

# Long Term Care News

Volume I, Issue 5

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- ◇ Director of Nurses
- ◇ Infection Control Coordinator
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- ◇ Activities
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## Medicare Part D is Coming!

The following message comes from the Centers for Medicare & Medicaid Services (CMS):

“CMS has released the Toolkit for Healthcare Professionals: Medicare Prescription Drug Coverage. To access the toolkit and other educational resources, visit the drug coverage information webpage (Medlearn) for physicians and other healthcare professionals, <http://www.cms.hhs.gov/medlearn/drugcoverage.asp>, or click on the direct link below.

“The Toolkit for Healthcare Professionals: Medicare Prescription Drug Coverage” (<http://www.cms.hhs.gov/medlearn/provtoolkit.pdf>) (PDF, 860 KB) includes downloadable educational materials specifically for physicians and other healthcare professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials to distribute to their Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources.

Physicians and other healthcare professionals and their staff, partner organizations, social workers, financial counselors, and discharge planners will find this toolkit a valuable resource to get information to people with Medicare. You may add your logo and business information to these materials and copy freely, if you wish.”

A sample of the Provider Toolkit is enclosed in this newsletter for your review. In addition to the Provider Toolkit, under the heading “Training Materials for Health Care Professionals”, you will find downloadable PowerPoint slide presentations (short and expanded versions) revised as of September 21, 2005, complete with the presenter’s note pages containing talking points that may facilitate educating key staff and physicians and physician extenders.

OHFLAC will be sharing additional information as it is made available to us.



## The 2005—2006 Influenza Season

The Centers for Disease Control and Prevention (CDC) maintains a webpage with up-to-date information about influenza at <http://www.cdc.gov/flu>. All providers are encouraged to access this website in preparation for the upcoming flu season. Enclosed with this newsletter is a copy of CDC’s latest

Influenza Vaccine Bulletin, as well as recommendations for prioritizing the distribution of the flu vaccine and samples of educational materials available from CDC’s Flu Gallery (<http://www.cdc.gov/flu/gallery>.)

Having an effective program for ensuring that all residents

are offered the flu vaccine annually is a requirement under the Nursing Home Licensure Rule, as the current accepted standard of practice, as espoused by CDC, has identified persons age 65 years or older and residents of long-term care facilities as target groups for vaccination.

## Preventing the Spread of Infection—State Licensure Rule

Licensed nursing homes are required to comply with 64 CSR 13-8.20.c.1., which states, "A nursing home shall establish and implement policies and procedures consistent with current accepted standards of practice regarding administration of pneumococcal vaccine, influenza vaccine, and screening for tuberculosis."

### Tuberculosis Screening

OHFLAC has obtained, from the WV Bureau for Public Health's Division of Surveillance and Disease Control (DSDC), their expectations of TB screening in WV long-term care facilities, dated 09/18/98. Key elements are as follows:

- Mantoux tests should be administered to all new residents and staff as soon as their residency or employment begins, unless they have documentation of a previous positive reaction. A two-step procedure is advisable for the initial testing to establish a reliable

baseline. *If both skin tests are negative, repeat the skin test yearly.*

- All persons with a positive reaction to the skin test (refer to CDC guidelines) should have a chest x-ray to identify current or past disease. X-rays should be read by a radiologist or sent to the DSDC's TB Control Program for interpretation. Converters (from negative to positive) should be treated unless there are contraindications, such as liver disease or other increased risk of toxicity to the medication.
- Persons with abnormal chest x-rays and/or symptoms compatible with TB should also have sputum smear and culture examinations.
- Each TB-positive resident / employee with a normal chest x-ray should be evaluated annually and a record should be kept that documents the presence or absence of symptoms of TB. Further chest x-rays are not necessary for residents unless there has been a new exposure or symptoms develop. Employees

whose work brings them in contact with residents should receive a chest x-ray yearly.

A copy of DSDC's "Tuberculosis Screening—Recommendations for Tuberculosis Screening in Long-term Care Facilities" is enclosed in this newsletter for your review. For more information, please contact the DSDC's TB Control Program at 558-3669.

### Pneumococcal Vaccine

According to CDC's National Immunization Program (NIP), *pneumococcal disease* (which may present as pneumonia, middle ear infections, blood stream infections, sinus infections, or meningitis) ***kills more people in the United States each year than any than all other vaccine-preventable diseases combined.*** Most individuals will only require the pneumococcal vaccine once, for lifetime immunity. CDC rec-

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## Immunization Standard for LTC Facilities—Proposed Rule

CMS has proposed a rule to *require* Medicare / Medicaid certified all long-term care (LTC) facilities to offer each resident immunization against influenza and pneumococcal disease. A copy of the proposed rule has been enclosed with this newsletter for your review.

The goals of the rule are to increase the immunization rates of residents in Medicare and Medicaid partici-



pating LTC facilities and to decrease the vaccine-preventable morbidity and mortality caused by influenza and pneumococcal diseases.

According to CDC, "influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Immunization is the primary method for preventing invasive pneumococ-

cal disease as well as influenza and its more severe complications."

The rule proposes adding §483.25(n), which would require LTC facilities to offer each resident, between October 1 and March 31, immunization against influenza annually, as well as lifetime immunization against pneumococcal disease, unless medically contraindicated or unless the resident or legal representative refuses consent.

## Section W of the Minimum Data Set (MDS)

Effective October 1, 2005, **Section W. Supplemental Items** is being added to the Minimum Data Set (MDS) Version 2.0.

Item W1. National Provider ID is intended to record the facility's National Provider Identification (NPI) number.

Item W2. Influenza Immunization must

be completed for all residents on all assessment types (OBRA and/or PPS) with Assessment Reference Dates (ARD) and all discharge tracking forms with Discharge Dates from October 1 through June 30. Discharge tracking forms are included in order to capture influenza vaccines administered to residents whose influenza vaccines were not captured on

an MDS assessment.

Item W3. Pneumococcal Immunization must be completed for all residents on all assessments types (OBRA and/or PPS) and all discharge tracking forms (regardless of ARD).

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## Preventing the Spread of Infection—State Licensure Rule

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ommends the following individuals be vaccinated against pneumococcal disease:

- People age 65 years or older;
- People who have problems with their lungs, heart, liver, or kidneys; and
- People with health problems like diabetes, sickle cell disease, alcoholism, or HIV/AIDS.

Additional information about pneumococcal disease is available at NIP's webpage at <http://www.cdc.gov/nip/diseases/pneumo/default.htm>.

### An Effective Immunization Program

A review of the CDC's publication entitled "Prevention and Control of Vaccine-Preventable Diseases in Long-Term Care Facilities" suggests that an effective immunization program will:

- Adopt standing orders for administering the influenza and pneumococcal (I&P) vaccines.
- Assess the immunization status of new admissions and transfers;
- Obtain informed consent (or document refusal or the physician's determination that the vaccine was medically contraindicated);
- Vaccinate current residents and new arrivals;
- For each vaccination event, record the trade name or manufacturer of the vaccine and lot number, date received, injection site, and any adverse reaction occurring within 72 hours;
- Record any adverse events that occur within the first week of receiving the I&P vaccines;
- Report any serious adverse events to the Food and Drug Administration (FDA) on the Vaccine Adverse Events Reporting form;
- Maintain a record of each resident's history of vaccination events from admission to discharge, using an individual immunization

record maintained as part of the permanent medical record;

- Identify residents who refuse immunization and may be at higher risk for disease during outbreaks;
- Summarize, on a monthly basis, the immunization status of residents discharged from the facility;
- Provide a copy of the vaccination record to each person or receiving facility upon transfer/discharge; and
- Conduct an annual influenza vaccination campaign.

This CDC publication also has recommendations regarding the tetanus-diphtheria toxoid primary series for adults and boosters.

A copy of this publication can be downloaded from: <http://www.cdc.gov/nip/publications/long-term-care.pdf>.

## Information from the Center for End-of-Life Care

Alvin H. Moss, MD, Director of the WV Center for End-of-Life Care, and Angela R. Demanelis, MPA, Senior Program Administrator for the Center for End of Life Care, have authored a "job description" for medical power of attorney (MPOA) representatives and health care surrogates (HCS), to educate them on their roles as proxy health care decision makers.

Enclosed in this newsletter is a copy of an article by Dr. Moss and Ms. Demanelis

entitled "What does it mean to be a proxy decision maker?", which contains the "job description". The "job description" outlines the authorities and responsibilities of a MPOA representative or HCS as delineated in the WV Health Care Decisions Act, as well as the limitations to his / her authority.

Also enclosed in this newsletter is an article entitled "Using the POST Form—Guidance for Healthcare Professionals",

which may be useful to staff when assisting residents and / or their legal health care decision makers in completing the "Physician Orders for Scope of Treatment" (POST) form.

The WV End-of-Life Center has available a variety of materials for educating health care professionals, residents, and families. For additional information, call 1-877-209-8086 or visit their website at [www.wvendoflife.org](http://www.wvendoflife.org).

## Section W of the Minimum Data Set (MDS)

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Items W2 and W3 are intended to aid CMS in determining the rate of influenza and pneumococcal vaccinations of residents in long-term care facilities and the reasons for non-vaccination.



A copy of the August 2005 revisions to the Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0 have been included with this newsletter, including a sample of Section W, as well as copy of the "Section W2. Influenza Deci-

sion-Tree" handout that was provided as part of the CMS live satellite broadcast and webcast shown on September 8, 2005.

For more information on the revisions to the MDS, check out the CMS MDS 2.0 Manuals and Forms webpage at <http://www.cms.hhs.gov/quality/mds20>.

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**Q & A's from the Nursing Home Licensure Rule Seminars**

A few questions popped up during the provider trainings on the current Nursing Home Licensure Rule. Please find the questions and answers below:

**Q—Can a medical power of attorney (MPOA) “temporarily” delegate his / her powers to another person (e.g., as when the MPOA is out of town on vacation)?**

**A—**The *MPOA* cannot delegate the power to another person under any circumstances. The only person who can grant the power is the grantor, in this case, the resident. That is why the MPOA documents should list a secondary or even a tertiary grantee.

However, if the *resident* has named a successor representative (the usual language for a successor MPOA is “If my representative is unable, unwilling, or disqualified to serve, then I appoint ...”), then the primary representative may give the facility a written statement that he / she is temporarily unable to serve and would like the successor to act in a time-

limited, temporary capacity as a resident’s MPOA.

If the resident did not appoint a successor representative, and the MPOA is unable to serve for a period of time, then the MPOA *CAN- NOT* name a successor and delegate the powers to this individual; however, the resident’s physician can appoint a health care surrogate to act during the time period that the MPOA is unable to do so.

**Q—64CSR13-8.15.d.1.A.** states, “Meals shall be prepared and served the same day.” Does this mean that food items cannot be prepared in advance (e.g., pies and cakes baked on one day and served on the next)?

**A—**The intent of the rule was to ensure that nursing homes could not use “leftovers” as the basis for an entire meal; this rule is NOT intended to prohibit the use of food items pre-



pared the day before service.

**Q—64CSR13-4.15.c.2.** states, “Medicaid residents and their legal representatives shall be informed that if they desire a private room, they may privately supplement the Medicaid payment by directly paying the facility the difference between the semi-private room rate and the private room rate.” Does the phrase “semi-private room rate” refer to the Medicaid reimburse-

ment rate for a semi-private room or the per diem amount paid for the semi-private room by an individual who is private pay?

**A—**The phrase “semi-private room rate” refers to the per diem amount paid for by an individual who is private pay. Any questions regarding this issue should be directed to Emily Keefer, Program Manager of the Long Term Care Unit at the Bureau for Medical Services, at (304) 558-1700.