LONG-TERM CARE
Survey Alert
Your Guide to JCAHO & State Survey Success

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How was your last survey? We'd like to know! *Survey Alert* is always looking for new trends in survey enforcement. Please call us with any news, comments or suggestions. Call Karen Lusky, Associate Editor, at (615) 370-5042, or Erin Core, Managing Editor, at (888) 812-6939.

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Survey Management

10 THINGS NEVER TO SAY OR DO DURING A SURVEY

Have you ever really put your foot in your mouth during a survey, hoping surveyors would forgive or forget? Or stood in shock as a nursing aide discussed your staffing woes with a seemingly sympathetic surveyor or paraded patients half clad to the bath down the hall?

"Surveyors walk in and staff perceives them as gods so they … may find themselves saying and doing things that they never would otherwise," says **Marilyn Mines**, a nurse consultant with **FR&R HealthCare Consulting** in Deerfield, IL.

While many of these faux pas can be chalked up to survey anxiety, others are common oversights that can easily be avoided. Below, survey experts provide a rundown of things facility staff should never say or do during the survey — and ways to recover if they do happen.

1. Give surveyors free roam of the facility. Claire Hoffman with **Hoffman Associates** in Royersford, PA, says she's surprised how often she sees facilities allow surveyors to do this. "It's best to have a knowledgeable person accompany the surveyors to provide explanations of situations that may otherwise appear to be a deviation," she says.

"You have the right to be with the surveyors, as long as you don't interfere with their duties," agrees **Gene Larrabee**, principal of **Primus Care Inc.**, in Valparaiso, IN. Resident interviews are, however, off limits. "If you sense that your facility may be in trouble with surveyors, you definitely want to see what the surveyors are seeing, because that's how you establish your defense," he adds.

2. Admit to working short staffed. "It's not unusual for surveyors to strike up a bit of a banter with a nursing assistant or LPN where they'll say, 'I bet it's tough when you have to work short,'" Larrabee cautions. "Staff who are trying to be polite may say, 'Yes, but we make do.' Then, bingo! Your facility has an F tag for staffing."

Nursing administrators can head this issue off at the pass by explaining to surveyors how the facility does staff to census or acuity levels. If you staff by acuity, show surveyors that you have assessed acuity levels and staffed accordingly to meet resident needs and any state staffing mandates.

3. Tell surveyors "Sorry, that's not my job." "Certified nursing assistants would be most likely to say this," says **Richard Butler**, president of **Survey Management** in Indianapolis, IN, although he reports hearing such comments from some line nurses.

What this usually means is that the surveyor has asked about something outside of their expertise or responsibility. "What the staff should say instead is, 'Let's go talk to the RN or director of nursing or rehab therapist about that issue,'" Butler suggests. "Then the staff person should take the surveyor to that person or page her immediately." Larrabee also advises giving surveyors a roster of staff available to answer questions about different areas of care.

4. Answer "No, we don't do that here," when surveyors inquire about the facility's care planning or other care protocols. What should you do if the surveyor asks if your facility does X, Y and Z for residents and the answer is, "Some or none of the above"? State what your facility does do to meet the regulatory requirement in that area of care.

For example, say the surveyor asks a staff nurse if the facility does a lot of extraordinary things with the care plan. Instead of saying no, or getting defensive, the nurse could simply say, if true: "At this facility, we tailor our care planning and service delivery to the emerging needs of the residents or patients," which is what the regulations require. If the surveyor pressed the issue, the nurse could show him the quality assurance plan that ensures the care planning process is on target in meeting residents' needs.

5. Put the survey before residents. Surveyors will be looking to see that staff at all levels puts the residents first. It's easy to become consumed by the survey process, however, if you aren't careful. A survey consultant tells **Eli** she once heard a flustered DON tell surveyors, "I don't have time for residents," when the surveyor asked her for the second time if she'd like to answer a resident's call light.

6. Talk about residents in their presence or within earshot of other patients or visitors. Sometimes the road to F tags for privacy and dignity are paved with resident-centered intentions. For example, one facility was eager to show off its interdisciplinary "talking rounds" to surveyors — and ended up with deficiencies rather than acco-

lades. "Any type of 'talking rounds' … should follow some basic rules," cautions Hoffman. "For one, always ask the resident/family permission to conduct the rounds, don't talk about the resident as if he weren't there, and watch out for privacy issues, such as roommates."

7. Let surveyors leave the facility without knowing what documents they have copied to build their case against you. "It's best to designate one person to copy documents requested by surveyors and make a second copy for the facility's records," Larrabee suggests. Otherwise, you won't be able to keep track of the information surveyors have in their possession.

Also, by reviewing the documents, you may be able to figure out what surveyors are going to hit you with in the exit conference in order to prepare an effective counter argument, skipping an F tag altogether.

8. Get heavy-handed with a survey that's going well. "You don't want to overwhelm surveyors with all the things you have a right to do to control the process if things seem to be going well," warns Larrabee. And you shouldn't get adversarial with surveyors, which is a surefire strategy to win a battle but lose the war, caution survey consultants.

9. Overdo the hospitality. On the other hand, you don't want to appear so hospitable that a surveyor might accuse you of trying to "brown nose" or even bribe her. "In terms of playing host to the surveyors, it might be OK to offer coffee, cookies or muffins," says Hoffman. "But in Pennsylvania, for example, surveyors aren't even allowed to eat lunch at the facility without paying for the meal," she cautions.

To play it totally safe, Larrabee advises his clients to provide surveyors a small conference room to work in and then bring in a pot of coffee and plate of pastries with a little sign listing a nominal price. To be helpful, the facility can provide surveyors information about local restaurants or provide take-out menus to various local restaurants.

10. Accept incorrect findings. Finally, don't let a significant misstatement or misinformation stand, resulting in what may have been an avoidable F tag. "You always show you are in control during the survey," says Butler. "So it's best to say, 'I'm sorry I misspoke. I am nervous with the survey going on. What I meant to say is …," he advises. "And you must always correct misinformation. You have to assume surveyors are bright enough to understand what you said was wrong and will use it against you — which isn't inappropriate on their part."❖

Quality of Care

NEW MEDICARE RESOURCES CAN IMPROVE YOUR DEMENTIA CARE

It's the best news that facilities struggling to provide good dementia care on limited resources have received in ages.

On April 1, CMS Administrator **Tom Scully** announced that Medicare would be paying for rehabilitation therapies, psychological services and other care long denied to beneficiaries with a diagnosis of Alzheimer's disease or dementia.

The **Centers for Medicare & Medicaid Services** actually implemented the payment change without fanfare last September in a program memo to Medicare contractors (PM AB-01-135). Scully was forced to make the formal announcement this month after the *New York Times* reported on Medicare's change of heart on the coverage issue, which triggered a cascade of related media reports on the financial plight of people with AD.

"Intuitively [Medicare's] longstanding approach appeared to discriminate against Alzheimers' patients, and we are glad to fix it," Scully said in his announcement.

Gail Schober, director of the Alzheimer's program at **Sherrill House**, a nursing facility in Boston, tells **Eli** that her facility has been getting phone calls from family members in response to the recent media reports. "They want to know what it means for their loved ones," she says. "People with AD have been financially neglected by Medicare for a very long time."

According to Scully, Medicare is now paying for rehab therapies (including speech and occupational therapy); neurodiagnostic testing and medication management by a physician or other qualified health care provider; and psychological therapy.

"Long-term care groups have been fighting for this change for a very, very long time," says **Susan Polniaszek**, a reimbursement specialist for the **American Association of Homes & Services for the Aging**.

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Even so, the new policy represents progress but not a panacea.

"Medicare contractors can still deny rehab therapy services once it turns into maintenance therapy, which Medicare doesn't cover," Polniaszek explains. "And that is more likely to happen sooner with someone who has AD."

Yet, as long as the resident shows some progress, the Medicare contractor may continue to pay for the rehab services. In addition, the new policy means nursing facilities should have an easier time getting paid for physical therapy to treat people with AD who fracture a hip, as an example. "In many cases, contractors were denying all therapy claims if the patient had AD," says Polniaszek.

Under the new policy, facilities should also have an easier time securing Part B psychiatric and psychological services for residents with AD. ❖

Editor's Note: The original PM issued by CMS last September can be viewed at www.hcfa.gov/pubforms/transmit/AB01135.pdf.

Alzheimer's Disease

GET TO SURVEYORS' BOTTOM LINE ON ALZHEIMER'S CARE

Is your facility's dementia care ready for surveyors who have citations on their minds?

Survey experts predict that the recent media blitz on Medicare's more liberal coverage policy for Alzheimer's disease (*see p. 35*) will focus residents' families and surveyors more sharply on how well facilities are treating residents with AD and other forms of dementia.

When it comes to Alzheimer's disease, surveyors often target quality of care (F309-F333) and quality of life issues (F240-F258) — especially dignity, resident participation, accommodation of needs and activities.

"Surveyors expect facilities to help residents with Alzheimer's disease to achieve the OBRA goal of attaining/maintaining their highest practicable level of well-being and functioning — up until the late stages of the illness," says **Marilyn Mines**, a nursing consultant with **FR&R Healthcare Consulting** in Deerfield, IL.

"So facilities must make sure they are providing the necessary care and services for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan," Mines says.

In this regard, surveyors will be looking to see if your facility is encouraging residents with cognitive impairment to perform their own activities of daily living. "F312 (ADL services) was the 13th most prevalently cited deficiency by surveyors in 2001," cautions **Steven Littlehale**, chief clinical officer, **LTCQ Inc.** in Bedford, MA.

Yet, a simple change in mind frame can help stave off this F tag. "Facilities must move from a 'doing for' approach to residents to one where they find the best way to help each resident help himself," Littlehale says. *(For specific ADL support techniques, see the following story.)*

Ensure Dignity, Quality of Life

Surveyors are known for honing in on even a single instance where a staff member talks to a resident with AD as if he were a child, or where care doesn't promote a resident's dignity or meet his unique needs or preferences for nutrition, activity, companionship and comfort.

Nutrition is always a major survey focus that can be cited as a quality of care or quality of life issue. So facilities should make sure to tailor this area of care to the resident with dementia.

Sherrill House in Boston feeds residents with AD all day long, says **Gail Schober**, associate director of nursing for the facility and director of its Alzheimer's program. "We may hand them a quarter of a tuna sandwich, for example, while they wander, cueing them to put it in their mouth," she relates. "Or we sit down with them for a minute and offer them a cup of something to drink."

Sherrill House also makes these "mini meals" into social occasions where staff converses with residents. "People with AD like to be social. They often don't lose their social graces until close to the end," Schober says.

Schober also advocates activities that help trigger a resident's long-term memory, opening a momentary window to the person they once were, which can be priceless to loved ones. "Residents with dementia oftentimes respond to religious music, even if they haven't attended religious services since childhood," she observes.

Survey Management

GET SURVEYORS ON YOUR PAGE WITH DEMENTIA SERVICES

Sometimes even the best dementia care program won't make surveyors happy, especially if they aren't up to speed on Alzheimer's disease.

"Some surveyors are very savvy about Alzheimer's disease and others get very concerned about things like placement of call lights," says **Gail Schober**, director of the Alzheimer's program at **Sherrill House** in Boston. "Yes, you have to have call lights but usually a person with even moderate AD isn't going to be able to use a call light appropriately."

So your facility may have to educate surveyors in a "collegial way" about AD, your dementia care program — and the clinical rationale for creative and flexible approaches that some surveyors may initially mistake as irresponsible, Schober advises. "You can help surveyors understand what people with AD can and cannot do at various stages of the disease, for example," Schober says.

You may have to explain why your staff changed a medication schedule to accommodate a particular resident's behavioral pattern. Or that you are allowing a resident to forego wearing a sling for an arm cast, as an example, because it causes her extreme emotional distress to wear it. These "deviations" should, however, be on the care plan. ❖

Spirituality can provide solace to residents even in the late stages of Alzheimer's. "A lot of certified nursing assistants find that reading scripture seems to give that person a sense of peace and comfort," she adds. "It also helps the CNAs feel like they are providing good care."

Make sure to assess and treat people with AD for conditions that can make their dementia appear worse than it really is. Top on the list: depression and pain. However, the right corrective lenses or a hearing aid have been known to alleviate social withdrawal and agitation attributed to cognitive decline.

As part of the ongoing assessment process, staff should watch for behavior changes, especially agitation and aggressive behavior, which may signal depression in the elderly resident with AD. "Once you've ruled out the resident being in pain, then you can try prescribing a low-dose antidepressant" to see what effect that has on the behavior change, Schober reports. "You have to be a detective in caring for this population."❖

Alzheimer's Disease

USE VERBAL, NONVERBAL CUES TO HELP SLOW ADL DECLINE

Functional decline is an inevitable effect of Alzheimer's disease and other forms of progressive cognitive impairment. But facilities can help slow the progression of this decline — and demonstrate to surveyors that they're giving residents the highest level of care — by using a variety of strategies developed by experts.

First, perform a baseline assessment to see what the resident can do on his own. To get an accurate picture, "it's vital to actually observe someone do ADLs in an unobtrusive manner as part of the functional assessment," says **B.J. Collard**, a restorative nurse specialist and principal of **CTS Inc.** in Westminster, CO.

As part of the assessment process, **Steven Littlehale**, chief clinical officer of **LTCQ Inc.** in Bedford, MA, teaches caregivers to use a decision tree in determining the level of ADL support required by a resident, as follows:

- Self-Care with simple one-step commands: Can the resident follow simple one-step commands?
- Self-Care with physical prompts (reminders): Does the resident know what to do with items handed to her? Does she continue the activity?
- Self-Care by imitation: Can the resident copy the activity when demonstrated by caregivers?
- Self-Care by "jump starting": Can the resident continue an activity once you start it? Can he withstand distractions? Complete the activity?

"CNAs who are educated in these methods will say, 'I didn't know this person we have been dressing all along could dress herself if we just laid out the clothes in the right order,'" Littlehale says.

"Caregivers may find that residents with

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cognitive impairment can still participate in performing their own ADLs by following one-step verbal prompts," Littlehale tells **Eli**. "However, caregivers need to be educated on how to provide these type of prompts, so they can better engage residents in activities." For example, "Go to the dining room for lunch now, please" does not qualify as a one-step verbal prompt, he cautions.

The resident with mild to moderate cognitive impairment might be able to follow that same request, however, if it were broken down into four directives: "Please stand up. Walk with me. Sit here. Enjoy your lunch."

Other residents might require the directive to be broken down into even smaller bytes. "The key is knowing what works best for the individual resident," Littlehale says.

Moving Down the Decision Tree

Once verbal prompts no longer work for a resident, the caregiver can move to different levels of nonverbal interventions. "For example, some residents can perform an activity through mimicry if the caregiver mirrors it first," says Littlehale. Or the caregiver may have to physically guide the resident through the first part of the activity. "Often, once you 'start' the activity, the resident can finish," Littlehale explains.

Once residents are at the stage where nonverbal prompts work best, they will be distracted by verbal intrusions or prompting, Littlehale cautions. "So it's best to control the environment for distractions, turning off the TV or radio or ensuring privacy in the room, so the resident can focus his attention solely on performing the ADL.

"Caregivers also have to learn when nonverbal reinforcement, such as a smile or therapeutic touch, works better with a resident than a verbal reward or praise." ❖

Fall Management

MAKE SURE YOUR FALL PROTOCOLS DON'T FALL SHORT

Talk about double jeopardy. Surveyors not only hand out F tags for falls, they will cite your facility for inadequate follow-up of a resident's fall-related injuries.

The problem with falls, however, is that you can't always tell up front how serious a resident's injury might turn out to be — and along with putting residents at risk, this can put your facility at the mercy of regulators, trial attorneys and even criminal prosecution.

"Symptoms of subdural hematomas, for example, may not show up for a day or two," cautions **Barbara Miltenberger**, a nurse attorney with the law firm of **Husch & Eppenberger** in Jefferson City, MO.

"There are too many falls with no apparent injuries that turn out to be significant," agrees **Dennis Stone**, chief medical officer for **HealthEssentials** in Louisville, KY, which provides long-term care facilities with nurse practitioners. "So we have our practitioner see the patient who falls that very day, if needed, or the next day."

Facilities should thus implement protocols for managing patients immediately after a fall, including a directive to contact the attending physician, or the medical director if the attending isn't responsive, Miltenberger suggests.

"The facility's fall protocol should also include directives for staff to contact the resident's family and to report the fall to the state as a sentinel or reportable event, suggests **Joseph Bianculli**, a health care attorney with **Bianculli & Impink** in Arlington, VA. "The facility also needs an appropriate clinical protocol including neurological checks and designating who is responsible for reporting a change in condition."

Report These Parameters

Miltenberger and other experts recommend facilities inform physicians of the following objective parameters:

• Subjective complaints of pain appearing after the fall. "At HealthEssentials, we follow the old adage that an elderly white lady with pain in the hip has a fracture until proven otherwise," says Stone. "Also, any persistent pain should always be x-rayed."

• The results of neurological checks.

• Information about relevant medications the resident is taking, especially any form of blood thinner, such as aspirin, Coumadin or heparin. These drugs place the resident at high risk for intracranial bleeding from bumps on the head.

• Pertinent medical history, such as seizure activity or clotting disorders.

"The facility policy should require the nurse to document in the nursing notes the specific information given to the physician," says Miltenberger. "It's then the physician's call as to whether a head scan is warranted." The physician evaluations and head imaging (CAT, MRI or PET) are separate from the facility's Medicare PPS rate.

Buck Stops With Facility

Don't be lulled by a physician saying the patient is OK after a fall, however, especially if you sense otherwise.

Bianculli reports a recent immediate jeopardy case where a facility called the physician after a resident fall. The physician came to the resident's bedside and pronounced her to be uninjured. "The woman died from a ruptured spleen the next night," Bianculli says. "However, the coroner can't tell if the spleen was injured from the fall, the CPR performed by staff when they found the patient unresponsive — or due to the patient's longstanding cirrhosis of the liver."

Even so, the facility got tagged with IJ and failure to report a change in condition. The lesson is, of course, that even if the physician gives the patient a clean bill of health after a fall, the facility should continue to monitor the resident following its own evidence-based protocol.

"The facility can, if necessary, send the patient to the emergency room, if it cannot obtain satisfactory medical evaluation or treatment" from the attending physician, says Bianculli. ❖

Survey Appeals

ALJ RULINGS PROVIDE INSIGHT INTO WINNABLE APPEALS

To appeal or not to appeal: That's the big decision when your facility disagrees with survey citations. Looking at published appeals decisions can provide clues to which issues are — and are not — likely to win sympathy from administrative law judges.

Facilities can also use an ALJ ruling as an argument for challenging a deficiency in an informal dispute resolution, says **Howard Sollins**, a health care attorney with **Ober/Kaler** in Baltimore.

Below are some highlights of ALJ decisions presented by **Anne Hall**, assistant regional counsel, for Region IX with the **Department of Health and Human Services**. Hall spoke at the recent **American Health Lawyers Association's** annual Long-Term Care and the Law conference:

• **Failure to follow the facility's own internal policies and procedures.** In this case, a facility was found out of substantial compliance and had its provider agreement terminated for several deficiencies. While the ALJ upheld the **Centers for Medicare & Medicaid Services'** determinations and termination action, the ALJ did find that a facility's failure to follow its own policies and procedures under F325 (adequate nutrition) does not establish a basis for a deficiency unless the protocol includes a regulatory requirement. This ruling is important, as surveyors often cite facilities for failing to follow internal protocols that exceed what the government actually requires.

However, the ALJ upheld a deficiency cited under F309 where documentation showed the facility's nursing staff failed to question a physician's order for the resumption of Lasix, a diuretic, to a resident who had signs of dehydration. (DAB CR746, Feb. 23, 2001)

• **Overreliance on alarms to prevent resident elopements.** In this case, the ALJ sustained CMS' determination of immediate jeopardy and a civil monetary penalty of $10,000 per day. The ALJ found that a facility had failed to monitor a resident known to be at high risk of elopement who wandered from the facility and died of exposure.

The judge said the staff's reliance on an alarm device, Wanderguard, was inappropriate, considering the facility knew that residents wearing alarm bracelets could leave the facility without triggering the alarm. (DAB CR775, March 21, 2001)

• **Alleged resident sexual abuse committed by a family member.** Here's one where the ALJ ruled in a facility's favor. The ALJ concluded CMS had no basis for imposing remedies in a case where the roommate of the resident reported seeing a resident's son sexually abuse her at the facility. The administrator directed that the son be prohibited from visiting the resident without supervision.

CMS argued that under federal regulations, even a single incident of abuse requires a facility

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be found out of compliance. The ALJ countered, however, that facilities are only required to take all necessary steps to support a resident's right to be free from abuse.

As to the facts of the case, the ALJ found no credible evidence that the resident's son sexually abused the resident, other than hearsay. (DAB CR818, Sept. 14, 2001)

• **Resident injured during one-person assist transfer.** In this appeal, the ALJ concluded the facility had failed to comply with F324 (accident prevention) when on at least two occasions the nursing staff used one person to transfer a resident the facility had determined required a two- or three-person assist.

On both occasions, the resident was injured during the transfer. The judge sustained CMS' determination of noncompliance and a per instance civil monetary penalty of $1,500. (DAB CR845, Dec. 13, 2001)❖

Risk Management

HEAD OFF CITATIONS, LIABILITY CAUSED BY TEMP STAFF

A nurse from a temporary agency leaves a resident unattended in the bathtub and he slips and falls trying to climb out on his own. Luckily, the resident isn't injured, but the facility lands on the fast track to decertification.

As unfair as it may seem, a defense built on "the temp nurse did it" won't hold water with surveyors. The **Centers for Medicare & Medicaid Services** takes the position that the facility is ultimately liable for what goes on in its facility.

That's also true under most state licensing laws, according to **Harvey Tettlebaum**, an attorney with **Husch & Eppenberger** in Jefferson City, MO. "As a practical matter, the facility is responsible no matter what in today's marketplace," he adds.

With that in mind, facilities can take the following steps to oversee temporary and private duty staff and mitigate survey and litigation woes.

• **Set uniform standards for temp or private duty staff.** "These would include a criminal background check, training, expected conduct while on duty, and the person's willingness to adhere to the facility's corporate compliance program," says Tettlebaum. "There should also be procedures for notifying the family if the private duty person becomes unacceptable."

• **Maintain written evidence of abuse screening.** Many state laws require temporary agencies to screen employees whom they send into nursing homes. If the agency does such screening, "ask the temp staff person to bring a copy of her background screening from the agency the first time she works in the facility," suggests **Richard Butler**, president of **Survey Management** in Indianapolis, IN. Otherwise, the facility should perform its own background check.

"The facility can also refuse to allow families to employ a person as a private duty nurse unless a criminal background check has been completed by the facility at the family's expense," Tettlebaum adds.

• **Perform background checks on temporary agencies.** Temp agency staff aren't the only ones in need of a background check. "At the very least, make sure the agency has liability insurance and is paying its various obligations," suggests **Rick Carter**. Carter is president and CEO of **Care Providers of Minnesota**, an **American Health Care Association** affiliate that has been instrumental in getting Minnesota to pass a state law requiring temp agencies to meet standardized requirements.

• **Spell out and follow training and orientation requirements.** The facility can require that the temp staff or private duty person show successful completion of the state and federally required training before working in the facility.

Butler recommends the facility also have a system to orient all temp or private duty caregivers to the facility and to the specific residents assigned to them. "The facility should … ensure the temp staff is capable of caring for patients who have complex comorbidities or skilled nursing procedures."

• **Try to limit temporary and private duty staff to your own staff or those familiar with the facility.** For example, some facilities are allowing facility staff to moonlight as private duty nurses hired by residents' families. "The advantage is that the facility knows the private duty staff is credentialed and the facility has better oversight and coordination of care," says **Howard Sollins**, a health care attorney with **Ober/Kaler** in Baltimore. Facilities can also ask temporary agencies to supply a regular group of staff that is familiar with the

facility, if possible, Carter adds.

• **Seek indemnification from financial liability.** Of course, the facility can't contract away its liability from survey sanctions. But it can attempt to pass along financial liability and damages resulting from the acts or omissions of a temp agency or private duty staff person. The facility's contract with the temporary agency, for example, should include an indemnification provision.

"The facility would also be wise to require the family to hold the facility harmless and to indemnify it from the negligence of the private duty person," suggests Tettlebaum. "Or the facility could require the private duty person to carry casualty insurance naming the facility as an additional insured entity." ❖

Federal Developments

LEGISLATION WOULD MAKE SURVEYS KINDER, GENTLER EXPERIENCE

Legislation introduced in Congress March 20 would transform surveys into a more collaborative process between the government and nursing home providers with a goal toward improved resident care.

The Medicare and Medicaid Nursing Facility Quality Improvement Act of 2002 (H.R. 4030), introduced by Rep. **Dave Camp** (R-MI), would reward excellent facilities and extend a helping hand to those struggling to meet regulatory requirements for quality of care.

Camp's bill would enable nursing home inspectors to advise providers on ways to improve services for residents, which current regulations prohibit. The legislation would also shorten the waiting period for resumption of on-site nurse training associated with some survey penalties. Nurse aide training programs could resume as soon as the problem that led to the penalty is corrected and verified by inspectors. Current law prevents facilities from training certified nursing assistants onsite for two years after the problem that led to the prohibition.❖

Federal Developments

CMS GIVES GREEN LIGHT TO FEEDING ASSISTANTS

Nursing facilities will get some staffing relief under a proposal unveiled late last month.

The **Centers for Medicare & Medicaid Services** proposes allowing trained feeding assistants to help residents eat and drink, especially at meal times. Individuals would be required to complete a state-approved course to qualify as trained assistants.

Currently, only certified nursing assistants and other health care professionals, or family and volunteers can help residents with this task. HHS envisions that students and retirees may serve as feeding assistants. CMS published the proposed rule on feeding assistants in the March 29 *Federal Register* with a 60-day comment period.❖

Abuse Prevention

SURVEYORS GET MARCHING ORDERS ON ABUSE REPORTING

Expect state survey agencies to do a better job reporting resident abuse to law enforcement and Medicaid Fraud Control Units, if they follow a strongly worded directive from the **Centers for Medicare & Medicaid Services**.

In a March 28 letter to state survey agencies and CMS regional administrators, CMS Survey and Certification Group Director **Steven Pelovitz** clarifies agency policies on abuse and lays out the time frames within which states must process allegations of misconduct.

The missive comes in the wake of a March 4 Senate hearing that highlighted horrific instances of nursing home abuse and a **General Accounting Office** report stressing that abuse allegations too often go unreported.

The letter stresses that, if a survey agency validates a finding of abuse, it "must report the substantiated findings to law enforcement and, if appropriate, the Medicaid Fraud Control Unit." ❖

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Risk Management

FACILITIES GET LIABILITY INSURANCE BREAK FOR MATTRESS SYSTEM

A new campaign claims that a highly touted new mattress and treatment system appears to be appealing to residents and liability insurers alike.

Because of its beneficial effect on pressure sores, the use of a specially designed mattress, coupled with a treatment program of special salves and ointments, can reduce the cost of nursing home liability insurance, according to **Bentley Lipscomb**, director of the Florida **AARP**, the *St. Petersburg Times* reports. AARP is not receiving any financial gain from its advocacy of the program, according to Lipscomb.

A pilot program at **Marriott** facilities and **Delta** nursing homes found that the system dramatically reduced the number of bedsores, according to Tempur-Med, manufacturer of the mattresses. Two insurance companies, **Marsh USA** and **Provider Alliance**, will discount policies for nursing homes that use the system.❖

Quality Improvement

QI PROJECT RESULTS WON'T PLEASE ALL FACILITIES

The results of the pilot project to share new nursing home quality measures with the public are set to hit the streets in the next few weeks — and they might not please many nursing home administrators, the head of the **Centers for Medicare & Medicaid Services** warns.

CMS plans to run full-page newspaper ads in each of the participating states — Colorado, Florida, Ohio, Rhode Island, Maryland and Washington — when it releases the results.

CMS chief **Tom Scully** has said that "nursing homes are going to go nuts" upon seeing the compiled results from the pilot states. Some administrators may be surprised by where their facilities show up in the rankings, he suggested. But Scully thinks the project will be valuable to consumers in making more informed long-term care choices.

Quality Improvement Organizations — formerly referred to as Peer Review Organizations — expect heavy demand for their services as facilities turn to them for guidance on meeting the initiative's quality goals, according to **David Schulke**, head of the **American Health Quality Association**.

QIOs will offer some assistance, training and networking resources to facilities wishing to improve the quality of their care and, consequently, the quality of their publicly available data.❖

Pharmacology

ACE INHIBITORS MAY IMPROVE SENIORS' STRENGTH

ACE inhibitors may do more than lower blood pressure and ease cardiac overload. Researchers at **Wake Forest University** found that, among older women, use of angiotensin-converting enzyme inhibitors may decrease or even stop the loss of muscle strength in elderly women with high blood pressure, even without congestive heart failure. Over three years, compared to women taking other hypertension medicines or no medications at all, women taking ACE inhibitors retained more muscle strength and experienced a decline in walking speed 10 times less severe, according to the study, which appeared in a recent issue of *The Lancet*.❖ .

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