

LONG-TERM CARE Survey Alert

Your Guide to Survey Success & Quality Innovations

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MEDICATION MANAGEMENT

Caring for Patients With Parkinson's Sx? This Review Could Provide a Critical Clue

► *Your astute assessment could cure the person's symptoms.*

If you automatically think Parkinson's disease when you see a patient with Parkinson's symptoms, you may be missing a critical assessment step.

When "a patient comes into the facility with Parkinson's symptoms or develops symptoms while in the facility, do a careful medication review to look at their current and past medications," advises **Brian J. Gates, PharmD**, at Washington State University in Spokane.

Clinical rationale: Parkinson's disease is due to dopamine deficiency in the brain. And some drugs block dopamine, which can cause Parkinson's symptoms in people who don't actually have the disease.

Look for These Common Culprits

Check for these drugs known to cause Parkinson's type symptoms:

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REGULATORY COMPLIANCE

How to Navigate DEA's Tougher Stance on Controlled Meds in Nursing Homes

► *Know what you're up against and 2 ways to work around it.*

Has tougher Drug Enforcement Administration enforcement caused your facility to experience delays in treating residents' pain? For a rundown on the clash between nursing homes' focus on managing pain — and the DEA's concerns about prescription drug abuse and diversion in the nursing home setting — read on. Experts also share tips on how facilities can keep patient care on track while complying with the tougher rules.

The basics: The Controlled Substances Act, which was enacted almost 40 years ago, hasn't changed. But last year, the DEA began saying that the resident's

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LEGISLATIVE TRENDS

Be Aware of These 2 Healthcare Reform Legislation Measures

► *Wannabe whistleblowers may soon be trolling your survey records for a qui tam case.*

The healthcare reform bill provides a new roadmap for your survey management efforts — one with a few twists and turns. Here's a rundown of what's coming down the pike.

1. A more give-and-take approach to survey civil monetary penalties. Currently a facility's survey fines are stayed until the facility

receives a ruling in a hearing, including a federal court appeal, if the facility takes its appeal that far, according to attorney **Neville Bilimoria**, with Duane Morris LLP in Chicago.

Under the new legislation, however, the Health & Human Services Secretary is authorized to place facilities' CMPs for actual harm and immediate jeopardy level citations in escrow. This would occur after the facility completed informal dispute resolution or 90 days after the CMPs were imposed, whichever came first, according to a summary of the bill by

the American Association of Homes & Services for the Aging. If a facility won its appeal, it would get its CMP back with interest. In cases where the facility lost its appeal, a portion of the CMPs could be used to pay for activities that benefit residents, including facility improvement efforts approved by the HHS Secretary.

Another provision in the new law allows CMS to discount CMPs for a self-reported deficiency by up to 50 percent when a nursing facility corrects the deficiency within 10 calendar days of the date of the CMP. (The

"If surveys can be used as a basis for a qui tam lawsuit — look out."
Neville Bilimoria, JD

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Legislative Trends

SNF Patients' Excruciating Pain Grabs Senate Subcommittee Attention

► *Nursing home provider puts a face on delays caused by DEA restrictions on controlled meds.*

Senate lawmakers recently received an earful from frustrated nursing home providers weary of DEA red tape that the providers say is having a negative effect on patient care.

In a Senate Special Committee on Aging "listening session" convened in March to examine the impact of a DEA clampdown on narcotic medications in nursing homes, a facility administrator relayed how a patient in severe pain failed to get the pain relief she needed — even though it was readily available.

The case involved an elderly woman admitted to the SNF on a Thursday in February 2010 after surgery to repair her lumbar (L2) vertebrae. The woman's physician prescribed a Fentanyl patch, which provides continuous drug delivery, along with oral Percocet every four hours for break-through pain. By Saturday, however, the patient's pain had escalated to the point that the facility staff realized that the patient's supply of the Percocet would be gone much sooner than anticipated, the administrator told lawmakers.

Long story short: The facility staff contacted the attending physician to get a renewed prescription. Meantime, the facility had extra Percocet in its emergency kit to give the patient when her supply ran out. Yet, the staff couldn't legally give it to her without a prescription from the physician, the administrator testified. By Monday just before noon, "the patient's pain had become so intense and unmanageable that she had to be transported by ambulance back to the hospital emergency room." "Ironically," around that time, the pharmacy also received the doctor's prescription for the medication, but it was too late. Once hospitalized, the woman had to receive IV pain medication and an epidural to manage her pain, the administrator relayed.

Testimony also revealed that the DEA's actions are taking a toll nationwide. According to a survey conducted in 46 states by the Quality Care Coalition for Patients in Pain, 65.4 percent of nearly 900 clinicians had experienced delays in getting controlled medications to their patients (www.ascp.com/advocacy/qccpp/report/). Among respondents specifying the length of the delay, 40 percent reported up to a day — "another 40 percent reported delays of up to two days and 12 percent reported delays of two or more days." ■

*Medication Management, continued from cover***Dopamine-blocking agents.**

The older generation of antipsychotics, such as Haldol, is perhaps the most notorious for causing Parkinson's type symptoms, which are usually referred to as extra-pyramidal symptoms (EPS). But don't be fooled: While the atypical antipsychotics tend to be less likely to cause the problem, they can do so, depending on the dose, Gates cautions.

Some anti-nausea medications also block dopamine. These include metoclopramide, which is used to treat nausea and also gastroparesis, a condition most common in people with diabetic-related nerve damage, Gates says. Other anti-nausea medications, such as prochlorperazine, also block dopamine while others, such as Zofran (ondansetron), don't, he adds.

SSRI antidepressants. The SSRIs are known to induce abnormal movements, noted **Herbert Sier, MD, CMD**, in a presentation on Parkinson's disease at the March 2010 American Medical Directors Association annual meeting. While the SSRIs affect serotonin, Gates explains, they may produce indirect effects on dopamine that contribute to the Parkinson's symptoms. Thus, "it's worthwhile to evaluate the possibility of SSRIs causing problems," if the patient isn't taking dopamine-blocking agents, such as an anti-nausea medication.

Anticonvulsants. "Anticonvulsants can cause some movement disorders although these are usually tremors," says Gates. By contrast, "some of the drugs that block dopamine produce more Parkinson's symptoms overall, such as rigidity and trouble moving rather than just a tremor."

Assume Symptoms May Be Reversible

Whether the Parkinson's symptoms go away when you stop the medication depends on the medication and other factors.

SSRI-related "symptoms do seem reversible," Gates says. And "the tremor associated with anticonvulsants would normally go away when you stop the drug," although that's not a certainty. But the tremor is likely due to the medication's effect on the person's central nervous system, he notes.

On the other hand:

Antipsychotics that block dopamine over long time periods do appear to cause more permanent symptoms, Gates observes. Ditto for symptoms caused by metoclopramide. Even so, "symptoms can be reversible if caught early enough, and in my experience, this does seem to vary with each patient."

Best practice: Consider doing the AIMS (Abnormal Involuntary Movement Scale) on patients taking antipsychotics, if your team isn't already performing this assessment (<http://rolla.mo.networkofcare.org/dd/CountyContent/rolla/AbnormalInvoluntaryMovementScaleDirections.pdf>).

Check These Meds for Patients With PD

If a resident with PD shows worsening Parkinson's symptoms, do a medication review to see if he's on a medication that could be causing or exacerbating the problem.

For example, Parkinson's drugs themselves can cause nausea and psychotic symptoms (hallucinations and delusions). And if the clinician doesn't look to see if perhaps lowering the Parkinson's drug might help

eliminate those problems, he may sometimes treat the person with dopamine-blocking anti-nausea medication or antipsychotics. And this can undermine the person's Parkinson's therapy, Gates cautions.

Instead: "The best way to determine whether a person's psychotic symptoms might be caused by [Parkinson's medications such as] Sinemet or a dopamine agonist would be to taper the medication down and observe if the psychosis lessens," says **Katherine Anderson, PharmD, CGP**, at Harding University College of Pharmacy in Searcy, Ark. However, "sometimes the psychosis is a part of the Parkinson's disease and will persist" even though the clinician lowers the Parkinson's medication dose.

In some cases, the clinician may have to add an antipsychotic, but the drug should be given at a low dose, Gates counsels. "For Parkinson's patients, the antipsychotic quetiapine is often used" for that purpose because it's associated with less EPS.

Studies indicate that clozapine may be the best antipsychotic for treating psychosis in PD, but the drug can cause neutropenia which requires ongoing blood testing to identify (see *Clin Neuropharmacol.* 2003 Jan-Feb;26(1):8-11 at www.ncbi.nlm.nih.gov/pubmed/12567158). ■

"Anticonvulsants can cause some movement disorders although these are usually tremors," says Brian J. Gates, PharmD. By contrast, "some of the drugs that block dopamine produce more Parkinson's symptoms overall, such as rigidity and trouble moving rather than just a tremor."

CAREGIVER SAFETY

5 Tips Help You Steer Clear of Sharps Injuries

► **Don't stick with this No. 1 bad habit known to cause injuries.**

Prevention is the best remedy for needlestick and other sharps injuries, which can be largely avoided if you follow these key strategies.

1. Know the ropes for safely disposing of sharps. “OSHA requires you to put the needle and syringe together in the” sharps container, says **Terry Jo Gile**, a safety expert in Ft. Myers, Fla. She also notes that OSHA requires you to close and dispose of sharps containers when they are three-fourths full.

Most containers have a line on the label indicating the point beyond which they should not be filled, adds **Dennis Ernst, MT (ASCP)**, director of the Center for Phlebotomy Education in Corydon, Ind.

An accident waiting to happen: “Nurses should not allow sharps containers to overfill,” stresses Ernst. He recounts, in fact, that he got stuck

“People have to activate the safety features and make sure they are not recapping needles, which historically has been the single most notorious behavior leading to accidental needlesticks.”

Dennis Ernst, MT (ASCP)

by a contaminated needle that poked through the bottom of an overflowing sharps container as he tried to force the container into a lock position. “The containers are puncture-resistant — not puncture-proof,” Ernst warns.

2. Always use the needle product's safety features. “OSHA mandated use of safety needles in 2001, but that solved only half of the exposure risk dynamic,” says Ernst.

“People have to activate the safety features and make sure they are not recapping needles, which historically has been the single most notorious behavior leading to accidental needlesticks.”

3. Have a plan for managing unpredictable resident behaviors. Patients, especially those in nursing home environments, can be unpredictable in how they react to having a needle come near them or pierce their skin, advises Ernst. “Nurses should stabilize the arm being punctured and make sure the person can't swing the other arm at you. Healthcare providers should seek assistance from another caregiver when that possibility even exists.”

4. Don't use the old-fashioned lancets for finger-sticks. “Lancets by law must be retractable and single use,” says Ernst. Even so, some

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Legislative Trends, continued from p. 34

provision doesn't apply to actual harm or IJ deficiencies.) Attorney **Joseph Bianculli** finds the CMP discount provision to be “peculiar” in that “most rational facilities promptly identify and correct errors and omissions” when they are aware of them. That's why, many, if not most serious deficiencies, “come as unwelcome surprises.”

Bianculli is thus unsure how CMS will interpret and apply that provision: “It's conceivable, for example, that CMS might read it narrowly to apply only to self-reported incidents.” Or CMS could apply the

provision to any citation that a facility conceded and fixed quickly, he adds.

The CMP escrow requirement and discount option go into effect in a year following the legislation's enactment, according to an American Health Care Association overview of the reform bill.

2. A free-for-all for qui tam lawsuits. Effective on March 23, 2010, the reform legislation “lifted the bar for qui tam relators to use public documents to bring a whistleblower lawsuit under the qui tam provisions in the False Claims Act,” reports Bilimoria. Previously, the whistle-

blower had to be the original source of the information about the nursing home, he adds. Although the measure actually applies to all providers, Bilimoria predicts nursing homes will be hardest hit. As Bilimoria sums it up: “If surveys can be used as a basis for a qui tam lawsuit — look out.”

Proactive strategy: “It's more important than ever for facilities to challenge survey findings through IDRs and hearings,” stresses Bilimoria. (For inside tips on doing IDR and appeals, check out the next *Long-Term Care Survey Alert*.) ■

Regulatory Compliance, continued from cover

doctor has to contact the pharmacy directly to provide a prescription for a controlled substance, notes **Al Barber**, director of pharmacy services for Golden Living, and president elect of the American Society of Consultant Pharmacists (ASCP).

Reasoning: Under the act, “the nursing home nurse can’t act as the agent of the prescriber because the nurse is not employed by the prescriber,” says Barber. Thus, the prescriber or his agent, who could be a secretary, has to call in or fax the prescription to the pharmacist, he adds.

Barber assumes, however, that for “most of the last decade,” the DEA has known that nursing home nurses would call doctors during off hours to obtain a phone order for a controlled med to treat a resident’s pain. And if that medication were in the emergency kit, the nurse would administer a dose. The nurse would then notify the pharmacy that she had removed a dose from the kit, and request however many doses required to treat the person’s pain. “The pharmacy would then request a prescription from the prescriber to cover the emergency dose and a separate prescription for

the patient’s ongoing medication needs,” Barber explains.

If you work in a SNF in a hospital and wonder if these rules apply to your SNF — they might. “Whether a pharmacy can dispense to residents in a hospital-based SNF based upon a chart order will depend on whether the hospital-based SNF is licensed as part of the hospital and included within the hospital’s DEA registration,” says **Claudia Schlosberg, JD**, director of policy and advocacy for the ASCP. “If not, then a hospital-based SNF must obtain prescriptions just like any other nursing facility.”

Be Aware of the Potential for E-prescribing

The DEA published an interim final rule on March 31 that would allow prescribers to electronically transmit a prescription for a controlled substance. Using e-prescribing, the doctor would get a phone call from the nurse at 2 a.m., for example, enter the prescription on his smart phone, and transmit it simultaneously to the nursing home and pharmacy, says Barber. The pharmacy could then provide the medication if the prescription included all the elements of a retail

prescription. The smart phone could have a fax feature if the pharmacist couldn’t receive the prescriber’s electronic transmission, Barber adds.

A catch: “Unfortunately, the vast majority of physicians in this country are not set up to do electronic prescribing yet,” says Barber. He believes, however, that in “two to three years, or maybe more like five, people will have that ability and it will help resolve a lot of these issues.”

2 Ways to Expedite Pain Management

Facilities can help ensure patients get needed pain relief by implementing these two strategies.

1. Develop a Plan B for an emergency. Nursing homes “need to have a back up plan for dealing with situations where residents are in severe and unexpected pain,” advises Schlosberg. Some experts note, for example, that having nurse practitioners onsite who prescribe controlled substances can expedite pain management in emergent situations.

2. Get hospitals and attending physicians on the case. As an example, when St. Elizabeth Home gets patient referrals from the hospital, “we ask the physician to provide the

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facilities have “squirreled away” some of the old-fashioned lancets that don’t automatically retract after using them. And use of such devices is an OSHA violation, he warns. “They pose a risk to anyone doing finger-sticks.”

5. Use safe phlebotomy procedures. If you or other caregivers at your facility draw residents’ blood for stat labs, as an example, pay close attention to your venipuncture tech-

nique. For one, never put your index finger above the puncture site while you’re inserting the needle, Ernst cautions.

Also use a safety transfer device when evacuating blood from a syringe to a blood collection tube. When drawing blood with a syringe, “OSHA wants us to activate the safety features on the needle, remove it, discard it, and attach a safety transfer

device” to fill the blood collection tubes, says Ernst. Too often, however, “the individual pulls the needle out of the patient’s vein and punctures the stopper of the blood collection tube with the same needle.” And that practice has caused many nurses to sustain a needlestick injury — for example, you can impale a finger on the hand holding the tube, he cautions. ■

OCCUPATIONAL SAFETY

Know Your Options for Managing Needlestick Injuries

► You should consider HIV prophylaxis in this scenario.

Picture this: You're administering an injection to a resident who jerks away and the contaminated needle jabs your hand. What you do next can have a major impact on whether you end up with a blood-borne infection.

Key: The Centers for Disease Control & Prevention "recommends that all healthcare workers who have a percutaneous or mucous membrane exposure to blood and body fluids seek occupational health counseling as soon as possible," says CDC's **Tara MacCannell, PhD**, an epidemiologist. That means you need to get advice within a couple of hours post-exposure at least — "and certainly within 24 hours."

Follow This Decision Tree

If you can identify the patient involved in the staff person's exposure, the facility can ask the patient (or his responsible party) permission for the patient to undergo testing for HIV, hepatitis B (HBV) and hepatitis C (HCV).

If you can't trace the needle to a specific patient (for example, a used needle left on a counter in the med room or exam room), the occupational health provider should assess the nursing home populations' prevalence of HIV and HBV to decide how you should proceed, says MacCannell.

When someone has an "unknown exposure" in a low-risk environment, the CDC doesn't recommend HIV post-exposure prophylaxis. Healthcare workers in institutions with a greater risk of HIV transmission should, however, initiate the prophylaxis, says MacCannell.

The currently recommended HIV prophylaxis typically consists of a 28-day course of Combivir, which contains AZT and 3TC, although "alternate regimens are available," she notes.

What if you have a sharps injury involving a patient who is HBV-positive? "Vaccinated healthcare workers with an unknown response to the vaccine should get an anti-HBV titer. If the healthcare worker is a known non-responder [to the HBV vaccine] or unvaccinated, they should receive

HBIG immunoglobulin and start the HBV vaccine series," advises MacCannell.

There's currently no vaccine for HCV. "The recommendation [post-exposure] is to have follow-up anti-HCV and ALT [alanine aminotransferase] levels testing to potentially identify early onset of the disease."

Reassuring news: "The rate of HIV transmission from a percutaneous exposure is very small," says MacCannell. "HCV is 1.8 percent whereas HIV is 0.3 percent."

Develop a Culture That Encourages Reporting

Your facility can enhance the chances that staff will report sharps injuries and get the ball rolling for prophylactic measures, if they need them. Whether people report does depend on the organization's culture, says **Terry Jo Gile**, a safety expert in Ft. Myers, Fla. "There's always the fear from the employees' standpoint that they might lose their job for reporting," she says.

Seattle-based long-term care expert **Nathan Lake, RN, MSHA**, thinks, however, that "most nurses in nursing homes do report needlestick injuries because you don't know if patients in the facility have HIV." ■

The Centers for Disease Control & Prevention "recommends that all healthcare workers who have a percutaneous or mucous membrane exposure to blood and body fluids seek occupational health counseling as soon as possible," says CDC's Tara MacCannell, PhD, an epidemiologist.

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narcotic prescriptions so" the SNF has those at admission, relays **Lisa Lavigne, RN**, at the East Greenwich, R.I. facility. "It's also important to

educate physicians that they have to provide that prescription to the pharmacist or the patient won't get the medication."

Editor's note: A Senate subcommittee recently held a "listening session" to examine the impact of the DEA's clampdown on resident care in nursing homes. For more information, see the sidebar on page 34. ■

MDS 3.0 CORNER

Get Up to Speed on the Latest MDS 3.0 and RUG-IV Developments

► *Check out a helpful CMS-posted Q&A on MDS 3.0.*

If you feel like MDS 3.0 and RUG-IV implementation have become moving targets, you're not alone. Here's the latest, as of press time.

- The healthcare reform legislation delayed RUG-IV implementation for a year (until Oct. 1, 2011) but not MDS 3.0. That means, absent congressional intervention or a regulatory remedy, RUG-III will remain in place until then — sort of. The legislation also calls for CMS to implement two features of RUG-IV on Oct. 1 of this year: (1) the limitation on concurrent therapy (where only half of concurrent minutes count toward rehab RUG placement) and (2) elimination of the hospital lookback for services that affect RUG classification. Industry trade

group reps say to “stay tuned” as they are seeking a legislative fix to the delay.

- CMS has completed the train-the-trainer sessions. That included training for state Medicaid representatives and state RAI coordinators, etc., in March, and industry association representatives and providers in April. CMS has posted a set of Q&As on the MDS 3.0 from its training for state representatives (www.cms.gov/nursinghomequalityinits/25_nhqimds30.asp).

Example: One question asks when a facility will no longer be able to submit an MDS 2.0 assessment or correction. CMS notes that “assessments with an ARD [assessment reference date] of 09/30/2010

must be an MDS 2.0. Assessments with an ARD of 10/01/2010 must be an MDS 3.0.” CMS goes on to note that the agency “has not determined the cut-off date for when an MDS 2.0 record may not be modified or inactivated.”

Good idea: Check CMS' MDS 3.0 page often. In April, CMS posted a new version of the MDS 3.0 item set, which includes numerous minor changes. ■

Do You Have a Reader Question?

Please send it to the editor at:
KarenL@inhealthcare.com

STRESS MANAGEMENT TIP

Tune Out Work-Related ‘To Do’ Lists and Ruminations With This Simple Strategy

► *This works well for some busy nurses, says expert.*

You have a zillion things to do at work tomorrow but you can't quiet your mind to go to sleep or relax when watching TV before bed.

One way to shift your mind into neutral, says nurse consultant **Shelley Cohen, RN, MSN, CEN**, is to do something that requires concentration on a specific task. She finds playing a handheld computer

card game at bedtime does the trick. She knows a nurse colleague who finds working a crossword puzzle takes her mind off work, allowing her to unwind for the night.

Another nurse finds getting absorbed in coloring a coloring book helps her stop thinking about a difficult day at work. In fact, that person, a director of nursing, is

known to keep some crayons and coloring books in her cabinet at work, Cohen reports. When stress levels escalate, the nurse finds that coloring for a few minutes calms her so that she can better tackle the tasks at hand, reports Cohen, principal of Health Resources in Howenwald, Tenn. ■

SURVEY & CLINICAL NEWS TO USE

AAHSA-compiled stats help you read between the lines for Medicare initiatives. For one, the numbers reveal the staggering price tag for nursing home care, which explains the government's growing interest in moving more functional individuals out of such settings. "More than 1.5 million people reside in U.S. nursing homes, at a cost of more than \$120 billion per year," notes the American Association of Homes & Services for the Aging compilation, citing "Advancing Nursing Home Quality Through Quality Improvement Itself," Rachel M. Werner & R. Tamara Konetzka, *Health Affairs*, January 2010, vol. 29, page 81.

The stats also help explain the federal government's growing focus on finding ways to rein in rehospitalization for post-acute patients. Rehospitalization rates for SNF patients jumped by 29 percent from 2000-2006, the AAHSA report notes. "By 2006, more than one-fifth (23.5 percent) of all hospital discharges to a skilled nursing facility returned directly to the hospital, at a total cost of \$4.34 billion per year to the Medicare program. ("The Revolving Door of Rehospitalization From

Skilled Nursing Facilities," Vincent Mor, Orna Intrator, Zhanlian Feng & David Grabowski, *Health Affairs*, January 2010, vol. 29, page 62)."

Doing a sleep assessment might uncover whether residents have a potential risk factor for stroke.

A major study has linked obstructive sleep apnea to a heightened stroke risk for middle-aged and older adults, according to a release from the National Institutes of Health's National Heart, Lung, and Blood Institute, which supported the study.

"Overall, sleep apnea more than doubles the risk of stroke in men," states the release. The risk occurs separate of known stroke risk factors, including hypertension and diabetes. The study also found for the first time an association between sleep apnea and stroke risk in women, although the risk is less than it is for men.

"This is the largest study to date to link sleep apnea with an increased risk of stroke. The time is right for researchers to study whether treating sleep apnea could prevent or delay stroke in some individuals," says **Susan B Shurin, MD**, acting director of the NHLBI, in the release. ■

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