

Sunflower Connection

http://www.kdads.ks.gov/AdultCareHomes/Newsletters/Newsletter_Index.html



July 2013

Volume 10, Number 3

All Adult Care Homes

TB Shortage	1
Emergency Dietary Prep	3
Bed Bugs in LTCF	4-6
Improve Dementia Care	8
Surveyor Web	9
Award Letters	15
Enforcement Statistics	18
Vera's Farewell	18
TB Guidelines	19-22

Nursing Homes

S and C Letters	2
F386 §483(B) Physician Visits	3
Reporting for Alleged Violations	3
Alarms	7
Resident Funds	7
Advancing Excellence	8
Accessing Data of AP Use	8
QM Manual	9
Case Mix	10-11
MDS Murmurings- May Update	12-14

Nationwide Shortage of Tuberculin Products

According to a June 17, 2013 update by KDHE, the nationwide shortage of the tuberculin products used for tuberculosis skin testing (TST): TUBERSOL® (Sanofi Pasteur Limited), and APLISOL® (JHP Pharmaceuticals, LLC), is ongoing and earlier estimated information for return to normal supply from the manufacturers has proven to be inaccurate. The duration of the shortage is unknown at this time. “Recommendations for Use of Tuberculin During the Nationwide Shortage” is posted at <http://www.kdheks.gov/tb/index.html>.

Adult care home providers should follow the general principles of the recommendation for conducting TST and TB symptom screen of residents and staff: **At time of admission or hire:** Conduct the TB symptom screen. Use Interferon Gamma Release Assay (IGRA) if it is available. If IGRA is not available, administer one TST and defer the second step TST until the shortage resolves. If the home is not able to obtain any tuberculin, defer both TSTs until the shortage resolves. **Annual re-testing:** Conduct the TB symptom screen. Use IGRA if it is available. If IGRA is not available, defer the annual TST until the shortage resolves. (See Revised TB Guidelines and Symptom Screen Questionnaire later in SF Connection).

The KDHE supply of the Aplisol based PPD solution available for purchase by adult care home providers is becoming more limited. The TUBERCULIN PURIFIED PROTEIN DERIVATIVE (PPD) order form is available at http://www.kdheks.gov/tb/download/request_for_ppd.pdf KDHE ships the product via Fed Ex on Monday through Wednesday to assure the product remains at proper temperature so homes should plan accordingly. Please direct questions to Phil Griffin, KDHE TB Controller, (pgriffin@kdheks.gov or 785-296-8893).

Survey and Certification Letters

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html>

REF: S&C: 13-37-NH

DATE: June 7, 2013

SUBJECT: Rollout of Quality Assurance and Performance Improvement (QAPI) Materials for Nursing Homes

MEMORANDUM SUMMARY

- **QAPI Website: Creation of new webpage on CMS website** to house QAPI training materials, tools and resources. <http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQA-PI.html>
- **Rollout of QAPI Materials:** Introductory materials available on the CMS QAPI website:
 - ◇ **QAPI at a Glance** – a guide for understanding & implementing QAPI in NH
 - ◇ **QAPI Tools** – process tools, within QAPI at a Glance, to help providers establish a foundation in QAPI
 - ◇ **QAPI News Brief** – newsletter describing basic principles of QAPI
 - ◇ **Video** – Nursing Home QAPI – What’s in it for you? - introduces QAPI, its value to residents, their families and caregivers, and what is in it for nursing homes that embrace QAPI
- **Nursing Home Quality Improvement Questionnaire:** Analysis is nearly complete on wave one of the Nursing Home Quality Improvement Questionnaire; results will be released on QAPI Website later this summer.

REF: S&C: 13-35-All

DATE: May 24, 2013

SUBJECT: Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for **F309 – Quality of Care** and **F329 – Unnecessary Drugs**

REF: S&C: 13-28- ICF/IID-QIDP

DATE: May 3, 2013

SUBJECT: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) –Nomenclature Change (Qualified Intellectual Disabilities Professional (QIDP)

MEMORANDUM SUMMARY:

- **Rosa’s Law:** The enactment of Rosa’s Law on October 5, 2010 changed all references to “mental retardation” in Federal law to “intellectual disability” and changed all references to a “mentally retarded individual” to “an individual with an intellectual disability.” These changes were codified in regulation by the Centers for Medicare & Medicaid Services (CMS) on May 16, 2012.
- **Revised Nomenclature for Qualified Mental Retardation Professional (QMRP):** Pursuant to these regulatory changes, previous nomenclature for a QMRP, as referenced at 42 CFR 483.430(a), is changed to Qualified Intellectual Disabilities Professional.

REF: S&C: 13-24-NH

DATE: April 12, 2013

SUBJECT: Report of the National Background Check Program (NBCP) Long-Term Care (LTC) Criminal Convictions Work Group. The purpose of the report is to document the Work Group’s findings and options for CMS regarding definitions of a “direct access employee” and disqualifying convictions and rehabilitation factors.

REF: S&C: 13–21- ALL

DATE: March 22, 2013

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

MEMORANDUM SUMMARY:

- **Survey Findings Posted on <http://www.cms.gov>:** In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare.
- **Other Web-based Tools Based on These Data:** At least two additional websites, provided by private parties (ProPublica and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- **Plans of Correction (POC):** The posted CMS data does not contain any POC information.

F386 §483.40(B) Physician Visits

The physician must--

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) (Frequency of Visits) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

Reporting Requirements For Alleged Violations

Are you wondering what is required for reporting Alleged Violations of Mistreatment, Neglect, and Abuse, including Injuries of Unknown Source, and Misappropriation of Resident Property. The information in the CMS S & C Letter 05-09 dated December 16, 2004, is still appropriate for today. It is available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-09.pdf>

When Disaster Strikes - Is Your Food Service Operation Prepared?

Both state and federal regulations require adult care homes to have disaster and emergency plans. (K.S.A. 26- 41, 42, 43- 104 & 28-39-163). F517 in the State Operations Manual requires the nursing facility to "have detailed written plans and procedures to meet all potential emergencies and disasters". F518 requires facilities to "train all employees in emergency procedures when they begin work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures."

In 2009, CMS published an emergency preparedness checklist for health care facilities as a tool for effective emergency planning, updating an earlier release. If your facility used this recommended checklist in developing its emergency plan, it will have a Shelter in Place Plan and an Evacuation Plan. What do these plans require of your food service operation?

What amount of potable water is defined as an adequate supply for sheltering in place for at least 7 days? What amount and types of food are in supply for the same period? What provisions are in the evacuation plan for an adequate food supply and logistical support for transporting food? Has each staff member in your food service operation been trained to be knowledgeable and follow all details of the plans? And are exercises or drills conducted at least semi-annually, and is the food service operation participating in such simulations?

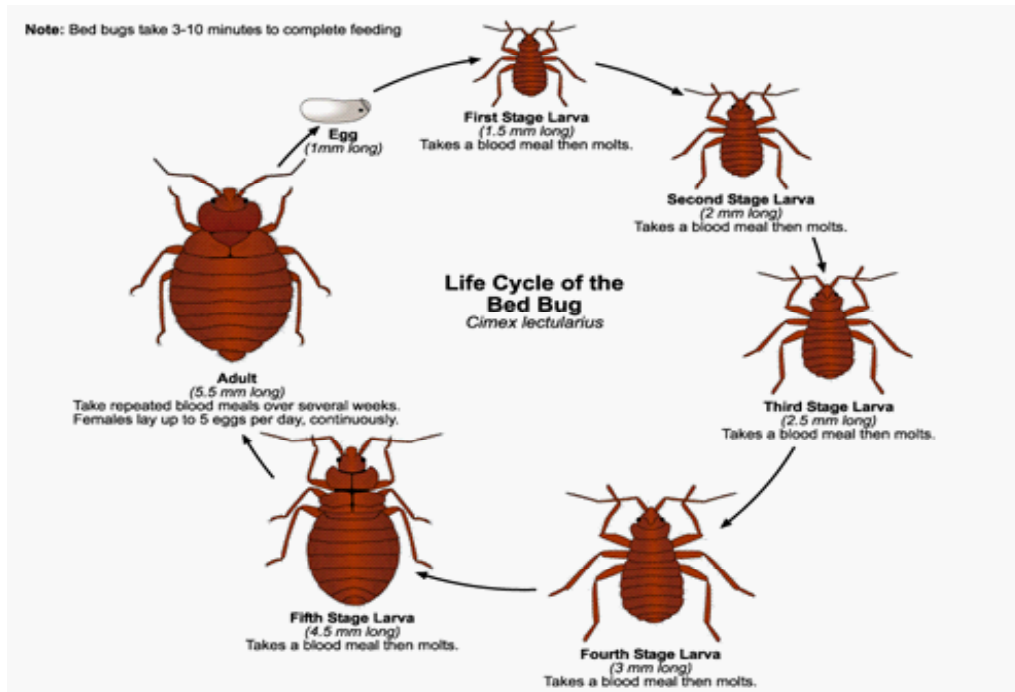
Such questions clue whether your planning and training are sufficient, and whether your food service operation is adequately prepared to respond to disasters.

A few emergency preparedness resources specific to food service operations are listed below...although written for retail food establishments, the information will be helpful for adult care homes as well. For easy access, just click and follow the link or copy and paste the link in your web browser.

- [Emergency Management for the Healthcare Professional](#) This 2012 emergency manual was published by the Dietetics in Health Care Communities, a dietetic practice group of the Academy of Nutrition and Dietetics, it is downloadable for a nominal fee.
- [Restaurants and Grocers Reopening after Hurricanes and Flooding](#) This FDA publication provides food safety suggestions and information for foodservice operations that are resuming business after a disaster.
- [Emergency Action Plan for Retail Food Establishments](#) This document was published by the Conference for Food Protection in an updated version 2006-2008 and is a practical guide for foodservice operations to plan for and respond to emergencies that create the potential for imminent health hazard.
- [Indiana Emergency Preparedness Resource Center](#) This resource center focuses on the issues of all hazards emergency preparedness in health care facilities, particularly long term care facilities. It provides many tools, templates and resources, some of which are specific to foodservice operations.

GOODNIGHT, SLEEP TIGHT....DON'T LET THE BED BUGS BITE!

Joseph M. Scaletta, MPH, RN, CIC
KDHE Health-Associated Infections Program Director



Until fairly recently, most people (even pest control professionals) had never seen a bed bug (*Cimex lectularius*). Bed bug infestations used to be very common in the United States before World War II. With improvements in hygiene, and especially the widespread use of DDT during the 1940s and '50s, bed bugs all but vanished. The pests persisted, however, in some areas of the world including parts of Africa, Asia, and Eastern Europe. Over roughly the past decade, bed bugs have made a dramatic comeback in the U.S.; they're increasingly being found in homes, apartments, hotels, dormitories, shelters, schools and health care facilities (including long term care facilities).

Bed bugs are small, flat, parasitic insects that feed solely on the blood of people and animals while they sleep. They are reddish-brown in color, wingless, range in size from 1mm to 7mm (roughly the size of an apple seed), and can live several months without a blood meal.

Although bed bugs can harbor various pathogens, transmission to humans has not been proven and is considered unlikely. They can however, cause localized itching and inflammation from their bites. Though not known to carry diseases, bed bugs can substantially reduce quality of life by causing discomfort, sleeplessness, anxiety, and embarrassment. According to some health experts, the added stress from living with bed bugs can have a significant impact on the emotional health and well-being of certain individuals.

In the fiercely competitive long-term care industries, patient or resident satisfaction is crucial. Bed bug infestations, aside from potential health concerns, can spark complaints about sanitary conditions and lead to long-term reputation damage. Despite the fact that the presence of bed bugs is not an indicator of poor sanitation, pests of any kind are accompanied by a perception of being "dirty." The following information is intended to help long term care facilities keep bed bugs at bay and describes actions to take if infestation is suspected or confirmed by a pest management specialist.

Continued on page 5.

AN OUNCE OF PREVENTION: STOPPING BEDBUGS AT THE DOOR

In a long-term care facility, preventing bed bugs from entering on residents' personal effects is the best way to lower the potential for an infestation. The methods suggested below are effective and relatively easy to implement.

Recommendations include:

- o Check mattresses – Conduct a visual inspection of bedding as it is brought in for evidence of bed bugs.
- o Consider requiring that mattress and box springs be encased. An inexpensive synthetic covering on mattresses and especially box springs prevents bed bugs from reaching the fibrous interior or hiding along edges or under tags. For pests that have already found harborage, the encasement prevents their escape and access to food sources. (Life Safety Code requires all mattress and/or box spring encasement to be UL or NFPA fire rated/tested or the resident's bedroom to have a smoke detector).
- o Perform an inspection of incoming furniture; much like bedding, couches, plush chairs and other furniture can easily harbor bed bugs.

OUT OF SIGHT, NOT OUT OF MIND: MONITORING & EARLY DETECTION

Monitoring and early detection are crucial to preventing bed bugs from causing an infestation. A pest management professional can educate your staff on the importance of being aware of the problem and train them to recognize the signs of a bed bugs presence. As nocturnal pests, bed bugs typically hide during the day, but evidence of their nightly wandering can be found on mattress edges and tags. Small dark brown-colored stains in these areas may be the only evidence of bed bugs that you may find.

In a long-term care facility or long-term care units in a hospital, integrating bed bug monitoring into regular cleaning routines can help identify problems before they spread throughout the facility:

- o Weekly – Monitor for evidence when changing the sheets. Check the mattress cover and the edges of the mattress.
- o Monthly – Inspect the box springs for similar signs.
- o Quarterly – Conduct thorough inspections of potential harborage locations – behind pictures and headboards and in furniture, sofas or plush chairs.

SEND BED BUGS PACKING: TREATMENT

If routine monitoring uncovers a bed bug problem, contact your pest management professional immediately. Remediation tactics will be less invasive if initiated in the early stages of an infestation. Non-chemical and environmentally conscious methods include the following strategies:

- o **Dispose** – If furniture or other items harboring bed bugs can be disposed of, it increases the chances of a successful eradication.
- o **Launder** – For items that can be laundered, wash in hot water with detergent and dry in a dryer. The combination of heat and soap will kill bed bugs and remove any eggs.
- o **Heat** – Pest management professionals can use special equipment to heat the room or the room's belongings to the necessary temperature for a sustained period of time that will eradicate any bed bugs in the room. Use dry steam on carpet, mattress edges and cushioned furniture.
- o **Freeze** – Due to bed bugs' need for moderate temperatures, cold seems to be as effective as heat. Pest management professionals also have the equipment to cool bed bug harborage areas, which should kill any bed bugs in the space.

Continued on page 6.

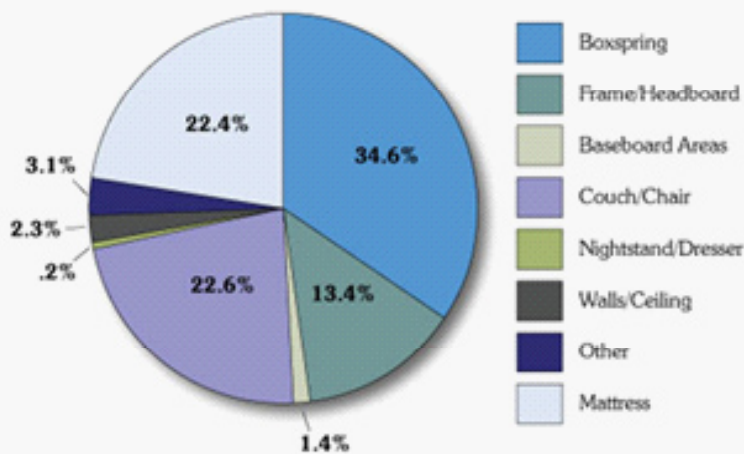
INFESTATION MANAGEMENT IN LONG TERM CARE FACILITIES

A wide-spread infestation possibly affecting multiple locations within the facility will require a more aggressive approach involving chemical treatments. Chemical treatments should only be applied by a licensed, trained pest management professional who can advise you of the best course of action:

- o **Fumigate** – A chemical material will kill all pests and leaves no residual. It does require the facility to be completely cleared, which can be a challenge.
- o **Non-residual Chemical Treatments** – Alcohol will create a chemical solution that kills bed bugs.
- o **Residual Chemical Treatments** – Chemically treat carpet edges, baseboards, furniture, headboards, etc.

Treating for bed bugs does present some challenges. In some cases, the pest can be resistant to chemicals. They may also be repelled by chemicals and be driven to seek chemical-free areas elsewhere in the facility after treatment. Resident sensitivity to the use of chemicals in a long term care facility is also a concern and should be discussed with your pest management professional.

BED BUG HIDING SPOTS



Distribution of bed bugs found in 13 infested apartments
Source: University of Kentucky

For more information, about bed bugs or other communicable diseases, please contact the KDHE Epidemiology Hotline at 1-877-427-7317.

References:

CDC. Bed bug FAQs.

<http://www.cdc.gov/parasites/bedbugs/faqs.html>

Harrison RL, Lawrence B. Pulling back the sheets on the bed bug controversy: research, prevention and management in hospitals and long-term care facilities.

www.ahe.org/ahe/content/orkin/ahe-bedbug-white-paper.pdf

Bed AND/OR Chair Alarms

F258 §483.15(h)(7) states “The facility must provide for maintenance of comfortable sound levels.” At a recent culture change conference, well-known culture change advocate Carmen Bowman, Edu-catering, challenged nursing home staff to eliminate the use of bed and chair alarms. Many residents find the noise bothersome. The sudden sounding of an alarm can be frightening for a person with dementia, triggering a negative response.

The regulations require homes to assess each resident individually to determine if they are at risk for falls or have fallen and to implement appropriate interventions. Homes are not required to use chair and/or bed alarms as fall interventions. However, if a home has included the use of bed and/or chair alarms as a care plan approach and surveyors observe the alarm(s) is not in use, the home may likely receive a citation.

Several homes in Kansas have already successfully eliminated the use of alarms in their homes. It has required developing and implementing a plan that included family and staff education, and consistent follow through by staff. Helpful information to assist homes in reducing and eliminating the use of alarms is available via a recorded interview and workshop offered respectively by the Minnesota QIO entitled Effective Fall Prevention Strategies Without Restraints or Alarms (04/24/2012)

<http://www.stratishealth.org/events/recorded.html> and the Connecticut Culture Change Coalition, entitled Best Practices for Reducing or Eliminating Alarm Use in Nursing Homes (03/15/2013) <http://ctculturechange.org/> (Do note these resources are provided as a courtesy and are not KDADS endorsed.)

Protection of Resident Funds and Surety Bonds

The Protection of Resident Funds is addressed in C.F.R. §483.10(c)(1)-(8). The regulations afford the resident the right to manage his or her financial affairs or to request the home to manage them. When a resident provides written authorization to the home to manage their financial affairs, the home must hold, safeguard, manage, and account for the resident’s personal funds. This article will cover a home’s responsi-

bilities as specified in F159. Management of Personal Funds and F161. Assurance of Financial Security, paragraphs (c)(3)-(5) & (7) respectively.

When a home is managing a resident’s funds, it must place the resident’s funds in excess of \$50 (when current payer source is not Medicare) and in excess of \$100 (when current payer source is Medicare) in an interest bearing account that is separate from the home’s operating accounts. The funds of more than one resident may be placed in the same account. The interest on the account must be credited individually to each resident. A home may maintain a resident’s funds under \$50 (when current payer source is not Medicare) and under of \$100 (when current payer source is Medicare) in a petty cash account at the home to ensure the resident can readily access monies in the evening or on weekends. The home must ensure those funds are maintained in a safe, secure manner. Regardless the type of account in which the resident’s funds are maintained, the home must keep a written accounting of all deposits, withdrawals, and the current balance of the account. The home must give a quarterly statement of the account(s) to the resident or their legal representative. When the funds of a resident whose stay is covered fully or partially by Medicaid are within \$200 of the Medicaid eligibility limit requirement, the home must notify the resident or their legal representative.

When a home is managing the funds for a resident or several residents, the home must have a surety bond protecting the total amount of the residents’ funds to compensate the resident (or state on behalf of the resident) for any losses of funds due to acts of negligence, incompetence, or dishonesty

State regulations for the protection of resident funds can be found at K.A.R. 28-39-149.



Advancing Excellence - New Goals - Sign Up Now

The National Campaign for Advancing Excellence in Nursing Homes now has nine new goals from which to choose to improve quality in your nursing home. Information on each of the goals is easily available on the website at: www.nhqualitycampaign.org. All homes are encouraged to review the goals and sign up to participate in this continued effort.

Most of the goals will align with homes' efforts related to PEAK, the Partnership for Improving Dementia Care (reducing use of antipsychotic medications) or the Nursing Home Quality Care Collaborative (NHQCC), so you can combine your efforts without duplication of work. For questions about usernames or passwords or the website in general, please contact Darlene Smikahl, Brenda Groves or Dana Thompson, QIO staff at 1-800-432-0770. Make Kansas a 100% participating state.

Kansas Partnership to Improve Dementia Care

Have you started using the CMS Hand in Hand Training?

See what one home had to say about it.

“We found the Hand in Hand training provided by CMS as an excellent resource. We have completed one section per month and held several sessions so all our staff can attend. It is not overwhelming doing it just a piece at a time.

It has been so well received that family members are now attending. We only have Section 6, the last one, to do this month. But we may repeat the series as necessary. The bottom line of this training is really about respect & dignity of residents, even though it was meant to reduce medication use.”

CMS sent every Medicare and/or Medicaid Certified Nursing Home a free copy of the training in the format of a three ring binder with videos in the back sleeve this past December and January. If you did not receive a copy or want a second copy, it may be purchased by calling 1-800-553-6847 and requesting the Hand in Hand: A Training Series for Nursing Homes on Person-Centered Care of Persons with Dementia and Prevention of Abuse for \$100.00 plus Shipping and Handling. The product number is AVA21573CDRM. Alternatively, you may download the series and create your own toolkit from the website

<http://www.cms-handinhandtoolkit.info/Downloads.aspx>

CMS Resources and Teleconference Call Advancing Excellence Website

http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare

Look for information at the website under Initiatives and Presentations on the June 4, 2013 Quarterly Call. Presentations included the Consultant Pharmacist's Role in Dementia Care and Innovative Non-Pharmacological Approaches.

Register for the National Provider Call: CMS National Partnership to Improve Dementia Care in Nursing Homes — Wednesday, July 10; 12:30-2pm CT

During this National Provider Call, CMS subject matter experts will discuss the progress that has been made during the implementation of the national partnership, its successes, and next steps. Additional speakers will share personal success stories from the field. A question and answer session will follow the presentation.

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted on the [FFS National Provider Calls](#) web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

Upcoming Kansas Education

Notice of education is done as a courtesy. It is not KDADS sponsored or endorsed.

KHCA/KCAL Workshop - Inside Dementia – A Guide for Caring Staff

ALF – July 15, 2013 and NF – July 16, 2013

Presenter: Teepa Snow, OTR/L, FAOTA

Registration: Contact KHCA 785-267-6003

LeadingAge Kansas Webinar - Activity Programming for People with Advancing Dementia

July 18th, 2013 10:00 - 11:00 am

Faculty: Karen Craig, RN-C, GERTI

Registration: Contact LeadingAge Kansas

785-233-7443

<http://www.leadingagekansas.org/i4a/pages/index.cfm?pageid=3356>

Sources for Accessing Data of Antipsychotic Use

CMS Partnership to Improve Dementia Care Resource

Nursing Home Compare Website

1. Visit the Nursing Home Compare (NHC) website www.medicare.gov/nursinghomecompare
2. Find your nursing home using the search bars
3. Navigate to the quality measures tab
4. Compare the facility's QM scores to state and national averages
 - a. You can also graph the values on NHC
 - b. Note: QM values on NHC are a three quarter average, and lag by 3 months

Five-Star provider preview reports

Each nursing home is given advanced access to their Five-Star ratings, via the Five-Star provider preview reports. Included in this report are quality measure values for each quarter, the 3-quarter average, and the national comparison. These reports are generated early in the week of the NHC refresh, which is typically on the 3rd Thursday of each month. Quality measures are updated quarterly (Jan, Apr, July, and Oct).

To access these reports:

1. Select the CASPER Reporting link located at the top of your MDS State Welcome page.
2. Once in the CASPER Reporting system, click on the 'Folders' button and access the Five Star Report in your 'st LTC facid' folder, where st is the 2-character postal code of the state in which your facility is located and facid is the state-assigned Facility ID of your facility.

CASPER Reports

For more real time data you can access CASPER reports through the same system as the Five-Star Provider Preview Reports listed above.

National and State Antipsychotic Rates

Based on CMS Quality Measures, Kansas AP baseline rate (an average of Quarters 2, 3, & 4, 2011) was 25.3%. The current rate (an average of Quarters 2, 3, & 4, 2012) is 23.8%. This is a 7.8% decrease. Nationally, the baseline rate was 23.9%. It is now 22.9% with a 6.4% decrease.

Surveyor Web-Based Videos Available for Providers

<http://surveyortraining.cms.hhs.gov/index.aspx>

CMS surveyor web based training, webcasts, and achieved webinars are now available to providers. Password access is not required. They are available at the above website.

The most recent posted webcasts include:

- Overview of Antipsychotic Medication Use in Nursing Homes
- Surveying for Antipsychotic Medication Use in Nursing Homes
- Severity and Scope Guidance – Antipsychotic Medication Use in Nursing Homes. This training addresses severity and scope and other aspects of deficiency citations, based on the new guidance at F309, Care of Residents with Dementia, and revised guidance at F329.

Other webcasts that home embarking on culture change may find helpful include:

- From Institutional to Individualized Care Part I — Integrating Individualized Care and Quality Improvement
- From Institutional to Individual Care Part II: Transforming Systems to Achieve Better Clinical Outcomes
- From Institutional to Individual Care Part III: Clinical Case Studies in Culture Change
- From Institutional to Individualized Care Part IV: The How of Change

Quality Measure(QM) User's Manual V8.0

The MDS 3.0 Quality Measure (QM) User's Manual V8.0 and a table entitled Quality Measure Identification Number by CMS Reporting Module V1.2 is available at the Quality Measure web site: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html>. The MDS 3.0 QM User's Manual V8.0 contains detailed specifications for the MDS 3.0 quality measures. Quality Measure Identification Number by CMS Reporting Module V1.2 is a table that documents CMS quality measures calculated using MDS 3.0 data and reported in a CMS reporting module. A unique CMS identification number is specified for each QM.

Kansas Medicaid Case Mix Basics

**Carol Job, RN, Nurse Consultant
Myers and Stauffer**

Case mix reimbursement has become the most frequently used payment system for Medicaid nursing home care. Approximately twenty-nine states have implemented a Medicaid case mix system. Medicare has been paying under a case mix system since 1998 when the Prospective Payment System (PPS) was implemented nationwide. The term "case" refers to the residents. The term "mix" refers to differences or variety. Therefore, "Case Mix" describes differences in residents within a population in terms of their functioning, and the resources that are used in their care. Case Mix reimbursement systems measure the intensity of care and services required for each resident and translate those measures into groupings. In other words, residents with heavy care needs will have higher payment because they are more resource intensive and payment will be lower for a resident with lighter care needs.

The Minimum Data Set (MDS 3.0) is a resident assessment and care planning instrument that is mandated for use in all Medicaid and Medicare certified nursing homes. Federal regulations require not only the completion, but also the electronic submission of this data to a national repository. The MDS contains items which reflect the acuity level of the nursing home resident, including diagnoses, treatments and an evaluation of the resident's functional status. After the resident has been assessed the information is used to determine a case mix classification. The Resource Utilization Groups (RUG III or RUG IV) is the classification system used in the calculation of the Medicaid and Medicare case mix reimbursement systems.

Currently, the Kansas Medicaid case mix system utilizes the RUG III 34 classification system. In the RUG III classification system there are eight major categories: Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems and Reduced Physical Function. Each of the major categories is further divided into subgroups based on the resident's Activities of Daily Living (ADL) score, absence or presence of depression and restorative nursing programs. The ADL score reflects the degree of assistance needed in four specific areas: eating, toileting, transferring and bed mobility. The ADL score ranges from four to eighteen. A low score represents independence or minimal supervision and a high score means the resident needs more extensive assistance or total assistance and more than one staff person.

Once the MDS has been completed and a RUG group determined the next step is to link it to reimbursement. Each RUG III category has been assigned a weight. These weights represent the mean resource use of individuals within that group compared to the distribution of resident groups in the population. These weights or case mix indexes (CMIs) are used in the rate calculation to adjust for case mix. For example, a resident that classifies into the Extensive Services (SE3) category has a CMI of 2.10 and a resident that classifies into a Reduced Physical Function A category has a CMI of 0.59. On average it would take over 3 times more direct care resources to care for the resident in the Extensive Services category and the payment would be higher. The following table is a complete list of the RUG III categories and case mix weights used in Kansas Medicaid.

The Kansas case mix system is a facility average system. On a quarterly basis, the MDS assessments are classified and the CMIs are averaged. The CMI average is then used to set the rates.

Continued on page 11.

RUG-III GROUP	ADL	CODE	CMI
EXTENSIVE SERVICES			
Extensive Special Care 3	>6	SE3	2.10
Extensive Special Care 2	>6	SE2	1.79
Extensive Special Care 1	>6	SE1	1.54
SPECIAL REHABILITATION			
Rehab all levels	17-18	RAD	1.66
Rehab all levels	14-16	RAC	1.31
Rehab all levels	13-13	RAB	1.24
Rehab all levels	4-9	RAA	1.07
SPECIAL CARE			
Special Care	17-18	SSC	1.44
Special Care	15-16	SSB	1.33
Special Care	4-14	SSA	1.28
CLINICALLY COMPLEX			
Clinically Complex w/Depression	17-18	CC2	1.42
Clinically Complex	17-18	CC1	1.25
Clinically Complex w/Depression	12-16	CB2	1.15
Clinically Complex	12-16	CB1	1.07
Clinically Complex w/Depression	4-11	CA2	1.06
Clinically Complex	4-11	CA1	0.95
IMPAIRED COGNITION			
Cognitive Impairment w/Nursing Rehab	6-10	IB2	0.86
Cognitive Impairment	6-10	IB1	0.85
Cognitive Impairment w/Nursing Rehab	4-5	IA2	0.72
Cognitive Impairment	4-5	IA1	0.67
BEHAVIOR PROBLEMS			
Behavior Problem w/Nursing Rehab	6-10	BB2	0.86
Behavior Problem	6-10	BB1	0.82
Behavior Problem w/Nursing Rehab	4-5	BA2	0.71
Behavior Problem	4-5	BA1	0.60
REDUCED PHYSICAL FUNCTION			
Reduced Physical Function w/Nursing Rehab	16-18	PE2	1.00
Reduced Physical Function	16-18	PE1	0.97
Reduced Physical Function w/Nursing Rehab	11-15	PD2	0.91
Reduced Physical Function	11-15	PD1	0.89
Reduced Physical Function w/Nursing Rehab	9-10	PC2	0.83
Reduced Physical Function	9-10	PC1	0.81
Reduced Physical Function w/Nursing Rehab	6-8	PB2	0.65
Reduced Physical Function	6-8	PB1	0.63
Reduced Physical Function w/Nursing Rehab	4-5	PA2	0.62
Reduced Physical Function	4-5	PA1	0.59

MDS Murmurings

CMS MDS 3.0 Link

<https://www.qtso.com/mds30.html>

MDS 3.0 RAI Manual

MDS 3.0 QM User Manual Version 8.0

MDS 3.0 Training MDS 3.0 Technical Information

CMS Youtube Video – Discharge Assessments and the Use of Dashes

‘Discharge Assessments and the Use of Dashes’ video can be found in the Related Links section at, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html> or at: <http://youtu.be/Qkn22jv2HSY>. Discharge Assessments and the Use of Dashes are addressed in the new MDS 3.0 Provider Update Training Series. This training series is the first web-based training offered in 2013 to providers addressing post-acute care topics. Video No. 1 covers MDS 3.0 updates for the Nursing Home setting. It includes a CMS Introduction, a panel presentation explaining what the MDS 3.0 RAI Manual and the MDS 3.0 Assessment Instrument are, and includes two training topics. The first training topic focuses on our relatively new discharge assessments, and the second topic explains how to properly code with dashes. PowerPoint slides on these topics will be available in the near future that you may download.

May 28, 2013. YouTube Training Videos in download Sections A, G, K, M, N, O, Q, X and Z have been removed and transferred to the MDS 3.0 Training Archive section since they are no longer current. New information will be posted as it becomes available.

MDS 3.0 UPDATE - MAY 2013

This listing is not all inclusive. Change Tables with all changes available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

Chapter 2

- **Assessment Reference Date - (2-8)**
 - o Facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed.

- **Medicare Advantage to Medicare Part A - (2-45)**
 - o If a resident goes from Medicare Advantage to Medicare Part A, the MDS PPS schedule must start over with a 5-day PPS assessment as the resident is now beginning a Medicare Part A stay.
- **ARD Combining PPS & Discharge Assessments (2-61, 62, 64, 67, 69) Clarification**

Chapter 3

- **New Items that cannot be dash filled. (3-4)**
 - o M0300.B.3. - Date of Oldest Stage 2 Pressure Ulcer
 - o A0310 – Type of Assessment
 - o A0800 – Gender
- **CO100 - Should BIMS be conducted? –Code 0, no; if the interview should not be attempted because resident rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. (C-1)**
- **Rejection of Care & Change in Behavioral or Other Symptoms Scenarios - Correction of look back period in scenarios from 5 day to 7 days. (E-16, 22)**
- **Examples for G0300E. Surface-to-Surface Transfer (Transfer from Between Bed and Chair or Wheelchair). (G-28)**
- **H0200. A. Trial of a Toileting Program** Look back period revised. It is now since most recent admission/entry or reentry or since urinary incontinence first noted within the facility. (Inclusion of since most recent prior assessment deleted.) **(H-4)**
- **I15100 Quadriplegia.** This item should be coded only if there is physician documented diagnosis of quadriplegia (r/t spinal cord injury) It should not be coded for conditions that cause functional immobility similar to quadriplegia, e.g. CP spastic quad type, CVA, severe rheumatoid arthritis, or End stage Alz, Disease. **(CMS Open Door Forum Call)**
- **J1700. Fall History on Admission/Entry or Re-entry. (J-26)** Screen Shot Replaced.
- **J1800. Any Falls Since Admission/Entry or Re-entry or Prior Assessment (OBRA or Scheduled PPS) whichever is more recent.** Screen Shot Replaced. **(J-29)**

Continued on page 13.

- **K0300, K0310. Weight Loss For Subsequent Assessments, Weight Gain, Weight Gain for Subsequent Assessments** - Look back period changed from current weight from 7 day look back to “current observation” period. **(K-5, 8, 9)**

- **Section M** – Throughout this section, verbiage was added to emphasize classifying and staging a PU based on what is seen or palpated in the area or wound bed. The term “numerical” was added when speaking of PU Stage 1-4 and the term phrase “increased in numerical” was added in place of “worsened to a higher” stage.

- o **M0210. Unhealed PU.** Coding Tips – Do not code Oral Mucosal ulcers caused by pressure in Section M. Code in Item L0200C, Abnormal mouth tissue. **(M-5)**

- o **M0300B. Stage 2 PU.** Planning for Care - If PU fails to show some evidence toward healing within 14 days, the PU (including potential complications) and resident’s overall clinical condition should be reassessed. **(M-9)** Coding Tips –

- Do not code moisture associated skin damage as a Stage 2 PU. **(M-10)**

- o **M0300D. Stage 4 PU.** Coding Tips - Code PU with exposed cartilage as Stage 4 PU. **(M-15)**

- o **M0300F. Unstageable PU R/T Slough and/or Eschar.** Coding Tips – Code PU covered with slough and/or eschar as unstageable because true depth of soft tissue damage cannot be determined. **(M-17)**

- o **M0700. Most Severe Tissue Type for any PU-24)** Coding Tips – Do not code Stage 2 PU as having granulation, slough, or eschar tissue. Code Stage 2 PU as “1”– Epithelial tissue. **(M-24)**

- o **M0800. Worsening in PU Status.** Coding Tips – Restatement of what is considered as a PU that has worsened. New – Two PU that merged are not coded as worsened unless increase in numerical stage. **(M-26, 27)**

- o **M0900. Health PU.** Health-Related QOL - Clarification and additional information on what takes place when a PU heals and why back staging is not allowed. **(M-28, 29)**

- o **M0900. Healed PU.** Look back period is ARD of prior assessment. If PU was not coded on prior assessment (this is first OBRA or scheduled PPS assessment) do not complete. Skip to M1030.

(M-29)

- o **M1040E. Surgical Wounds.** Coding tips. – Information explains surgical debridement of PU and reinforces that a debrided PU is not a surgical wound. Information also explains on excision of PU and placement of graft or flap and that once it is done the area becomes a Surgical wound not a PU. **(M-34, 35).**

- o **M1040H. MASD.** Information of MASD characteristics, complications, and need for early intervention to prevent skin breakdown. **(M-35)**

- o **M1040. Examples.** Surgical Wound, Skin Tears, MASD, Infection of Foot, Other Lesions, and Burns. **(M-35, 36)**

- o **M1200F. Surgical Wound Care.** Similar information as under Surgical Wounds regarding debridement, excision, and graft/flaps. **(M-39)**

- **O0400. Coding Instructions - Therapy Start Date.** Record date the most recent therapy regimen (since most recent entry/reentry) started. **(O-16)**

- **O0450. EOT-R. Coding Tips.** To code therapy must resume within 5 days and each therapy service must resume at same level for each discipline. **(O-30, 31)**

- **O0100. Physician Orders.** Coding Tips. Do not count either Medicare Certification or Recertification as physician order. **(O-41)**

- **X0300. Gender.** Cannot use dash in A0800 but may use in X0300 for modification or inactivation if used previously in A0800 on original record. **(X-3)**

Chapter 5.

5.2 Timeliness Criteria. Completion Timing. An error was identified in the May 2013 update that will be corrected in October 2013 Update. – For the Admission assessment, the MDS Completion Date (Z0500B) must be no later 13 days after Assessment Reference Date (ARD) A2300. It will be corrected to “must be no later 13 days after Entry Date (A1600)”.

5.7 Correcting Errors in MDS Records ... Modification Requests and Inactivation Requests. Detailed information regarding items formerly requiring inactivation that may now be modified as long as the Items Set or Look back period is not changed. **(5-10-13)**

Chapter 6.

- **(6-10) Billing for EOT and EOT-R when take**

Continued on page 14.

place in different payment periods.

- (6-16) Billing EOT and EOT-R
- 6-18) ARD of SOT
- (6-25, 26) Therapy Billing Minute Calculations and RUGS
- (6-52-54) Early Assessment, Late Assessments, Missed Assessment effect on
- Billing

October, 2013 Item Sets Draft Revision

Items: H0200A, K0700, K0710, M0210, N0310, O0400A4, B4,&C4; O0400A3A, B3A, &C3A

Draft Item Sets Posted at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html> Go to Downloads “MDS 3.0 Subsets 1.11.1 for October 1, 2013 Release”

Posting Nursing Staff Information

F356 §483.30(e) Nurse Staffing Information--

(1) Data requirements. The facility must post the following information on a daily basis:

- (i) Facility name.
- (ii) The current date
- (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
 - (A) Registered nurses.
 - B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
 - (C) Certified nurse aides.
- (iv) Resident census.

(2) Posting requirements.

- (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.
- (ii) Data must be posted as follows:
 - (A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

- Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.
- Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

In meeting this regulation nursing homes need to understand the posted nursing staff information must accurately identify the number of staff working in the home and the specific hours each staff person is working. Although a master schedule may be used to initially create the posting, when scheduled staff do not come to work or leave work early, corrections must be made in the posting to reflect the situation. If replacement staff is secured, homes need to identify the actual hours of both the individual who worked and the individual who is currently working. When a home has resident units located in a main building and in individual houses, the staffing information should be posted both in the main building and in the houses.



Award Letters

Facility	City	Type	Date	Exemplary	Deficiency Free Survey
Caring Hearts for Senior Living	Wichita	HP	1/3/13		x
Clare Bridge of Wichita	Wichita	RCHF	1/13/13		x
Salina Presbyterian Manor	Salina	SNF/NF	1/22/13	x	
Heritage Harbor	Smith Center	BCH	1/23/13		x
Sunflower Adult Day Services	Salina	ADC	1/24/13		x
Fowler Residential Care	Fowler	SNF/NF	1/28/13	x	
Sterling House of Tallgrass	Wichita	ALF	1/29/13		x
Guest Home Estates VII	Garnett	RCHF	1/30/13		x
Sterling House of Derby	Derby	ALF	1/30/13		x
Meadowlark Adult Care Home 2	Wichita	HP	2/13/13		x
Meadowlark Adult Care Home 3	Wichita	HP	2/11/13		x
Meadowlark Adult Care Home 5	Wichita	HP	2/12/13		x
Meadowlark Adult Care Home 6	Wichita	HP	2/12/13		x
Delaware Highlands Assisted Living	Kansas City	ALF	2/18/13		x
Premier Living by Warden LLC	Wichita	HP	2/19/13		x
Reflection Living of Hidden Lakes LLC	Wichita	HP	2/20/13		x
St. Luke Living Center	Marion	SNF/NF	2/25/13	x	
Grace Gardens of Leawood Assisted Living	Leawood	RCHF	2/27/13		x
Seniorcare Homes Nantucket House	Overland Park	HP	2/28/13		x
South Maple House	McPherson	ICF/ID	3/7/13		x
Council Grove Health Center	Council Grove	SNF/NF	3/11/13	x	
Linwood Park of Meriden North	Meriden	HP	3/11/13		x
Seniorcare Homes Newport House	Leawood	HP	3/18/13		x
Comfort Care Homes of KC #9833	Leawood	HP	3/20/13		x
Sterling House of Arkansas City	Arkansas City	ALF	3/20/13		x
Sterling House of Hays	Hays	ALF	3/20/13		x
Community Care Home	Clifton	NF	3/26/13		x

SNF/NF - Skilled Nursing Facility/Nursing Facility; ALF - Assisted Living Facility; BCH - Boarding Care Home; ICF/ID - Intermediate Care Facility for Intellectually Disabled; RCHF- Residential Health Care Facility; ADC- Adult Day Care; HP- Home Plus

The Physician's Role in Quality Care for People with Dementia

Created by Kansas Partnership for Improving Dementia Care in collaboration with the Kansas Medical Directors Association



July, 2012 Office of Inspector General's report to Congress:

- Nursing facilities must meet Federal quality and safety standards to participate in Medicare and/or Medicaid programs
- Standards require extra protections for nursing facility residents receiving antipsychotic drugs
- Residents who have not previously taken antipsychotic drugs are not given them unless it is necessary to treat a specific condition as diagnosed and documented in the residents' clinical records
- When antipsychotic drugs are given, residents must receive gradual dose reductions and behavioral interventions in an effort to discontinue the drugs' use, unless clinically contraindicated

Dr. David Gifford, American Health Care Association Senior Vice President of Quality and Regulatory Affairs: "While many clinicians and consumers believe these medications are effective, we know from medical literature that antipsychotics have limited effectiveness and actually increase the health risks for individuals. We also know there are many facilities that have very low use of antipsychotics and are focusing on non-pharmacological approaches that have been shown to improve care and quality of life for residents. It's time to put everything we know to good use. Providers are up to the challenge... AHCA is encouraged CMS and others are assuming this same mission by joining the Partnership to Improve Dementia Care. Through this partnership...skilled nursing centers across the country have a confirmed commitment, additional assistance and a common cause to better serve our residents who are living with dementia."

Antipsychotic Ordering Standard of Practice Guidelines

Antipsychotic medications and other psychoactive medications that may cause drowsiness may be helpful in certain limited circumstances including psychotic situations such as schizophrenia, Tourette's disorder or Huntington's disease, or to temporarily alleviate a situation in which the resident's behavior causes self-danger or danger to other residents, staff or family members. When ordered, it is vital and sound medical judgment to order the medication in the lowest dose possible for the shortest amount of time and gradual dose reductions are planned and implemented in a timely and medically prudent manner.

Care must be taken by the facility staff and the physician to ensure appropriate behavioral and environmental interventions are implemented prior to initiation of the drug and during the administration of the drug to reduce dangerous behaviors of the resident, which will result in reduction and elimination of the inappropriate use of these drugs.

Continued on page 17.

Antipsychotic medications should not be used to mask symptoms by sedating the resident. The use of antipsychotic medications to replace quality care may be considered a form of chemical restraint and is prohibited by Federal law.

Each resident is ensured Resident Rights, including

- o Informed Decision-Making: Residents have the right to be informed about the risks and benefits of any medication
- o Right to Refuse: Residents have the right to refuse a medication
- o Freedom from Chemical Restraints: It is against the law to give medications that do not benefit the resident and are administered for the convenience of the staff

This facility asks that as the Primary Care Physician for residents in this facility, you:

- Complete an Informed Consent with the resident and/or Responsible Party prior to ordering administration of a psychoactive medication
- Order an automatic 3-day stop date for any emergency antipsychotic or anxiolytic drug order to allow time for appropriate, comprehensive assessment and comprehensive care plan development
- Consider a taper order for each psychoactive medication with the original order
- Ask the facility staff what behavioral and/or environmental interventions have been attempted prior to ordering a psychoactive medication
- Order all psychoactive medications for approved qualifying diagnosis(es) for specific targeted behaviors for specific time periods with ordered gradual dose reductions to monitor for efficacy

ROUTING SLIP			
Administrator _____	Nurse Manager _____	Therapy _____	DON _____
Assist. DON _____	Social Service Director _____	Break Room _____	
Activities Director _____	Dietary Manager _____	Human Resources _____	
MDS Coordinator _____	Other _____		

State and Federal Remedies

STATE REMEDIES Assisted Living, Residential Health Care, Home Plus, Adult Day Care and Boarding Care Facilities; Intermediate Care Facilities for the Mentally Retarded	2nd Quarter Apr- June 2012	3rd Quarter July - Sept 2012	4th Quarter Oct - Dec 2012	1st Quarter Jan - March 2013
Civil Money Penalties	6	7	4	3
Correction Orders	28	23	22	11
Ban on New Admissions	5	5	3	3

FEDERAL REMEDIES Nursing and Skilled Nursing Facilities; Nursing Facilities for Mental Health	2nd Quarter Apr- June 2012	3rd Quarter July - Sept 2012	4th Quarter Oct - Dec 2012	1st Quarter Jan - March 2013
Civil Monetary Penalties Recommended	2	3	1	4
Denial of Payment for New Admissions Imposed	7	5	5	4
Terminations	0	1	0	0
No Opportunity to Correct	7	6	4	2

Total figures for previous quarters are updated as this remedy becomes effective.

Farewell



Vera VanBruggen

As I looked through all my usual resources, the Adult Care Home Regulations, the Federal Regulations, and the RAI Manual, I could not find any guidance on how to easily say goodbye to the many wonderful people who have enriched my life over the past ten years. As each of you entered in a different way –a concerned voice on the telephone, a question and signature on an email, a smiling face/chat at a conference, a word of knowledge at meeting, or a host at your home, you provided me the opportunity to learn more about the people who care for the elders of Kansas and their families. Thank you very much. You will always have a special place in my heart.

Vera VanBruggen,
Long Term Care Consulting Director

Tuberculosis (TB) Guidelines for Adult Care Home

Survey, Certification, and Credentialing Commission; Kansas Department for Aging and Disability Services

TB Control Program, Bureau of Disease Control and Prevention, Kansas Department of Health and Environment

The following guidelines are based on CDC's "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005" available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>

1. New Resident and New Employee - Initial Tuberculosis Symptom Screen and TB Infection Testing

A. Symptom Screen

Each **new resident** and **new employee** shall have an **initial** TB symptom screen that includes the components of the Tuberculosis Symptom Screen Questionnaire within seven days of residency or employment or at the time of administration of the tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA). If the resident or employee exhibits signs and symptoms of TB, the individual shall be referred immediately to a physician, advanced practice registered nurse, physician's assistant, or the local health department. The employee shall not return to work until released by the physician, advanced practice registered nurse, or physician's assistant. If the resident is diagnosed with active TB, the resident shall be transferred from the facility unless it has a TB infection control program consisting of administrative controls, environmental controls, and a respiratory protection program as directed by the CDC Guidelines.

B. TB Infection Testing

(i) Each **new resident** and **new employee** shall receive a two-step TST or an IGRA for *Mycobacterium tuberculosis* within seven days of residency or employment unless one of the following conditions is met:

(a) The new resident or new employee provides

documented evidence of a previous positive TST or positive IGRA, including the date the TST was administered or laboratory test drawn, the test results, the findings of anterior-posterior and lateral view chest x-rays and physician documentation confirming that the individual does not have active TB. Additional x-rays are not required unless the resident or employee has developed symptoms of tuberculosis (e.g., weight loss, cough, fever, ect.).

(b) The new resident or new employee provides satisfactory documentation of receiving the two-step TST or IGRA within six months prior to residency or employment that read not positive.

(ii) If a **new employee** provides a satisfactory documentation of receiving a single TST within six months prior to employment that read not positive, the employee shall only be required to have a single TST within seven days of employment.

(iii) The following conditions do not exempt a **new resident or new employee** from receiving the TST or an IGRA

(a) The new resident or new employee previously receives the Bacillus Calmette-Guerin (BCG) vaccine.

(b) The new resident or new employee is pregnant, as pregnancy is not a contraindication for receiving a TST or an IGRA according to CDC guidelines.

2. Resident & Employee - Annual Tuberculosis Symptom Screen Review & Tuberculosis Infection Testing

A. Symptom Screen

Each **resident** and **employee** shall have an **annual** TB symptom screen that includes the components of the Tuberculosis Symptom Screen Review Questionnaire. If the resident or employee exhibits signs and symptoms of TB, the individual shall be referred immediately to a physician, advanced practice registered nurse, physician's assistant, or the local health department. The employee shall not return to work until released by the physician, advanced practice registered nurse, or physician's assistant. If the resident is diagnosed with active TB, the resident shall be transferred from the facility unless it has a TB infection control program consisting of administrative controls, environmental controls, and a respiratory protection program as directed by the CDC Guidelines.

B. Tuberculosis Infection Testing

Each **resident** and **employee** shall have a TST or an IGRA at intervals based on the facility's risk classification.

3. Resident & Employee - Special Circumstances - Tuberculosis Symptom Screen & Tuberculosis Infection Testing

A. Resident or Employee Absence from Facility

(i) Each **resident** shall have a TB symptom screen questionnaire completed upon return from a hospitalization or a therapeutic leave. If the resident exhibits signs and symptoms of TB, the individual shall be referred immediately to a physician, advanced practice registered nurse, or physician's assistant, or the local health department. If the resident is diagnosed with active TB, the resident shall be transferred from the facility unless it has a TB infection control program consisting of administrative controls, environmental controls, and a respiratory protection program as directed by the CDC Guidelines.

(ii) Each **employee** shall have a TB symptom screen questionnaire completed upon return from an extended leave of absence or a leave of absence involving travel out of the country. If the employee exhibits signs and symptoms of TB, the individual shall be referred immediately to a physician, advanced practice registered nurse, or physician's assistant, or the local health department. The employee shall not return to work until released by the physician, advanced practice registered nurse, or physician's assistant.

(iii) If a returning resident or employee has positive findings on the TB symptom screen and has had exposure to an individual with active TB, the resident or employee shall have a TST or an IGRA completed immediately and be referred to a physician or the local health department. The facility must also contact the Local or State Public Health Officials and cooperate with their TB Contact Investigation.

(iv) If a returning **resident** or **employee** does not have positive findings on the tuberculosis symptom screen and has had exposure to an individual with active tuberculosis, the resident or employee shall have a skin test or an IGRA 8 to 10 weeks after exposure to the individual with active tuberculosis. The facility must also contact the Local or State Public Health Officials and cooperate with their TB Contact Inves-

tigation.

B. Declared shortage of TST solution

Facilities shall follow the recommendations for TB symptom screening and TST provided by the Kansas Department of Health and Environment when a declared shortage TST solution exists.

4. Procedure for Tuberculosis Infection Testing

A. Tuberculosis Skin Test (TST)

(i) The first TST shall be read within 48-72 hours of its administration. If the first TST is read as not positive, a second TST shall be administered within one to three weeks. The second TST shall be read within 48-72 hours of its administration. If the TST is not positive, the resident is considered to not have active TB. (Refer to CDC's Classification of the Tuberculin Skin Test Reaction presented in CDC's Fact Sheet "Tuberculin Skin Testing, October 2011", available at

<http://www.cdc.gov/tb/?404>; <http://www.cdc.gov:80/tb/publications/factsheets/testing/skintesting.html>

Any TST not read within 72 hours shall be repeated.

(ii) If the individual's first TST test is read as **positive** in accordance with the classification of TST reaction and the individual's symptom screen is **negative**, a second TST shall not be administered. The individual shall be referred immediately to a physician for further evaluation. The employee shall not return to work until released by a physician, advanced practice registered nurse, or physician's assistant. If the resident is diagnosed with active TB, the resident shall be transferred from the facility unless it has a TB infection control program consisting of administrative controls, environmental controls, and a respiratory protection program as directed by the CDC Guidelines.

(iii) If the second TST is read as **positive** in accordance with the classification of TST reaction and the individual's symptom screen is **negative**. The individual shall be referred immediately to a physician further evaluation. The employee shall not return to work until released by a physician, advanced practice registered nurse, or physician's assistant. If the resident is diagnosed with active TB, the resident shall be transferred from the facility unless it has a TB infection control program consisting of administrative controls, environmental controls, and a respiratory protection program as directed by the CDC.

B. Interferon Gamma Release Assay

If a sample of the resident's blood is drawn in the adult care home, the home should have policies and procedure that include the following:

- (i) Blood shall be drawn according the manufacturer instruction specific to the brand of IGRA testing chosen and submitted to a laboratory equipped to process the tests.
- (ii) All laboratory shipping requirements for the processing of the tests must be followed to assure accuracy of the test results.

5. Required Documentation in Resident's Clinical Record or Employee's File

Each **resident's clinical record** or **employee's file** shall contain documentation regarding the symptom screen review, skin testing, IGRA, and chest x-rays (if applicable).

A. Symptom Screen Review

- (i) Completed Tuberculosis symptom review questionnaire, including required signatures and dates.
- (ii) Follow up of any positive findings.

B. Two-step TST

- (i) Name and address of entity where testing took place.
- (ii) Date each TST was administered.
- (iii) Date each TST was read.
- (iv) Result of each TST in millimeters (mm) of induration.
- (v) Signature of representative verifying the two-step STS was administered and read.

C. Single TST

- (i) Name and address of entity where testing took place.
- (ii) Date the TST was administered.
- (iii) Date the TST was read.
- (iv) Result of test in millimeters (mm) of induration.
- (v) Signature of representative verifying the TST was administered and read.

D. IGRA

- (i) Name and address of the laboratory that performed the test.
- (ii) Date of test.
- (iii) Laboratory test result.

E. Chest Radiography (when applicable)

- (i) Name and address of entity where chest radiography took place.
- (ii) Date chest x-ray performed.

(iii) Interpretation of chest x-ray.

(iv) Printed or typed name of interpreter of the chest x-ray.

6. Reporting Positive Tests

All positive test results shall be reported to the local health department or to the Kansas Department of Health and Environment, Tuberculosis Section (785) 296-5589 or via facsimile (785) 291-3732 within the specified timeframes as indicated in K.A.R. 28-1-2, K.A.R. 28-1-4 and K.A.R. 28-1-18.

7. Facility Risk Assessment, Education, and Screening

A. The administrator or operator shall ensure the facility's TB infection control program is developed based on the facility's TB risk assessment, which shall be updated at least annually.

B. The administrator or operator shall ensure ongoing evaluations are conducted to determine if there is a change in circumstances that may affect the facility's risk for transmission of M. tuberculosis.

C. The administrator or operator shall ensure that policies are developed and procedures implemented for the screening and testing of residents and employees based on the facility's level of risk. The CDC's "Tuberculosis (TB) risk assessment worksheet" available at: http://www.cdc.gov/tb/publications/guidelines/AppendixB_092706.pdf may be used as a guide for conducting the facility's risk assessment. The regional rate of TB incidents may be obtained from the KDHE TB Control 7850296-5589.

D. Licensed nurses in the facility who administer TST and interpret the results shall be competent in the task.

E. All employees shall receive education on signs and symptoms of TB, mode of transmission, and prevention upon employment and at least annually.

8. Contract staff.

The administrator or operator shall ensure that documented evidence from the employment agency of two-step a TST or an IGRA, annual TB symptom screen, and annual TB education is maintained by the facility for any contract staff working in the facility.

9. Volunteers.

The administrator or operator may follow these guidelines for volunteers.

TUBERCULOSIS SYMPTOM SCREEN QUESTIONNAIRE

Complete per TB Guidelines for ACH. **Resident:** Initially upon Admission, Annually, Upon return from hospitalization and therapeutic leave of absence (LOA). **Employee:** Initially upon Admission, Annually, Upon return from extended LOA, and LOA involving travel outside USA.

Resident/Employee Name _____

Position/Title _____

Yes	No	1. Have you experienced any of the following symptoms in the past year?
		a. Productive cough longer than 3 weeks in duration
		b. Unexplained weight loss
		c. Persistent low fever
		d. Excessive fatigue
		e. Coughing up blood
		f. Shortness of breath
		g. Chills
		h. Severe night sweats
		2. Have you ever been told that you have active TB?
		3. Have you ever had contact with anyone with active TB?
		4. Have you ever traveled or lived outside of the country for three months or greater?

Please provide further details to any “yes” answers.

If you answered “yes” to Question 4.

a. **When** did you travel or live outside of the country for three months or greater?

b. **Where** did you travel or live outside of the country for three months or greater?

Resident (or Resident’s Legal Representative) or Employee Signature Date

Reviewer’s Signature and Title Date