Oldest American lives in Lakeland

According to the Gerontology Research Group, the oldest living American is living in a nursing home in Lakeland. John Ingram McMorran, 113, is an 11-year resident of Tandem Health Care of North Lakeland who assumed the distinction in late August upon the death of 114-year-old Adelina Domingues of San Diego, CA. McMorran is one of 41 known “supercentenarians” (people at least 110) on the planet, only 11 of which are men. See “GRG,” page 6.

Insurance task force

Gov. Jeb Bush has created the Select Task Force on Health Care Professional Liability Insurance to address the “impact of skyrocketing liability insurance premiums on healthcare in Florida.” The task force will hear testimony from experts, consumers and a broad range of stakeholders, and will submit a report of its recommendations and/or proposed legislation to the governor, Senate and House by January 31, 2003. For detailed bios on each task force member and for more information, go to www.myflorida.com.

Transportation disadvantaged program marks ten years

LTC patients and residents benefit

The Florida Commission for the Transportation Disadvantaged celebrated ten years and literally millions of trips transporting people who would otherwise be unable to get around or purchase transportation for themselves. CTD coordinates transportation at the community level, and last year alone, over 51 million trips (14 million medical trips) were provided through the coordinated system.

The program is funded by the legislature and by a unique “check off” program that allows Floridians to donate to their county TD program when they renew their vehicle registrations. To learn more about the Commission for the Transportation Disadvantaged or to contact a community transportation coordinator in your area, call the TD help line at (800) 983-2345.

Going, going, gone

Twenty Florida nursing homes have closed since January; funding cuts could trigger even more closings

Elder care advocates are closely watching a disturbing trend emerging across Florida — the unceasing wave of nursing home closings that has already removed more than 1,700 licensed beds — two percent of the total number — from the state “pool.”

Nursing homes large and small in both urban and rural areas have closed, some giving little advance notice. In the case of the urban closings, patients were placed in nearby facilities that had available beds. Rural facilities that closed caused families to have to look as much as 50 miles away to find a facility that could take their family member.

“We are witnessing exactly what we predicted would happen,” FHCA President Kelley Rice-Schild said. “If our homes can’t make it, they close and their patients have to look elsewhere for the care they must have to live.”

More to come?

The reasons for the closings vary, but a too-common cause is the fatal combination of insufficient patient reimbursement and increased facility operating costs caused by skyrocketing premiums for general and professional liability insurance. Worse, because insurance is scarce and facility coverage often inadequate, financial institutions are reluctant to lend, which closes off any chance for a financially troubled facility to stay in business. If cuts in Medicaid

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JFK and me

Keep your eyes wide open, but never lose your idealism

Even though I was just a baby at the time of his death, John F. Kennedy is still my favorite American president. Here was a man who was young, good-looking, Irish, Catholic and a Democrat, but for me, what sets him apart from others was the plain and simple way he summarized his political point of view. When asked, he would say, “I am an idealist, without illusions.”

I’ve long since lost all my illusions about caregiving, a profession to which I’ve devoted 20 years of my life. Caring for our elderly patients in Florida is a tough job, plain and simple. It’s very hard work dealing daily with chronic and terminal illness, once bright minds dimmed due to Alzheimer’s disease, a general public that seems uninterested in our mission and a news media that believes that good care by devoted people isn’t worth reporting on. Still, I cannot stop being an idealist, and if I may say so, neither should you.

My ideal world

In my ideal world, all nursing homes and assisted living facilities strive to put quality patient care first (see Lynne Fagan’s interview). The feds and the state reimburse all long term care providers for the real cost of caring for their patients. My ideal world also has plenty of nurses ready, willing and able to go to work, regulators who are reasonable and even-handed and a public that values our work as vital.

But back here in the real world, things aren’t quite so perfect. Every segment of the health care system is struggling with containing costs, the liability insurance crisis, staff shortages, over-zealous regulators and trial lawyers, and quite frankly, too many providers who don’t have their priorities in order.

Some fellow “idealists”

One more plain and simple truth: FHCA cannot solve all these problems by itself. Instead, we will look to other respected advocates who share our desire to ensure that all Florida citizens get the care they deserve. Florida AARP, for example, shares our firm belief that quality care should come first and that funding for elder care services should be increased. Do you think FHCA and AARP (along with their more than three million Florida members) can join together in promoting positive LTC legislation in Florida? You bet we can!

There are many other similar-thinking “idealistic” Florida groups who can stand with us, including the Florida Association of Homes for the Aging, the Florida Hospital Association, the Florida Medical Directors Association, the Florida Medical Association, the Florida Association Directors of Nursing Administration and the Florida Association of Nurse Assistants, among others.

Trendsetters

In his groundbreaking 1982 book, “Megatrends,” author James Naisbitt described Florida as a “bellwether” state, meaning the other 49 states look to us because what happens here today will happen in the rest of the nation in the future, and that’s particularly true in elder care. So as the rest of the nation watches, now is the time for all “idealists” to work together toward improving the lives of our patients and residents.

President Kennedy stated it better: “Let us go forth to lead the land we love, asking His blessing and His help, but knowing that here on earth God’s work must truly be our own.”

Note to Pulse readers

In addition to all FHCA members and associate members, FHCA Pulse is also mailed to legislators, opinion leaders, reporters and state/federal regulators in Florida. The wider distribution allows others to better understand long term care and the daily challenges faced by the nursing homes and assisted living facilities we represent.
FHCA's plainspoken Past President, Lynne Fagan, talks about the past, present and future of long term care

Pulse: What was it like when you first started in long term care?

Fagan: It was almost 30 years ago when the local Catholic parish in Daytona Beach convinced my father, Dr. B.J. Lacour, a pediatrician, to take responsibility for their home for retired priests. My father asked me to take the administrator/bookkeeper position for the 40-bed facility. There was one nurse and a dietary director in addition to the aides, and that was it. The regulations were a thin notebook and there were no CON requirements, although we had to have a license from the state. We felt like the facility was a retirement home, but our residents required nursing care as well.

Pulse: What factors led to your selling your 48-bed Holiday Care Center earlier this year?

Fagan: It wasn’t my illness. We simply determined we could no longer meet the requirements and provide the care given the increased staffing standards and the insufficient reimbursement. Now, a 48-bed facility basically has to meet the same staffing requirements as an 80-bed facility, but without the additional reimbursement revenue. The minimum staffing formula is one licensed nurse for every 40 residents, so a 48-bed has to staff the same as an 80-bed.

Pulse: What are you most proud of in terms of your career in long term care?

Fagan: Working with dedicated providers who really care about the residents in their facilities. I have had the opportunity to work with the best and the brightest. I’m also proud I was a responsible long term care provider and never went bankrupt. Even though the times got tough, I always paid my bills. We refinanced to pay our bills rather than taking money out of the company. How can you justify a company going bankrupt and then taking the money after not paying your bills? What about the food supplier, the paper and goods supplier, the therapists, and so on? They need to be paid too.

Pulse: You helped make many important decisions during your long association with FHCA.

Fagan: Yes, and I was on the committee that hired Bill Phelan 21 years ago as the Executive Director. It was an excellent decision, perhaps our best.

Pulse: How did you get involved with FHCA? It ultimately led to your being elected President.

Fagan: I was always very involved in the association and representing members’ interests with the regulatory agency. I have always been interested in rule development and implementation because it is what we have to live with in doing our life’s work. I am very proud of Kelley Rice-Schild, who just became FHCA President and the first female since me to be president. Her grandparents started FHCA almost 50 years ago. Kelley represents the committed providers and does a damn good job. The times continue to be difficult with increasing regulations and public payment concerns, not to mention the continuing liability challenges. Her leadership will be critical for FHCA.

Pulse: You also served on the original task force that established Florida’s superior-standard-conditional rating system and on the task force that years later recommended its elimination. What do you think of the replacement, the “Gold Seal” program?

Fagan: Getting the Gold Seal is so tough that few providers will ever consider it possible for them. For one thing, the required certified audit costs about $6,000. How do you justify that expenditure when you also have staffing and other costs that better justify the expenditure?

Pulse: How do you see the future of long term care in Florida?

Fagan: I foresee a decrease in nursing home beds because of the continuing constraints placed on payment, the increased staffing standards and reduced workforce and the state’s own drive to contain Medicaid costs. There’s also a federal intent to curb Medicare expenditures. I also think there will eventually be a CON for assisted living.

CONTINUED ON PAGE 5
A common dilemma facing nursing staff is what to do when doctor’s orders do not seem appropriate. Should they still be followed? Should they be ignored? What steps should be taken to protect the licensed staff and the facility?

First, nurses are required to follow doctor’s orders. However, this does not mean nurses should ignore their judgment and instincts and blindly proceed to harm a patient.

From a regulatory standpoint, a nurse is only required to challenge a physician’s order if he/she possesses the degree of knowledge necessary to evaluate the order and its effect.

**Act now**

If the nurse believes an order may be harmful to the patient, she should immediately contact the attending physician to determine if the order has been properly transcribed. Share the concerns with the physician. Get his/her rationale for the order. If the nurse is still not satisfied, the director of nursing and/or medical director should be called. Together, the three professionals should consider the degree of potential harm to which the patient is being exposed. In extreme cases, the medical director may be forced to override the attending physician. If this occurs, the medical director should meet as soon as possible with the physician to resolve the issue.

Get the pharmacist involved. Explain your concerns to him/her and ask for input. It may be a good idea to arrange a meeting among the pharmacist, medical director, nursing staff and the attending physician. If the professionals can develop a course of treatment that appears reasonable and within medical standards, the facility should be protected.

**Medication, treatment refusal**

A second dilemma involves a patient who refuses medication or treatment. If the patient is competent, he or she has an absolute right to refuse. The facility does, however, have an obligation to assess and deal with the situation. Among the approaches you should consider are:

- Does the medication have side effects that disturb the patient? Perhaps these can be alleviated.
- Is the treatment painful and can the pain be reduced?
- Make sure every deviation is recorded appropriately with information as to the “why” recorded. Keep the attending physician, medical director and director of nursing advised of the issues.
- Try innovative approaches. Respect the patient’s right to refuse medication or treatment but also try to make the process as pleasant for the patient as possible.
- Remember to protect the patient’s right to privacy. Only discuss the issue with the competent patient’s family with the patient’s permission. Document that you have obtained that permission.

**Incompetence**

The situation with the incompetent patient becomes much more complicated. First, make sure you have accurately identified the individual with legal authority to carry out the patient’s wishes. Second, explore with that individual what the patient would choose as his/her option if capable of doing so.

There may be a religious reason for why a certain treatment is being declined. In that case, the care plan team should explore alternative treatment.

Expense is not a legitimate reason to refuse necessary treatment. If the family cites expense as the issue, get the attending physician and medical director involved.

The substitute decision-maker generally cannot refuse care which could result in death absent a determination of terminal illness, persistent vegetative state or end stage condition. If such a refusal occurs without the appropriate diagnosis and the facility cannot dissuade the decision-maker, court intervention may be necessary. Act quickly.

Proxies, surrogates, and guardians cannot legally refuse comfort measures or palliative care. If they try to do so, immediate, decision measures are in order.

Involving appropriate family members in the care planning process will help resolve some of these conflicts.

The key to adequately protecting staff and the facility is to act aggressively in addressing these problems. Documentation of steps taken is critical as well.

This information is for general purposes only. Specific situations should be addressed with management and or facility attorneys.
“Any provider that puts its pocketbook ahead of its patients is simply in the wrong business and should get out, because it harms us all.”

— Lynne Fagan

**Tough times ahead?**

CONTINUED FROM PAGE 3

because with the increase in the aging population needing assistance, there will be more public dollars in ALF care. The state will have to figure out where to put all of the old people who are coming along. The emphasis on the new, expensive physical plants for private-pay assisted living will serve only those who can afford it, which is not the majority of elders. Many of the latter group can’t even afford their prescription drugs now, which leads to a spiral of declining health. The state will have to address these policy problems.

**Pulse:** What kind of job has Gov. Jeb Bush done, in your view?

**Fagan:** I think Jeb Bush recognizes the importance of long term care. His wife must be an influence, for long term care really is a women’s issue. He listened to the task force on long term care and faced up to difficult policy and budget decisions. I do think Gov. Bush should tell people thinking of retiring to Florida to plan ahead and have their own money for long term care — buy long term care insurance. Otherwise, Florida is going to have all these people who have retired with their 401Ks diminished and have no resources.

**Pulse:** How would you rate your care since your illness?

**Fagan:** Well, (AHCA’s) Susan Acker was right about the “low bed!” This bed goes down to nine inches off the floor and when you put someone like me in a bed, I will find a way to get up. Of course, my husband Dick is always right there beside me and has been wonderful. Also, having hospice and family providing care really makes a difference.

**Pulse:** Any additional thoughts?

**Fagan:** I’ve said it for the past 30 years and I’ve always tried to live by it: Put the patient first. Any provider that puts its pocketbook ahead of its patients is simply in the wrong business and should get out, because it harms us all. Also, please give my love to all the members and staff of the Florida Health Care Association.

**Going, going, gone**

CONTINUED FROM PAGE 1

reimbursement to nursing homes are made in order to offset state revenue shortfalls, still more could close, and soon.

“There’s every reason to believe this is only the beginning,” Rice-Schild said. “At some point, people who need nursing home care just won’t be able to get it. Then what?”

Despite historic elder care/lawsuit reform legislation approved in 2001, lawsuit filings continue across Florida and liability insurers have yet to offer the coverage facilities must have by law. Many facilities are only one lawsuit away from having to close, Rice-Schild said.

**Closed since January**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of CON beds</th>
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<tr>
<td>Apalachicola Health Care Center</td>
<td>60 Apalachicola</td>
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<tr>
<td>Bay St. George Care Center</td>
<td>90 Eastpoint</td>
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<tr>
<td>Centers for Long Term Care</td>
<td>120 Venice</td>
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<tr>
<td>Crystal Springs Nursing Center</td>
<td>180 Thonotosassa</td>
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<tr>
<td>Fawcett Hospital Skilled Care Unit</td>
<td>25 Port Charlotte</td>
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<tr>
<td>Florida Christian Health Center</td>
<td>120 Jacksonville</td>
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<tr>
<td>Gulf Coast Nursing &amp; Rehabilitation</td>
<td>103 Clearwater</td>
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<tr>
<td>Holiday Care Center</td>
<td>60 Daytona Beach</td>
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<tr>
<td>Holmes Regional Continuing Care</td>
<td>30 Melbourne</td>
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<tr>
<td>IHS of Florida at Sarasota Pavilion</td>
<td>180 Sarasota</td>
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<tr>
<td>Mariner Health of DeLand</td>
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<tr>
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<td>55 Pinellas Park</td>
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<tr>
<td>Pasco Nursing &amp; Rehabilitation</td>
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<tr>
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<td>Tampa Oaks Healthcare Center</td>
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<tr>
<td>Transitional Care Center at South</td>
<td>20 Miami</td>
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<tr>
<td>Vanderbilt Life Center</td>
<td>71 Tallahassee</td>
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<tr>
<td>Victoria Martin Nursing Home</td>
<td>38 St. Petersburg</td>
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* Closed for renovation

**News from across Florida**

Rob Yandek was honored by FHCA recently as the 2002 winner of the Willis J. Gregson Award for outstanding FHCA Associate Members. The award recognized Yandek’s long history of service to FHCA members.

Sen. Richard Mitchell (D-Jasper) meets with patients at TimberRidge Nursing & Rehabilitation Center during a recent campaign stop in Ocala.


FHCA Pulse welcomes news items, press releases, photos or guest articles of 500 words or less. For information, call (850) 224-6242. You may fax items to (850) 224-9823. Information also can be mailed to: Florida Health Care Association, P.O. Box 1459, Tallahassee, FL 32302-1459.
ALFs can get sales tax exemption, refund

Why pay more tax than you must?

Did you know that approximately 25 percent of an assisted living facility’s utility bill is comprised of federal, state, and local taxes? As an ALF operator, you may now be able to take a bite out of these charges to the tune of hundreds, possibly thousands, of dollars a year.

How it works

Based on the guidelines established by the Florida Department of Revenue, a nursing home or assisted living facility may qualify for Florida sales tax exemption when all the electricity or gas used in the facility is necessary for the ultimate care and daily living needs of the residents and is not consumed for non-exempt purposes or commercial activities. If your facility does qualify for the tax exemption, you may also qualify for a refund of taxes that have already been paid.

“Non-exempt” use or “commercial activities” includes the consumption of energy in a part of the premises used for conducting activities of a commercial nature, and not directly related to the care or daily needs of the residents. “Non-exempt purposes” includes, for example, a portion of the premises used as a bank or travel office. Such commercial activity would also include the rendering of therapy to non-residents.

All or nothing at all

There is no partial exemption granted, it’s all or nothing. However, if the area used for non-exempt purposes is separately metered, the facility will receive an exemption for the portion used for exempt purposes — i.e., the ultimate care and daily needs of the residents.

To apply for this exemption, complete the exemption forms that should be available from your local utility company. To apply for a refund on taxes that have already been paid, complete a refund form that should also be available from your utility company. If your facility is eligible for the tax exemption, your utility company should then calculate all taxes that have been paid by the facility during the period specified in the application form, within five years of application date, and refund the account accordingly.

More info

Contact Tony Marshall at the Florida Health Care Association at (850) 224-3907 or the Florida Assisted Living Affiliation at (850) 383-1159 for more information. Our thanks to Florida Power & Light Company for their efforts in notifying their customers of this exemption. We have examples of the Common Use Facilities Exemption and Application for Refund documents that Florida Power & Light uses that we can provide if your local utility company is unable.

GRG tracks world’s oldest

Investigators research and authenticate age claims

It was the Gerontology Research Group that authenticated the age of the oldest living American, John Ingram McMorran of Tandem Health Care in Lakeland (see “Update,” page 1).

The GRG, with chapters in Los Angeles, New York and Washington, D.C., investigates and authenticates claims of “supercentenarian” (older than 110) status made from across the world. The group was founded in 1960 as an educational not-for-profit organization made up of physicians, scientists, engineers and interested lay persons. Its goal is to educate its members on the latest progress on theories of aging and their long-term implications for clinical practice.

GRG says it is investigating the cases of three Floridians who claim record ages:

- Mary Parr lives in St. Petersburg and says she was born Feb 1, 1889 in Mishawaka, Indiana. If proven true, she would be some four months older than McMorran, and thus the oldest living American. The GRG has already found a 1900 census match (which also matches the names of her parents and siblings) that lists Parr as 11 years old. She moved to Florida in 1966 and currently resides in an elder care facility.

CONTINUED ON PAGE 15
Does this sound familiar? You need a nurse or CNA so as not to fall below minimum staffing standards and day two is rapidly approaching. You get on the telephone and start calling local health care services pools. “I need a late call right away,” you tell the voice on the other end. “I know it’s almost midnight, but my hours are down, my DON and ADON have already worked 16 hours today and I’m desperate.”

Eventually you find a nurse, but what kind of nurse will you get? And more important, what will it cost you? The price of the shift may be just the tip of the iceberg, because in many instances there are “hidden” costs you should recognize and guard against. Careful preparation can save you, your facility and your patients from exposure to unnecessary risks, and it’s your duty to take these precautions.

**Must have**

You should never use an agency for which you do not have the following three items on record:

- **Licensure:** Many “agencies” out there are not licensed by the Agency for Health Care Administration, even though the law says they must be. So first, check out the list of currently licensed HCSPs via the Internet by going to [www.floridahealthstat.com](http://www.floridahealthstat.com) and clicking on “Find a Health Care Facility” from the drop-down box menu under “Interactive.” Then, from the “Facility Type” drop-down box menu, click on “Health Care Services Pools” and follow the instructions.
- **Insurance:** Copies of their current professional and general liability binders, as well as their worker’s compensation coverage.
- **Agreement:** A written agreement that states:
  1) The agency meets all the requirements of Chapter 400.980, Florida Statutes, as well as Rule 59A-27, Florida Administrative Code, governing Health Care Services Pools; and
  2) If the agency uses independent contractors, they are identified as such and the agency has provided evidence of both worker’s compensation coverage and professional liability insurance coverage for each and every independent contractor utilized.

As FHCA Legal Consultant Karen Goldsmith often says, facilities should always have a written contract with the agency that spells out the responsibilities of each.
Letters from across Florida

Workforce “family”
“(We are writing) to express our appreciation for what we believe was excellent service by the dedicated employees and caregivers at Southern Pines Nursing Center… Please pass on our appreciation to the ‘workforce family’ who are indeed a special group of people.”

—Robert and Diane Fries, New Port Richey, thanking administrator Kitty Walsh and staff for the excellent care given Robert’s mother, Barbara Ruckh.

Extended family
“As I visited the facility, it occurred to me that society sees these residents as “old used-up people,” but that was never the attitude displayed by the staff. I really came to think of the staff as an extended family. I will certainly miss you all and keep you in my prayers thanking God for you and praying that he will continue to bless you in all your good works.”

—Dorinda Futch, Lakeland, to Wedgewood Healthcare Center administrator Bob Murphy, in praise of the care her grandmother received while at the facility.

Reassuring words
“Whenever I would leave (Aunt Claudia), I asked the nurse on duty to look in on her and take care of her. Every time I got the same response, ‘I sure will!’ I don’t know if the nurse on duty realized what those simple, reassuring words meant to me. I gained a new appreciation and respect for the nurses who work with these nursing home residents on a daily basis. Their patience and understanding in working with the elderly is amazing to me.”

—Angie Murray, Jacksonville, writing to administrator Alice Wilbur and the nurses and staff at All Saints Nursing Home in Jacksonville.

Comfortable and pleasant
“For two weeks I was a resident at IHS of Lakeland at Oakbridge. The cheerfulness of the nurses and their assistants helped make my recovery both comfortable and pleasant… My successful recovery from surgery is due in large part to the dedication of a very capable staff at IHS.”

—Ruth A. Sommer, Lakeland, a former rehab patient, writing to administrator Scott Allen.

Lots of love
“We saw how very much they cared for her and we are very thankful. In this very difficult time in our lives it is comforting to know that our mother was surrounded by such wonderful people who not only cared for her, but also showed her lots of love.”

—The Pina Family, Hialeah, to the staff at Heartland Health Care Center-Miami Lakes

Precious and peaceful
“I wish I had the ability to express our thanks and the heartfelt love my brothers and I have for each one of you that made our mom’s passing on to Heaven such a precious and peaceful experience… May God continue to bless each one of you as you continue to serve those around you!”

—Donnie Fussell and family, Hilliard, to the staff at Life Care Center of Hilliard

Your Prescription for Success

Over the past 31 years, KPS has gained the knowledge and experience necessary to meet the ever changing needs of our pharmacy customers in the senior care industry.

We are dedicated to delivering quality, cost-effective pharmaceutical care with a commitment to customer-defined service and a focus on maintaining the highest standards of ethics, integrity and compliance.

KPS offers flexible pharmacy distribution systems, consulting services, infusion therapy, enteral therapy and disease state management services with reliable delivery, accurate billing and flexible PPS pricing programs.

To learn more about your prescription for success, visit us online at www.KPS-Rx.com or call us

1.866.KPS.DRUG

KPS South Florida 1.800.432.4902
KPS Central/Southwest Florida 1.800.642.4262
KPS North Florida 1.877.268.1322
One of the most significant decisions a facility will make will be whether or not to take the steps to “Baker Act” a patient. The Baker Act, also known as the Florida Mental Heath Act (Chapter 394, Florida Statutes), is intended to “ensure that the rights of all persons whether voluntarily or involuntarily admitted to a treatment facility for services are protected.”

How can we most effectively deal with patients who could be a risk to themselves and/or others, including other patients? We are responsible for assuring the rights of all residents are protected from unnecessary voluntary or involuntary admissions for evaluation to a psychiatric treatment facility. We are also responsible for the safety and well-being of all our patients. You can be certain Agency for Health Care Administration surveyors will check a 100 percent sample of all patients who have been discharged to a psychiatric facility since that last survey. Are you 100 percent certain that your facility is adhering to compliance standards?

Problem behaviors

I attended AHCA surveyor training on the Baker Act recently and the message was clear: The Baker Act is not always the answer to problematic psych-related behavior. Presenters frequently mentioned the “reality of unstated expectation,” a mistaken belief held by some providers that “Baker Acting” will solve the problem behaviors. They believe the patient will return from a psychiatric hospitalization both cured and stable. Unfortunately, many of us have experienced the reality that the hospitalization may only be part of the solution. Returning patients are often still in the tenuous process of having medication titrated, adjusted or discontinued.

We as long term care professionals must balance the decision of whether or not to “Baker Act” against clear and convincing evidence that it is necessary and that the facility first did everything within its control to provide appropriate, timely and resident-specific interventions. Surveyors will look closely at the patient pre-Baker Act stay, and will then determine if there are potential cites.

Be certain you’ve first done everything else possible

Watch for…

**F285** Was the patient screened at admission? Did he/she have a diagnosis of mental illness or mental retardation? Was the Pre-Admission Screening Resident Review on the record? Were appropriate services provided? Explore your facility’s process for pre-admission screenings.

**F319** Based on the comprehensive assessment, the facility must ensure that a patient who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the addressed problem. The mental health sections (B and C) of the MDS will be checked to determine if the behavioral and cognitive areas were appropriately assessed. They’ll focus on specialized services, staff training and attempts to look for the underlying causes of the behavior. If drug therapy has been initiated, it will be probed to determine appropriate monitoring, dosing and response to treatment.

**F329** Surveyors will probe any psychoactive medications used to manage behaviors. Does the documentation describe what condition or symptom is being managed? Is there evidence that the patient is monitored for response to the drug and any adverse effects? Has the physician documented the risks and benefits of the psychoactive medication? Has the facility tried non-pharmacological interventions? Is there documentation that reflects that the drug improved the patient status and that behavior is improving? Check your facility policies on monitoring psychoactive medication use. Are patients on psychoactive meds being reviewed monthly as part of the facility behavior management plan? Are you aware of your patients with active behavior management plans who are at risk for a catastrophic reaction? Has your staff been educated on how to de-escalate behaviors and prevent catastrophic reactions? Surveyors were reminded that their role is not to question the facility’s medical approach, but rather to confirm the “evidence of an approach” as well as the effectiveness of the plan.

**N213** Was the safety of people within the facility endangered? What interventions were initiated by the facility? What was the response to treatment? Do the interdiscipli- nary notes match? For example, do the social workers’ notes reflect physical abuse while the nurses’ notes reflect only verbal abuse? Has the facility documented more than one change of intervention? What was the response to treatment? I suggest you examine the process for daily review of incident reports to be sure any and all episodes of patient-to-patient conflict are investigated.

The survey team will also explore F210, 202, 204 and 241, the Implementation of the Transfer/Baker Act; F250, the Baker Act examination; and F329, the post-Baker Act examination.

More documentation

AHCA’s clear expectation is that the facility will have heavy social services involvement. I strongly recommend you probe whether you have a plan for social services involvement and notification of potential BF-52s on off-shifts and weekends. You should review your behavior management policies and look at how you explore the possible causes of descriptive problematic behavior like kicking, biting or scratching during your attempts to give care. Does the facility rule out medical causes of the behavior such as pain, infection, medication side effects and impactions? What triggers the behavior? Does the physician, psychiatrist, psychiatric nurse or clinical social worker repeatedly update changes in the plan with chart documentation of on-site visits?

Reasonable, justifiable

Don’t think you can never “Baker Act” a patient, you can. Just make sure that if you reach that decision, it can be supported as reasonable and justifiable. I have undergone a complaint survey where a Baker Act transfer was reviewed, and fortunately, we met all the requirements of the F-Tag’s I’ve noted and were able to document it to the surveyors’ satisfaction. If you can do that too, you’ll improve your overall quality of care and you’ll also sleep much better at night!

Next month: More on the PASSR and doing better pre-admission assessments.
GAO reports on PPS billing practices

The report noted a shift across payment categories

On August 23, 2002, the General Accounting Office issued a report, “Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System by Changing Practices.” The report was commissioned by Senators Charles Grassley (R-IA) and Larry Craig (R-IN) to provide information on skilled nursing facility provider responses to the Medicare Prospective Payment System. In preparing their response, the GAO examined MDS initial assessment data from three points in time, the first calendar quarter from 1999, 2000, and 2001. The GAO reported that two years after the implementation of PPS, the mix of patients across Resource Utilization Group payment categories had shifted. The GAO found that fewer patients were classified in the most intensive and least intensive rehabilitation groups and more patients were classified into the high and medium rehabilitation payment groups. Although the report came short of stating any conclusions based on the study’s results, it does point out that the trend is “consistent” with the profession’s assertions that the “high” and “medium” rehab categories have more favorable payments, relative to their costs, than other categories. The GAO also points out that the share of patients initially assigned to rehab payment groups for which Congress gave additional pay increases grew, while other rehab categories remained the same or declined.

Reasons why

The report does offer some possible explanations for the shift in RUGS category classifications. First, the GAO asserts that SNFs increasingly used estimates of therapy needed instead of actual therapy delivered in assigning patients to RUGS categories. The study found that one-quarter of the residents classified based on estimated therapy minutes, did not eventually receive therapy at the estimated levels.

Second, the study found that SNFs increasingly used grace days in order to perform initial assessments later in the patient’s stay, thereby allowing facilities to provide additional therapy services resulting in the increased likelihood that patients would be classified in the “high” or “ultra high” rehab categories. The report does not go on to suggest that perhaps providers are effectively using grace days as they are intended, i.e., to postpone therapy services until patients, recuperating from a hospital stay, are ready to receive treatment. The study also found in the two years since the implementation of PPS, two-thirds of all Medicare patients, those classified into the “medium” and “high” rehab categories, received 22 percent — 30 minutes — less therapy per week, in comparing therapy minutes provided between 1999 and 2001.

If you want to read the entire 27-page report, go to www.gao.gov. Click on “Search” at the top of the page and enter “GAO-02-841.”

HIPAA privacy rules

As we previously reported, the initially published privacy rules mandated under the Health Insurance Portability and Accountability Act of 1996 had to be revised in order to eliminate any unintentional barriers to patients’ access to care. The revamped rules were finalized and published in the Federal Register on August 14th. The key revisions remove consent requirements for information disclosure connected with routine health care delivery, i.e., treatment, payment and health care operations. Instead of consent requirements, providers will have to furnish patients with a notice of the provider’s privacy practices and the patient’s privacy rights and patients will be asked to sign or otherwise acknowledge receipt of that notice. The revisions also protect entities subject to the requirements from incidental uses or disclosures of health information. The changes are also purported to dramatically reduce the paperwork for entities that have to comply with HIPAA standards.

As of August 26th, less than three percent of covered entities have filed their compliance plans required to obtain a one-year extension to the transactions and code sets compliance date, according to the Centers for Medicare & Medicaid Services. Under the Administrative Simplification Compliance Act, facilities that submit plans will have until October 16, 2003, to comply.

CMS’s Chief Operating Officer Ruben King-Shaw Jr. reminded providers that ASCA allows covered entities a one-year extension, as long as they submit a compliance plan, either by paper or electronically, by October 15, 2002. Hope you’re reading this in time to act!

CMS interest rate hikes

Effective August 8, 2002, interest on Medicare overpayments and underpayments will be calculated based on an interest rate of 12.625 percent. Medicare regulations provide for the assessment of interest at the higher of the private consumer rate or the current value of funds rate (five percent in 2002). The effective interest rate between May and August of this year was 11.75 percent, and as a result, this increase represents the highest percentage increase in five years.
On Target...
Advice for long term care professionals from one of our best

Kenyonn Demps is administrator of 120-bed Beauclerc Manor in Jacksonville. She is a seven-year veteran of long term care.

On the basics

I first started out in social services and later worked in marketing and admissions before I went back to school for my master’s in health care administration and NHA license. One thing I’ve since learned (that they never taught in school) is how to break even the most complicated problem down into its basic components. When you do that, there’s no problem you can’t solve.

On communication

I think the more you give your staff a “big picture” view of what’s going on in the facility, the better it is for them and you. For example, I explain to each CNA how the staffing formula works and what all the other departments are doing; it really brings everybody together. It seems to work, because I haven’t had to run a “help wanted” ad for CNAs in two years and we’re already all set for the new staffing levels that kick in January 1st. I wish it were that easy with nurses!

On support

We all have to stick together. I got incredible support from individual mentors like Paul Kovary, Judy Greenwald and Connie Bend, and today I have a strong “community of support” through groups like FHCA, the Florida Association of African-American Administrators in Long Term Care, my church and the American Society for Training and Development. It’s not just professional support, it’s also that personal word of encouragement from somebody who’s been there.

Building Code update

by Max Hauth

Emergency info phone line

As we approach the climax of the hurricane season, remember that the Agency for Health Care Administration maintains an emergency information telephone line for all health care providers. The information is regularly updated during an emergency event. The phone number is: (888) 774-7609. This line is for outgoing messages only.

The AHCA staff person who is on duty at the Emergency Services Function-8 desk is responsible for changing the outgoing message after the daily briefings at the Emergency Operations Center. The message will contain:

- Summary of the briefing concerning the emergency event
- Phone numbers of the AHCA Mutual Aid Offices that have been activated
- Contact persons and phone numbers of the health care member associations
- Phone number of the ESF-8 Desk
- General information concerning requirements for the re-entry (after the event).

Fire!

Florida law requires each nursing home to provide fire protection through the elimination of fire hazards. All portions of the existing facility shall comply with the requirements of the National Fire Protection Association Life Safety Code 101 for Existing Health Care Occupancy, as described in Rule 4A-53, Florida Administrative Code, and incorporated by reference and obtainable from the National Fire Protection Association, 1 Batterymarch Park, P.O. Box 9101, Quincy, Massachusetts 02269.

All fires shall be reported to the Agency for Health Care Administration, Office of Plans and Construction, (850) 487-0713, by the next working day after the occurrence. Upon notification of a fire, the Office of Plans and Construction will send a Fire Incident Report (AHCA form # 3500-0031, May 1998) to the facility. This report is to be completed and returned to the Office of Plans and Construction, 2727 Mahan Drive, Tallahassee, Florida 32308 within 15 calendar days.

Final product

The new proposed minimum construction standards for nursing homes go to the Building Code Commission this month for adoption. You can read the final product at www.floridabuilding.org.

AHCA seminar

The 18th Annual AHCA Office of Plans and Construction Seminar is being offered November 18-19, 2002 in Orlando. Call (850) 922-6437 for registration information or go to www.fdhc.state.fl.us.

(Editor’s note: Max Hauth is President, Hauth Health Care Consultants, Lakeland, and a frequent contributor to FHCA Pulse. Contact him at (863) 688-0863.)

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Having to waive essential job functions is not a “reasonable accommodation”

By Mike Miller Kunkel, Miller & Hamant FHCA Labor Relations Consultant


Expectation of assistance from co-workers held not a reasonable accommodation

Most employers know that the Americans with Disabilities Act does not require the company to excuse a disabled employee from performing the essential functions of the job. However, it is not always easy to determine when a function is “essential” and when it is merely “marginal.” The U.S. Equal Employment Opportunity Commission has stated in its regulations that removing a marginal function from a disabled employee can constitute a reasonable accommodation if it does not create an undue hardship on the employer. In a recent federal case, a truck driver contended that certain job functions which were contained in his job description, including the ability to lift over 50 pounds and frequent twisting, bending or squatting, were marginal job functions that the employer could have assigned to co-workers as a reasonable accommodation to his disability. The employee's doctor had restricted him from working in a position which required lifting more than 40 pounds or frequent twisting, bending or squatting. The employee was terminated after he could not return to work after 15 months with those restrictions. The court concluded that, even if these functions arose only infrequently, that did not make them marginal. In addition, it would be unduly burdensome for the employer to have to reassign co-workers to perform the essential functions of plaintiff’s job where, as the evidence showed, such help was not always available because plaintiff often performed his job alone. There also were safety concerns in that plaintiff would not be able to respond appropriately in an emergency situation. The court affirmed summary judgment for the employer.

Court holds that termination of employee on FMLA leave may also violate duty to provide reasonable accommodation

A period of leave may satisfy an employer’s obligation to provide a reasonable accommodation to a disabled employee under the ADA. In some situations, the employee also may be eligible for leave under the Family and Medical Leave Act. While it may be tempting for an employer to terminate a marginal or poor performer rather than allow the employee to take a lengthy period of leave, a decision from a federal court of appeals highlights the extreme care that must be taken in such cases. The employee in that case was diagnosed with breast cancer and requested FMLA leave, to which she was entitled. The employee had worked for the company for a number of years. During her leave, the employer discovered that she had not properly trained junior employees, an issue on which she had been formally reprimanded four months prior to taking leave. However, her performance was otherwise satisfactory and there appeared to be no real deadline for completion of the training. Two weeks before her scheduled return, the company fired plaintiff and she sued under both the FMLA and ADA. The trial court granted summary judgment for the company on the ADA claim, finding no evidence of disability discrimination. However, on this point the court of appeals reversed, observing that the failure to treat the FMLA leave as a reasonable accommodation could be a discriminatory act (the employee was, after all, legally entitled to take the FMLA leave). In addition, the ADA and FMLA claims both presented essentially the same issue; namely, whether plaintiff would have been fired had she not requested leave. The jury found for the plaintiff on that issue with regard to the FMLA leave, so the court of appeals sent the case back for consideration of damages under the ADA. This case again shows that an employer must be extremely careful in taking adverse action against an employee who is on medical leave.

EEOC taking close look at “English-only” policies

The U.S. Equal Employment Opportunity Commission has not been a big fan of so-called “English-only” policies (which generally require employees to speak English while performing their job duties) because of its belief that such policies may result in national origin discrimination against non-English-speaking employees. In fact, the EEOC in the last few years has stepped up its efforts in this area and continues to take a close look at these policies when they are put forth as evidence of discrimination. One recent example was a lawsuit brought by the EEOC against a Chicago-area business which was accused of discriminating against Hispanic employees by, among other things, promulgating a policy which allegedly forbade the speaking of Spanish at all times in the workplace. The employer also was alleged to have made derogatory statements to the workers and assigned them to janitorial duties which were not assigned to non-Hispanic employees. That case ended in a $240,000 settlement to six different plaintiffs. This office currently has several cases pending in which an English-only policy has been challenged as discriminatory. Therefore, it may be helpful at this point to review what is acceptable and what is not under current guidelines.

Despite the EEOC’s unease with English-only policies, courts generally have upheld them, especially when the employer has a legitimate reason for putting the policy into place. For example, one employer promulgated the policy because Spanish-speaking employees allegedly were making derogatory remarks about non-Hispanic employees in Spanish only, leading to disruption and dissension in the workplace. In a health care setting, an
Adverse event reporting to FDA

The Food and Drug Administration’s Center for Food Safety and Applied Nutrition is developing a new, comprehensive system for tracking and analyzing adverse event reports involving foods, cosmetics and dietary supplements. The FDA will use this system as a monitoring tool to identify potential public health issues that may be associated with the use of a particular product already in the marketplace. The system will involve reporting by individuals and by companies who are encouraged to report relevant information that they may be aware of involving their product. Go to the FDA Web site, www.fda.gov, for more information.

Dialysis services

A new information letter, S&C-02-39, from the Centers for Medicare & Medicaid Services provides further guidance regarding nursing home patients who are receiving end-stage renal disease services in a skilled nursing facility. The Balanced Budget Refinement Act of 1991 amended the Social Security Act to, among other things, eliminate the previous obligation of a skilled nursing facility to furnish (directly or indirectly) institutional dialysis to its patients.

Further, the SNF Prospective Payment System regulations allow the SNF the option to furnish institutional dialysis or to make arrangements for the dialysis. If the facility chooses not to provide dialysis, the patient can obtain dialysis services from an outside supplier that provides the services and bills Medicare directly for them under Part B. The ambulance service which transports the residents to and from the end-stage renal disease facility to the SNF may also bill Medicare directly for its services. Therefore, there is no longer a basis to cite the facility under 42 CFR 483.75(h) for not having an arrangement for the dialysis services. This is because the arrangement that a facility must have in place under Medicare concerns only services for which the SNF is paid. Consequently, if the facility chooses to provide the dialysis services itself under an arrangement and bills for these services through the facility, the guidance at 42 CFR 483.75(h) is still applicable. However, surveyors are still directed to cite the nursing home for dialysis problems related to a patient if there are problems in the lack of management and coordination of dialysis care and lack of staff understanding of the provision of such care under “quality of care or care plan” citations.

Pharmacy services

On September 4, 2002, CMS issued the final rule on “Medicare Endorsed Prescription Drug Care Assistance Initiative,” which can be accessed via the Federal Register at www.access.gpo.gov. One of the objectives of the rule was for Medicare to endorse qualified private sector prescription drug discount card programs based on a variety of factors and to permit the endorsed entities to market their programs as Medicare-endorsed. CMS does not require the drug discount card program sponsors to include institution-based pharmacies, but does not preclude their inclusion. CMS did state that it intended for the proposed rule to comport with the requirements of participation for long term care facilities. In its comments to CMS, the American Health Care Association stressed that the patient’s right to safety takes precedence over the right to choose a pharmacy through the discount card initiative, and that a long term care provider should never be forced to use a specific pharmacy in the face of its own judgement that the pharmacy cannot provide the needed services. CMS agreed with this comment and stated that nursing facilities can control how patients can receive medications, and may restrict which pharmacies supply drugs and pharmacy services to patients.

Ergonomics guidelines

On August 29, 2002, the Occupational Safety and Health Administration released for comment its draft voluntary guidelines on ergonomics, which is geared for all long term care providers. According to OSHA, the guidelines are intended to provide practical solutions for reducing ergonomic-related injuries and illnesses in long term care facilities and will not be used for enforcement purposes. The guidelines may be accessed on OSHA’s Web site at www.osha.gov, or you can call (800) 321-OSHA.

Federal monitoring

CMS also plans to contract with a private entity in an effort to strengthen federal oversight and monitoring of nursing facilities. The agency is looking for a private contractor to conduct some of the CMS regional office monitoring of state survey agencies’ nursing facility surveillance. CMS also plans to utilize the contractor in responding to crisis situations that endanger patients’ health and safety. By the time you read this, CMS should have awarded the contract so we will let you know more information as it is released.

Gifts

The U.S. Office of the Inspector General has just issued a special advisory bulletin alerting health care providers as to the scope of acceptable practices in this area as allowed by the law. Under the law, a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows (or should know) is likely to influence the beneficiary’s selection of a particular provider, practitioner or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties of up to $10,000 for each wrongful act. The OIG has interpreted the law to exclude inexpensive gifts, other than cash, or services that have a retail value of no more than $10 individually, and no more than $50 in the aggregate annually per patient.

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Free booklet
A free consumer booklet, “Paying for Long Term Care,” is available from the American Health Care Association by calling (800) 628-8140. The pocket-size booklet helps prepare families for the costs associated with long term care and corrects major myths about LTC financing. Quantities may be purchased in packs of 25. The booklet is also available at www.LongTermCareLiving.com.

CMS rollout
After testing it out in six states including Florida, The Centers for Medicare & Medicaid Services is ready for next month’s national rollout of an improved “Medicare Compare” nursing home Web site. The www.medicare.gov site is the first to feature facility-specific “quality” information derived from patient assessments (and subsequent progress) for both short- and long-stay stays. Other consumer Web sites include only data from annual facility surveys.

New LTC chief, council
Department of Elder Affairs Secretary Terry White named Kelly W. Reed as the head of the new Office of Long Term Care Policy within DOEA. This office and a 12-member LTC Policy Advisory Council was created by the 2002 legislature to help guide long term care policy, particularly in the area of home- and community-based options to nursing homes. The advisory council is comprised of the Secretaries of five state agencies — AHCA, Children & Families, Elder Affairs, Health and Veterans Affairs — two legislators and five citizens, three of whom must have knowledge and experience in the delivery of LTC services.

VHP kits available
A complete start-up kit for the FHCA-endorsed Veteran’s History Project is now available through FHCA. The kit provides valuable guidance and all necessary forms for a facility to begin collecting the oral histories of those who served in the armed forces and those who supported them. The VHP is a project of the U.S. Library of Congress. Call Ed Towey & Associates at (850) 224-6242 for more information.
GRG tracks world’s oldest
CONTINUED FROM PAGE 6

Juan Ramos of Tampa claims to have been born June 24, 1880 in Puerto Rico, which would make him 122 years old. Ramos moved to Cuba in 1888 and to the U.S. in 1993. GRG researchers doubt they will be successful in authenticating his claim because record-keeping in other countries was not always as thorough as in the U.S.

Pearl Gartrell of Jacksonville claims to be 114 years old, born April 1, 1888. Her family records were destroyed in a fire, leaving only census records and any remaining public records as the only means by which her claim could be substantiated.
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