**
2. **Workplace violence**
3. **Bloodborne Pathogens**
4. **Tuberculosis**
5. **Slips, trips, and falls.**

1. Safety and Infection Control Program-- complete procedures for all staff to follow best infection control. Committee may be desirable.

a. Standard precautions checked by OSHA; includes:

CDC hand washing procedures. Use alcohol-based solution to cleanse hands. (Except Dietary Employees and those staff members providing care to patients with C-Dif)

Soiled linens and bedclothes means used linens.

Contaminated linen is soiled by blood or other potentially infectious materials. **Mishandling is most frequent exposure to communicable materials**. OSHA requires contaminated to be containerized at location.

Aseptic cleaning of isolation area and an **OSHA** approved spill kit for cleaning blood spills.

CMS Standards for infection control

- Investigate, control, prevent infections
- Set up procedure for entire program
- Document incidents and corrective action
- Isolate infected resident
- No Ee with communicable diseases or skin lesions can have contact with food or residents
- Hand washing after each direct resident contact
- Handle, process, store, and transport linens in manner to prevent spread of infection

Infection Prevention and Control Program—Refer to Customer Care, Supports, and Services.

2. Blood borne pathogens (BBP) Focused on AIDS and Hepatitis B. (OSHA)

Training All staff trained in how to handle (1) blood spills and materials that may be infected, and (2) exposure incidents.

Personal protective equipment (PPE) Facility must provide gloves, gowns, lab coats, face shields, eye protection, mouth pieces, and resuscitation bags, pocket masks, or other ventilation devices. Trained to use.

Disposal of sharps and other contaminated materials (OSHA) must have container in nursing, laundry, etc. and policy on emptying container.

Regulated Waste Contaminated sharps, blood, pathological waste, etc. **Have written procedures** for handling.

Needlestick Safety and Prevention Act

- follow OSHA standards
- Engineering controls—shield, retracting needles, shielded catheters, needles housed in protective covering, and jet injections. NOW required to use safety syringes.
- Law requires employee input on what works best.

Isolation room characteristics

- Single occupancy
- Toilet
- Hand washing facilities
- Vented to outside
- Sign when in use

HBV requirements Vaccine offered free to all E<u>e</u>'s (OSHA)

<u>Employee</u> with lesions never works in kitchen or patient care area.

Post-exposure procedure Must have written plan for evaluation and follow-up. Individuals involved tested (consent may be gained-OSHA says not required)-test blood of exposed person.

Documentation-every exposure incident.

Reporting communicable disease to state agency

3. **Safety** mandated by CMS, OSHA

Goals:

a. **Reduce** work-related illness, injury, death in staff.

b. **Reduce accidents**, injuries among resident, families, visitors.

Program Procedure to cover preventive measures, investigating of accidents, documentation, corrective action, reporting. Committee may be useful - not required.

DART (days away, restricted, and transfers) OSHA will targeted facilities have a 10 or more employee per 100 full time employees who fall into the DART category.

Non-recordable: Those injuries that require first-aid only

Recordable: deaths, loss of consciousness, loss work days, modified work activity or transfers. Also any of those that require medical treatment beyond first aid.

Reportable Accidental death within 8 hours; loss of an eye, amputation or hospitalization with 24 hours.

National Emphasis Program—Nursing Homes and Residential Care Facilities experience one of the highest rates of lost workdays due to injuries and illness. (2.3 times higher than that of all private industry as a whole). The goal of the NEP is to reduce musculoskeletal injuries. OSHA may inspect facilities that have a high incident rate. They will evaluate:

i. Policies and Procedures
ii. Determine if employees had the opportunity to have input into those policies and procedures
iii. Determine if the facility had an adequate number of lifts, and transfer and positioning devices.

The NEP with the goal of reducing musculoskeletal injuries is no longer in effect; however because it was included in the literature you still may see a question about it.

Identify potential hazards

***Bedrails,** wheelchairs, walkers, (misuse or poor maintenance)

F-700 is specific to bedrail safety. Review the FDA Hospital Bed Safety protocols. Consider purchasing a HBSW Bed Safety Entrapment Kit

Wet floors Mopping, spills

Hot water-temperature set by state. Automatic control valves

Extension cords

Frayed electrical wires

Unattended cleaning carts (medication carts)

Restraints

Adapters (cheaters)

Accidents Unintentional damage to object or injury to person. Two causes: (1) unsafe behavior, (2)unsafe working or living conditions. **Investigate** every accident, document, corrective measures-identify patterns, discuss with dept. head.

Document on OSHA forms, log (Form 300) Must post in a conspicuous place the OSHA form 300 A, from February 1 through April 30 each year . Keep on file for 5 years. OSHA Form 301 is the form completed when an employee is injured or becomes ill due to a work-related incident.

Poster required by OSHA

4. **Hazard Communication Program (HCP)** Mandated by OSHA

Purpose: All chemicals are evaluated and information concerning hazard communicated to employer and employees.

Program written:

a. list of all hazardous chemicals (anything with a warning label)
b. label all chemical containers
c. prepare and distribute **safety data sheets (MSDS)**
d. **develop** and implement Ee training

Label must:

a. identify product
b. identify hazardous chemicals
c. contain appropriate warning
d. show name and address of manufacturer
e. sometimes pH content-7 is norm

Includes cleaning compounds, Clorox, furniture polish, pine oil, detergents, etc. Anything with **warning** label on it.

Employer Responsibilities—Employers must ensure that the SDSs are readily accessible to employees for all hazardous chemical in their workplace. They can be kept in binders or on computers as long as employees have immediate access to the information when needed, *without leaving their work area*. A backup must be available for rapid access to the SDS in case of a power outage or other emergency.

5. **Lockout/tagout** Control hazardous energy**. Purpose** is to require employers to establish program using lockout or tagout devices on energy isolating devices and to disable equipment and machines to prevent unexpected energizing, start-up, or release of stored energy in order to prevent injury.

Lockout device-lock (key or combination) that will hold device in safe position so it will not energize. Where to keep key? Maintenance person.

Tagout device-used when energy source cannot be locked out-tag or warning device **not** to use.

Right to know laws re: hazardous materials in some states. OSHA recognizes only in states with OSHA-approved program.

Types of Violations:

- **Serious and Other-Than-Serious Posting Requirements**
- **Willful or Repeated**
- **Failure to Abate**

Penalties OSHA can fine facilities, amounts based on severity of the deficiencies, give citations, and imprison.

6. Consultation—OSHA does trial run—no penalties

Safe Medical Devices Act of 1990 (SMDA)

1. **Medical devices-**"Any apparatus, implement, machine, implant, or related article intended for use in diagnosing, treating, curing, or preventing disease or intended to affect the body's function or

structure, which achieves its intended purposes without chemical or metabolic action within the body.
Examples: catheters, thermometers, pacemakers, contact lenses, hearing aids, restraints, blood glucose monitors, wheelchairs, geri-chairs, beds, infusion and feeding pumps, whirlpool suction machines.

2. **Policies/procedures-**Facility required to establish policies/procedures for programs of staff training, of reporting incidents, illnesses, and injuries, and of action taken.
3. **Monitoring-**the Food and Drug Administration (FDA) monitors.
4. **Reportable incidents-**Events that reasonably suggest a medical device caused or contributed to a serious illness or injury, or to the death of a resident-includes user error.
Serious illness or injury:

   a. Life threatening
   b. Results in permanent impairment to body structure or functioning
   c. Needs immediate medical or surgical intervention to prevent permanent illness or injury. Extent determined by a physician.

5. **Training-**Staff must be trained annually on commonly used medical devices and on reporting. Trained as necessary on infrequently used devices. Include step by step procedure for staff to use in handling and reporting.

6. **Reporting**
   a. **Designated person-**Incidents covered by SMDA are reported to a specified person within a specified time.
   b. **Deaths-**Designated person reports deaths to FDA and the manufacturer of the device within 10 days.
   c. **Serious injuries and illness-**Reported to the manufacturer, if known; if not, to the FDA within 10 days.

Security Broad term that applies to protection of residents, staff and visitors, theft, etc. Must be alert to what is now referred to as an **Active Threat** situation (formally Active Shooter). May consider having an AT drill, but first must a formalized plan in place.

Location determines security needs, e.g., high crime areas.

Security guard, especially at night; escort to cars

Entrances locked from outside

Alarm devices for wanderers and elopers

Drug abuser-- threat. Narcotic keys.

Local police relationships.

Resident valuables

Materials security Program of purchasing, receiving, storage, issuing, inventorying. Administrator monitor.

Residents dangerous to others safety

Fire, disaster, emergencies

Fire prevention and control CMS requires program, LSC gives specifics. (NFPA Guidelines)

1. Classes of fires and control
   a. Paper, wood-water (class A extinguisher) No more than 75' apart
   b. Grease, liquids-dry chemicals, hood (class B extinguisher)
   c. Electrical-dry chemicals (class B or C extinguisher)
      - B & C no more than 50' apart.
      - K-Kitchen extinguishers

2. **Prevention**

   Fire-rated building material and furnishings

   Have designated smoking areas and monitor per policy

   Regular inspections and reports

   a. Kitchen hood-semiannually
   b. Fire alarms
   c. Exit lights
   d. Auxiliary generator
   e. Automatic fire doors
   f. Smoke detectors
   g. Smoking procedures
   h. Sprinkler system
   i. Fire extinguishers (show dates)

Identify risk areas—NUMBER 1 CAUSE OF NURSNG HOME FIRES

ACCORDING TO THE NFPA IS <u>GREASE FIRES IN THE KITCHEN</u>

3. **Fire Control** Planned program with local firemen who learn facility layout, hookups, cutoffs. . .

Alarm Systems Regulated by ANSI and LSC

Highest ranking person on duty in charge. Follow RACE:

R remove (rescue) endangered resident

A sound **a**larm

C contain fire (know which extinguishers to use.)

E evacuate if necessary (blind) or extinguish

Doors automatic fire doors; doors to room closed.

Training and drills All staff trained before go on job**. Drills required quarterly on each shift by LSC.** Document. . .

Specific duties of each Ee. Surveyors will question.

Other disaster planning depends on location

1. main highway/railroad-chemical spills
2. factories-explosions
3. hurricanes, tornadoes, floods, wildfires, snow storms, earthquakes, other natural disasters

Preparedness program and training

Transfer of casualties, records-transportation

Shelter agreements

Evacuation routes

Care when evacuated --Medications

Special emergency procedures for cardiac cases

Backup sources-water, power

Emergency power Required by CMS if have life support equipment. State may require all. Supply power to: (LSC) alarm system, life supports, nurse's station, med. Preparation area, boiler room, communications (call system). CMS omits resident call systems, **but** says follow LSC.

Power transfer-10 seconds

Cranked weekly

Tested full load 30 min./month

Document

Battery backup (if no generator) for fire, life safety, alarm system; all entrances and exits. NO waiver.

Auditing and Reporting

Review program regularly-check all equipment, accident log, maintenance log, infection control measures, security practices, reports of theft.

Conduct and observe drills with firemen

Review documentation

Ask each Ee "duty?'

Reporting of fires to Fire Marshall required in most states.

Survey process

1. **Tasks surveyors perform:**
   a. **Off-site preparation-**Review CMS's Certification and Survey Provider Enhanced Reporting (CASPER) system and ***Quality Indicators*** to determine areas survey is to focus on.
   b. **Entry conference-**request any records
   c. Initial **tour-**may uncover new areas of concern which they list.
   d. **Sample selection and interviewing-**No longer look for light care and heavy care. Select residents according to Quality Indicator report. Administrators and DON's who study these report have an insight on which residents the surveyors will be reviewing.
   e. Information gathering.
   f. Information analysis
   g. Exit interview

2. **Deficiency scope and severity** Surveyors use a scope and severity grid.

a. **Scope—**How many residents involved.

- Isolated—One or a limited number of residents affected; occurs occasionally in limited number of locations.
- Pattern—More than very limited number of residents are affected.
- Widespread—Pervasive in facility; systematic, affected large portion or all of the facility.

b. **Level of deficiency—**How much harm to residents.

- **Level 1-** **No** Actual harm with potential for minimal harm; minor negative impact on residents.
- **Level 2**- No actual harm with potential for more than minimal harm; **Example**: Medication error rate, harm of short duration as falls, a laceration, etc.-easy to remedy.
- **Level 3**- Actual harm that is not immediate jeopardy. A negative outcome that has compromised resident's ability to maintain or reach highest level of functioning. **Example:** Pressure sore of urinary tract infection occurring after admission.
- **Level 4**- Immediate jeopardy. Immediate corrective action necessary because noncompliance in one or more requirements has caused or is likely to cause serious injury or harm, impairment or death. **Example:** Nurse

call system not functioning, severe staffing shortages.

3. **Exit interview**-includes resident and ombudsman. Define areas not in compliance (not by Tag Number). **Purpose**-to inform facility of observation and findings. Findings written and discussed
Surveyors must revisit for deficiencies with a scope and severity rating of "G" or higher. They have the option on all citings below the "G" level.
Double G's CMS imposes denial of payment when provider is cited for actual harm deficiency, corrects it, but is cited again within 9 to 15 months

4. Plan of correction (POC) -Facility submits plan of correction showing:

a. How corrective action will be taken for residents affected by deficient practice.

b. How facility will identify other residents having potential to be affected by deficient practice

c. What measures or changes will be made to ensure non-recurrence.

d. How corrective actions to be monitored to ensure non-recurrence.

No consultation can be given by surveyors or CMS.

Plan of Correction The Statement of Deficiencies is referred to by its catalogue number, 2567. Once the state sends this form to the facility it must be completed per the instructions and returned to the state agency within 10 days. The POC must be posted within the facility so anyone can review it. The facility must keep the past 3 consecutive years of POC's in-house.

Informal Dispute Resolution (IDR)-Facility may request informal resolution

process. Must include in writing what findings (by Tag #'s) you contest-time period specified by state.

5. Remedies—Imposed by CMS and the state.

a. Category 1 remedies for "d" and "e" deficiencies:

- Directed Plan of Care
- State monitoring
- Directed in-service

b. Category 2—For deficiencies widespread with no actual harm but potential for minimum harm (f).

- Denial of payment for new admits.
- Denial of payment for all Medicare and Medicaid residents as imposed by CMS Regional Office.
- Civil Money penalties of $50 to $3000 per day of noncompliance

c. Category 3—For cases of immediate jeopardy (level 4 deficiencies.

- Temporary manager appointed
- Termination of provider agreement and/or
- Civil money penalty (May be adjusted annually due to inflationary factors. CMP's may be directed per incident).

A CMP is a monetary penalty the Centers for Medicare & Medicaid Services (CMS) may impose against nursing homes for either the number of days or for each instance a nursing home is not in substantial compliance with one or more Medicare and Medicaid participation requirements for long-term care facilities. A portion of CMPs collected from nursing homes are returned to the states in which CMPs are imposed. State CMP funds may be reinvested to support activities that benefit nursing home residents and that protect or improve their quality of care or quality of life.

Acronyms for Leadership and Strategy

ACA	Affordable Care Act
EEOC	Equal Employment Opportunity Commission
EI/EQ	Emotional Intelligence/Emotional Quotient
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nurse Aide
CQI	Continuous Quality Improvement
DON	Director of Nursing
Ee	Employee
Er	Employer
GB	Governing Board
IDR	Informal Dispute Resolution
IIDR	Independent Informal Dispute Resolution
IJ	Immediate Jeopardy
LSC	Life Safety Code
LTC	Long Term Care
MBWA	Management by Walking Around
NAHC	National Association for Home Care & Hospice

NHPCO	National Hospice and Palliative Care Organization
NHQI	Nursing Home Quality Initiative
OCM	Organizational Change Management
OIG	Office of Inspector General
OBRA	Omnibus Budget Reconciliation Act (1987)
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Physician
POC	Plan of Correction
PR	Public Relations
PPR	Policy, Procedure, Rule
SWOT	Strengths, Weaknesses, Opportunities, Threats
QI	Quality Improvement
QRP	Quality Reporting Program
SFF	Special Focus Facilities
SOM	State Operations Manual
TQM	Total Quality Management

Leadership and Strategy

(11 core; 0 LOS)

Governing body required by CMS, whether sole proprietorship, partnership, or corporation

Corporations are required by state to have Articles of Incorporation that specify officers, board, membership.

Closely held-Less shareholders, most are 5 or less, less formal organization.

Public-Many shareholders, very structured, bylaws.

Make up May be one person or many-there is not typical board structure in NFs

Duties

Mission Statement-what facility is to do (major duty)

Board establishes measurable goals

Employ agent (NHA). Required by CMS

Establishing and implementing policies and procedures. CMS says legally responsible for operations.

Approve budget

Evaluate administrator's management

Board does not get into the day-to-day operations

Bylaws-mostly by corporations. Rules to govern corporation itself. Not too specific. Tells **what** corporation will do. Includes duties of Board, officers, committees. Prepared by corporate members. Used as basis for writing policies and procedures for each unit of corp. Tells **how** activities to be carried out. Usually prepared by administrator, and approved by board.

GB/administrator relationship-NHA only person reporting directly to GB, usually through the chain of command, e.g. regional director, vice president of operations, etc. **Represent** his/her staff in best light-accurate, objective, factual. **Reports to GB as requested**-census, personnel, financial reports, regulation changes. (Keep fully informed, otherwise grapevine gets to them).

Directives/policies/procedures of GB interpreted properly, whether agree or not. Let Ee's gripe, but support GB.

GB listen to Ee complaints but refer them to supervisor or NHA. Inform NHA.

Role confusion-GB members usually successful in another field. Not have same, clearly defined solutions

Management Creating and maintaining an environment within an organization that makes it possible for staff to work together toward common goals. Getting work done with and through others. There are three levels of management. They are:

--Top Management—Comprised of the administrator or the president. It may also include assistant administrators or vice-presidents and may be referred to as the *executive staff.*

--Middle Management—Comprised of supervisors who have managers over them and who direct subordinate supervisors. Usually they are department heads. The director of nursing with at least two shift supervisors is middle management.

--Line Management—Comprised of supervisors who have managers over them but only employees or line workers under their direction.

Managers are not paid to take action when in reality their goal is to 'get results.'

C. Functions of Managers (supervisors)

1. **Planning-**Setting goals, establishing PPR's, programs, budgets, etc. that determine what, how, when, where and by whom work is to be done. **Central task** is planning as it permeates all other functions.

   Purpose

   a. Primary focus on obtaining goals.
   b. Offset uncertainty and change
   c. Develop economical operation, and
   d. Facilitate control.

   Primary value Administrator in charge whether s/he is present or not.

Types of plans

Mission-Basic task assigned to an enterprise by society. In nursing homes the mission is **LTC**.

- **Goals or objectives-**end results or product toward which all effort is directed.

    a. short range b. long range

    - **Strategies**-General plan that focuses on long-range goals. What will facility be like, look like, feel like, sound like, and react like, in the future.

    - **Policies**-Broad general statements to guide decision making and to some extent action in achieving goals. Allows flexibility in judgment.

    - **Procedures**-Step by step means by which tasks are performed. Allows less flexibility in decision making.

    - **Rules**-Specific, authoritative guides that require an action be taken or not taken. Allows *no* flexibility in decision making. Employees can us no judgment, so should have as few as possible.

    - **Programs**-Summations of goals, PPR's, budgets, work and space assignments, and resources.

- **Budgets**-Plan expressed in numerical terms that outline expected results.

Evaluating effectiveness of policies and procedures. Are they:

--Written

--differentiated

--taught/understood

--monitored to be sure they are followed

--help meet goals

--flexible-if don't help, change

--reviewed and updated regularly

2. **Organizing** Grouping activities and people, assigning roles, delegating authority. Setting up department, shifts, work teams.

   Purpose-Allows for growth and expansion; seeks to reduce friction and unsought consequences.

   Departmentalization Makes it possible for the organization to expand.

   Organizational Chart--Shows lines of authority and communication, formal organization

   Span of management-How many Ee's a supervisor can effectively supervise. Usually 8 to 12 at line level. Depends:

- Difficulty of task
- Clearness of policies/procedures
- Training
- How well Sr communicates
- Experience
- Closeness of control required

Unity of command-Ee has only one Sr insofar as possible. Need clear authority lines-promotes job satisfaction, teamwork.

3. **Staffing** (Human Resources)-recruiting, interviewing, hiring, training, promoting, demoting, terminating, retiring employees.

4. **Directing (leading) -**Influence Ee's to do their work according to standard-who? when? how? Involves leading, motivating, communicating, giving instructions, goal setting, decision making, representing, coordinating, managing conflicts.

Leadership NH success depends on NHA's ability and willingness to lead. Basic characteristics of leaders:

- Visibility—out and about in facility out in front, not office-bound.
- Decisive—must use authority and be accountable for what happens.

- Listener—Hears what people say—good communicator with everyone.
- Pitches in—when needed, rolls up sleeves and helps.
- Understanding—Gives staff right to be angry, non-judgmental.
- Goal oriented—Quality resident care is foremost. Plans so all know the NH goals.
- Competitive—What his NH to be the best.
- Knowledge base—Broad knowledge base of all NH operations and of total health care.

Duties of leaders Duties are diverse. They include:

- Goal setting—Points the way. Good planner.
- Decision making—High priority, as it includes problem solving. Makes decisions when needed—no procrastination. Uses his authority.
- Giving instruction—types: specific or general, formal or informal, written or oral. Gives instructions of type staff best responds to.
- Listening—to problems of staff, residents, families, and public.
- Representing—his staff in best light.
- Coordinating—People have different approach to work—slow and fast, interested or not, apply self fully or not, etc. He must coordinate those differences and still get job done.

Superior/subordinate relationship-gives rise to jealousy and anger; trouble begins. Some people **do not want to work** or be told what to do.

Authority-Right to act or require action of others-instruct, approve/disapprove, veto action, change action, reward/withhold.

Line-over all under one's direction-hire, instruct, monitor, discipline, fire

Staff-advisory, recommend, teach. Cannot enforce decisions-consultants.

Functional-Authority over a function (hiring, purchasing...) but not over person who carries it out. Used in larger organizations.

Delegation-Effective when lowest person in echelon who is authorized and capable is making a given decision. Key to effective management.

Leadership Style A common classification (All leaders concerned with **task & relationships)**:

a. **Laissez-faire** Give instructions and leave alone, easy going and supportive. May work for professional staff, and for highly motivated, capable staff.
b. **Democratic**-Allow Ee input on how things are done. Majority rules. A factor in TQM. Admin. must retain veto power, cannot be 100% democratic.
c. **Paternal, sympathetic, parenting**-You do your job-I'll take care of leave, raises, benefits.
d. **Autocratic**-Dictatorial, threatening, intimidating. No confidence in staff; he knows all. "Don't care if he likes me or not-just so work gets done."
e. **Situational**—Leaders adapt their style at times to meet the circumstances in which they are working and/or the type of employee they are leading.

5. **Controlling** Measurement of the work performance to determine if it follows guidelines, and correction of any errors in performance. Requires good policies and procedures

1. **Purpose-**maintain harmony between plans and work performance.
2. **Purpose** of correcting errors is to improve work performance.

Three steps in correcting errors:

- Review how work was to be done-begin with mutual agreement.
- Point out error.
- Indicate remedy.

3. **Guidelines to correcting:**

- **Correct** first error, soon as possible, in private
- **Objective,** specific, factual-no exaggeration
- **Make** no excuse, be serious
- **Do not** threaten that will watch *to see*

D. **Management types**- Most effective now considered to be Total Quality Management (TQM) and Management by Walking Around (MBWA).

TQM-Builds Ee interrelationships through work teams; utilizes Ee knowledge. Requires open communication, trust, mutual respect among Ee's and mgt.

Focus on improving skills and quality of output. Concerned with productivity, safety, cost, resident satisfaction. How can improve quality of work, and their knowledge and skills.

Result is **continuous quality improvement (CQI),** greater job satisfaction, motivation, teamwork, growth of staff.

MBWA-NHA regularly visits all departments and observes performance and environment. Sends out strong messages.

- Interested, available
- Expects quality
- Monitoring
- Provides opportunity to:
  --Reinforce good work

  --Prevent some problems

  --Enhance communication

Employee-centered management is interested in needs and interests of Ees. Promotes positive work atmosphere, improves performance. (TQM and MBWA)

E. **Organizational Communication** -Process of transmitting information among two or more people. Occurs when message received with understanding.

1. **Direction**-upward, downward, horizontal (lateral), diagonal

2. **Process:**
    a. ideation
    b. encoding
    c. transmitting
    d. receiving
    e. decoding
    f. understanding
    g. feedback

3. **Key** to communication is listening-40% of time

    ***active listening-hear message and the feelings behind it*.**

4. **Best** is face to face-as secure immediate feedback by expressions, questions…
5. **Barriers:**

    a. Poorly worded-use language of receiver
    b. Inattention - tune out and think of something else
    c. Transmission barriers-noise, poor hearing, stuttering, etc.
    d. Distrust of sender
    e. Fear of consequences
    f. Poor retention-30% or less is retained
    g. Premature evaluation -- give answer before problem is presented
    h. Upward communication barrier-filtering out some information before passing it along
    i. Over/under-more than need to make decision

6. **Purpose** of communication is usually ***change***-schedule, procedure, new skill, further training.
7. **Timing-**Tell assistants first, department heads, supervisors, then

workers. Usually several days before implementation. Never tell all staff at once.

8. **Written communication** preferred when:

Info must pass thru several mgt. Levels

Ee's not well trained

Involves significant change

Provides guidelines of long duration

Supervisor tends to forget what has told Ee's

9. **Computerized information** -Learn basic terminology. Value-Provides quicker, more accurate, greater amount of information for decision making. Especially useful in financial management, inventory control, etc. Management Information Systems (MIS) needed in Nursing Homes.

   a. Certification and Survey Provider Enhancement Reporting (CASPER). All NH's must input assessment and care plan information. Surveyors use in planning **focus** of survey.
   b. Quality Improvement Evaluation System
   c. Extensively used in accounting, assessment, care plans.
   d. Internet-much information for NH-survey results
   e. FAX
   f. Voice response
   g. E-mail

10. **Informal organization** and communication

    Grapevine-Tends to be used and depended on more than official communication; tends to be believed and acted on. **Cannot** destroy. Learn to use.

    Offset by open, frequent, official communication. Srs trace rumors.

    Coffee cliques and other informal groups talk about work, procedures, changes, how they will react. Undue influence on performance.

11. **Privileged communication-**between physician/patient, attorney/client, nurse/patient, husband/wife**. NONE** in child abuse cases.

F. **Change-**Causes work slow-down or stoppage until Ees learn how it affects them.

Timing-announce before start, allow time to adjust, get off chest. Ask for reactions, promote discussion-how affects you?

No change in any unit until all others evaluate impact.

Principle of reciprocal action-No change can occur in any u nit of an organization without affecting all other departments directly or indirectly.

G. **Motivation** -Process by which administrators initiate and direct employee behavior.

1. Maslow's **needs hierarchy**-needs in ascending order of importance from biological (food, clothing, shelter) to self-actualization.
2. **Motivation** primarily internal--Ee want to be seen as capable, competent
3. **Well-motivated** Ees identify with facility goals, see as their own.
4. **Money** seldom motivates over period of time. Ees must know raises depend on performance. May motivate if sizable in terms of what accustomed to.
5. **Rewards—**Important to job satisfaction—

   organizational approval, pay increases, benefits, longevity pins, letters of recommendations, parking space, good supervisor relationship.

   Social environment important. Work with pleasant, cooperative employees—co-worker recognition.

   Work itself—interesting, stimulating, satisfying.

Marketing and public relations

1. **Marketing**-Act of offering services or product in the marketplace. Managing flow of goods between producer and consumer. Developing sales potential.

   Open market-Order by court. Cannot restrict advertising health services and prices.

   - **Research**-do market opportunity analysis first. Gives info on:
     a. needs of elderly
     b. nature and effect of competition
     c. structure and relations of current services.

     Start no new service, or expand, until research shows it's economically feasible.

- **Market opportunity** depends on demand for service, size, nature. Success depends on this.

- **Marketing attitude**-All marketing oriented to meeting consumer needs. Number one goal; starting point.

- **Advertising**- Emphasize unique aspects of your service. False advertising—such as "We meet and exceed all state and federal standards" is prime ammunitions for lawyers.

- **Strategy-**Plan of action used to meet goals. Marketing program lists strategies in sequence to be carried out, who, when, etc.

2. **Public relations**- Managing communications between organization and its many publics. Difference: marketing focused on potential user, PR focused on all people.

- **Overall goal**-Interpret facility to public and public to facility. Bonds and involve the two in an interrelationship.
  a. Earn respect and approval of community
- **Image building**-Major means of meeting goals is to sponsor fund raising event, donate proceeds to a charity-show interest in community. *Tour of facility* usually best method. Others:

  Wellness fair

  Be geriatric resource center

  Educate public officials on needs

  Respite care

  Serve on boards, committees of community organizations

  Speaking engagements

  Handling nursing home telephone

- **Use of news media**-Feature articles. Negative rumors—work with reporters.

- **Newsletter**-Inform public of facility services, inform residents/family of community resources. Send to agencies, civic organizations, local government, health care organizations.

- **Educational institutions**-Participate in HS career days, involve student groups (social studies classes, clubs). Inform of what nursing home industry involves.

- **Professional training**--Train AIT's, interns from colleges. Encourage professors to have students visit, do term paper on aging, LTC, facility operations.

- **Written program**-public relations program should be written. Show the role of employees, residents, family, volunteers, and administrator in improving relationships within facility (staff/residents, staff/family, staff/staff, staff/community).

Legislative Issue

1. Work with state health care associations and state and other health care groups.
2. Keep local legislators informed of LTC needs and issues.
3. Know applicable bills and let legislators know possible opposition.
4. Contact all members of legislative committees that will handle LTC bill. Do not wait until committee meets and try to educate them.

Omnibus Budget Reconciliation Act of 1987 (CMS) provides the Federal Care Guidelines (42CFR) for all nursing facilities that are certified.

1. **Licensed administrators** of all nursing facilities, except state may waive NHA for distinct part and swing beds.

2. **Ownership** All participating facilities file Disclosure of Ownership. (Form CMS-1513) If party has 5% or more ownership, show: (1) name and address, (2) relationships between any two owners, (3) any named person's 5% or more interest in any other participating facility (p. 280).

3. **Laboratory, radiology, other diagnostic-**Must have agreement with qualified sources.

4. **Transfer agreement-**(written) with one or more hospitals. Include transfer procedures, records. **Exception** Document if no hospital will sign.

Ombudsmen Program required. Includes state advocacy agencies for MI and MR. Established by Older Americans Act of 1965, as amended.

Duties-Primary: to investigate and resolve complaints made by or on behalf of LTC residents. An Ombudsman is an individual who protects and promotes the rights of individuals before, during and after a placement into a nursing facility, adult care home or other assisted living. The service is offered at no cost to the client and is confidential.

1. Services that could adversely affect health, welfare, safety, or rights.
2. Facility notify of survey noncompliance findings.
3. State notify of any action against facility.
4. Must have access to residents; records only with written consent.
5. Give resident the name, address, phone number of ombudsmen.
6. Fed and state notify when give facility waiver.
7. State notify of survey and allow to sit in on exit interview, suggest residents and families to interview.