ALLIANT
HEALTH SOLUTIONS

EXAMPLE LETTER
XXXXXX

ABC Nursing Care Facility
Attn: Administrator
567 Happy Lane
Happy, GA 23450

Provider Number: XXXXXX

Dear Administrator:

Alliant Health Solutions is contracted by the Department of Community Health (DCH) to perform an annual certified nurse aide staff development audit. All aspects of the staff development audit will be reviewed via the submission of verified documentation that supports compliance of the two federal regulations listed below.

- **The Code of Federal Regulations 483.35, (B), (7) requires that** "Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g)."
- **The Code of Federal Regulations 483.95, (g) requires that** "Required in-service training for nurse aides. In-service training must—(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (2) Include dementia management training and resident abuse prevention training. (3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff. (4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired."

The facility will have thirty (30) days from the closing date of the review period to mail the required documentation to **Alliant Health Solutions, Attn: Nurse Aide Training Program, P. O. Box 105753, Atlanta, GA 30348**. Please include page one (1) and two (2) of this letter along with the following documentation:

In-services conducted annually – **XXXXXX to XXXXXX**

Staff Development Documentation Request

Provider Number: XXXXXX

List of typed or printed in-services – see enclosed categorized in-service form. Include the date and time of the in-service;

- List of Certified Nursing Assistants (CNAs) employed during the review period (place a "T" if terminated or "R" if resigned next to the appropriate names), indicate whether full-time, part-time, leave of absence or PRN, date of hire and Certified Nursing Assistant's total in-service hours for the review period;
- **Attach a printed copy of current certification card or web portal print out as verification of current certification for each active CNA;**
- **CNA in-services must follow the federal guidelines - please review on page one of this letter;**
- **When recording in-services please see the attached list - choose the category in which the in-service title will fit and document the date of in-service - no other titles should be assigned to the in-service. There is a miscellaneous section to document any additional in-services and dates not listed. Please do not send a copy of individual in-service topics for each CNA. Use the in-service form enclosed to calculate the <u>total</u> number of hours for each in-service topic provided during the review year.**

<u>Please remember facility and job orientation to certified nurse aides cannot count as in-service hours.</u> A Certified Nursing Assistant has 120 days from the date of employment to transfer certification from another state to the Georgia Registry (the reciprocity form can be download from our website at www.mmis.georgia.gov). Also, frequently asked questions can be viewed on the website.

Facilities failing to mail the staff development information within the timeframe specified in this letter will receive an on-site review. Facilities cited for non-compliance will receive a letter detailing the deficiency and will have thirty (30) days to submit a corrective action plan. Those failing to submit a corrective action plan will receive an on-site facility visit. Random unannounced visits for follow-up validation will take place in order to perform quality assurance of the program. Please share this information with your staff.

Please find enclosure forms that will assist you in providing the needed information we are seeking. Please be advised they were designed to capture the information needed for our review. Copies of the blank forms can be found at www.mmis.georgia.gov/ click nurse aide/medication aide tab and go to Section IV and click on Staff Development Letter and Forms. Please keep a copy of all letters and reports from Alliant, because the state on-site surveyor may request to review the letter and/or report from Alliant.

If you have any questions or concerns please contact Mary Vaughan at (678) 527-3607.

Respectfully,
Nurse Aide Training Program

Name of Long-Term Care Facility: _____

Please Print or Type

Date: _____

Address: _____

Phone: _____

_____ Review Period: _____ E-mail: _____

Provider Number: _____

Administrator: _____ **Attach a copy of the CNA Certification Card or a Copy of the Web Portal Print Out**

Director of Nursing: _____

Staff Development Coordinator: _____

Certified Nursing Assistant If terminated or have resigned within the review period, please place a "T" or "R" in front of CNA's name - a CNA who was terminated or has resigned releases the facility from the responsibility for current certification and/or number of in-service hours	**WORK STATUS: FT/ PT/ PRN/LOA/ FMLA/ WORKERS COMP**	**Part time & PRN CNAs annual hours worked during review period**	**Hire Date**	**Total In-service Hours for the Review Period**

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STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter 1st	2nd	3rd	4th	**In-service Topics *List additional in-services or dates in Miscellaneous***	**Length of in-service (1hr., 30min., etc Document in 15 min. increments**
				ADL Documentation	
				ADL/Care/Safety	
				Abuse	
				Abuse Prevention	
				Acute Illness	
				Admission	
				Advance Directives	
				Allowing Residents to Make Personal Choices	
				Alzheimer's	
				Aphasia	
				Appropriate Responses to the Behavior of Cognitively Impaired Residents	
				Assisting with Eating and Hydration	
				Assistive Devices for ambulation, transfers, eating and grooming	
				Bathing	
				Basic Restorative Services	
				Behavior Management	
				Bowel and Bladder Training	
				Blood borne Pathogens	
				Body Mechanics	

STAFF DEVELOPMENT IN-SERVICE TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter 1st	2nd	3rd	4th	In- Service Topics	Length of in-service
				Braces/Splints	
				Bullying	
				CPR	
				Call Lights	
				Care of the Resident's Environment	
				Catheter Care	
				Chronic Illness	
				Cognitively Impaired	
				Combative/Aggressive Resident	
				Comfort Measures	
				Communication	
				Communication with the Cognitively Impaired	
				Confidentiality	
				Corporate Compliance	
				Cultural Diversity	
				Customer Service	
				Death and Dying	
				Dehydration	
				Dementia	
				Depression	
				Diabetes	
				Dietary	

STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter 1st	2nd	3rd	4th	**In-service Topics**	**Length of in-service**
				Dignity	
				Dialysis	
				Disaster Preparedness	
				Disease Process	
				Documentation	
				Drug Awareness	
				Duties of a CNA	
				Dysphagia	
				Dysphasia	
				Elopement	
				Emergency Response	
				End of Life Care	
				Ethics	
				Fall Prevention	
				Falls	
				Family Relations	
				Fire Safety	
				Foot Care	
				Grievance	
				Grooming	
				HIPAA	
				Handling Conflicts	

STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter				**In-service Topics**	**Length of in-service**
1st	**2nd**	**3rd**	**4th**		
				Handwashing	
				Hospice	
				Hydration	
				Hygiene	
				Incidents	
				Incontinent Care	
				Infection Control	
				Interpersonal Skills	
				Legal Aspects	
				Lifts	
				Mental Health and Social Service Needs	
				Methods of Reducing the Effects of Cognitive Impairments	
				Misappropriation of Property	
				Mobility	
				Modifying CNA's Behavior in Response to Resident's Behavior	
				Nail Care	
				Neglect	
				Nutrition	
				OSHA	
				Observation/Reporting abnormal body functions	
				Observation/Reporting **Depression**	
				Observation/Reporting **Pain**	
				Observation/Reporting **Pressure Ulcers** and When to Observe	
				Oral Care	

STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter 1st	2nd	3rd	4th	In-service Topics	Length of in-service
				Ostomy Care	
				Pain Management	
				Perineal Care	
				Personal Hygiene	
				Positioning	
				Pressure Ulcers	
				Privacy	
				Promoting Resident Independence	
				Proper Feeding Techniques	
				Providing/Reinforcing Behavior Consistent with the Resident's Dignity	
				QA	
				Quality Initiative	
				Quality of Life	
				Range of Motion	
				Rehabilitation	
				Repositioning	
				Resident’s Rights	
				Restorative Program	
				Restraints and Alternatives	
				Safety	
				Sexual Harassment	
				Signs and Symptoms	
				Skills	
				Skin Care	
				Smoking	
				Specific Resident	

STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter 1st	2nd	3rd	4th	In-service Topics	Length of in-service
				Stress Management	
				Survey	
				Teamwork	
				Theft in the Facility	
				Toileting	
				Transfers	
				Turning	
				Understand the Behavior of Cognitively Impaired Residents	
				UTI	
				DVD/CD/Video	
				Vital Signs	
				Wandering Residents	
				Weather Alert	
				Weights	
				Work Ethics	
				Workplace Violence	
				Wound Care	
				Younger Adults in LTC	

STAFF DEVELOPMENT IN-SERVICES TOPICS OFFERED

Review dates from _____ to _____
Facility Name: _____

Date & Quarter Document the date of the in-service under the appropriate quarter				**MISCELLANEOUS** LIST ANY OTHER IN-SERVICES TOPICS WITH THE DATE, LENGTH OF IN-SERVICE UNDER MISCELLANEOUS In-service Topics	Length of in-service
1st	2nd	3rd	4th		

Rev. 2.18.20 **NAPSDEV – F02**