



Date: January 30, 2006

Subject: The following Provider Bulletins are obsolete and not appropriate for updating; therefore, they are not included:

#	Title	Date
1	Medicare Certification Letter	1988
2	Licensure Guidelines	1988
3	Criteria for Exception 29 PA Code §211.12(7)(I) Staffing	1988
5	Licensure Guidelines PALTC 28 PA Code §201.18(j)(2) Patient Funds	1989
6	Heavy Care/ICF Services	1989
7	Influenza and TB Control	1989
8	L-tryptophan Update	1990
9	Deficiencies at Exit Conference	1990
10	Draft of Proposed LTC Regulation 28 PA Code §201.29	1990
11	HSQR Letter- Survey Modifications	1990
13	Nurse Aide Registry	1990
14	Salmonella Enteritidis-Guideline for Eggs	1990
15	Pharmacy & Infection Control Committee Composition	1990
20	Medicare Billing Notice	1991
23	Use of Geri-Chair-Conflict in State and Federal Regs	1991
26	Visiting Hours in Nursing Homes	1991
27	Resident Assessment	1991
30	Resident Assessment Letter –Use of Section II	1992
32	Advisory Bulletin – Ceramic Glazes	1992
33	Sclavo TB Testing Products	1992
38	Clarification of RAI Issues	1999
39	MDS Supplement	1993
40	Potential Hazard-Un-refrigerated Garlic, Spice-in-Oil	1993
45	MDS- How to count Assessment Days	1994
47	PA Nurse Aide Registry on the World Wide Web	?
52	Federal Requirements Regarding Use of MDS	1998
53	Resident's Choice of Pharmacy	1998
56	Metallic Mercury Precautions	2000

GUIDELINES AND RECOMMENDATIONS

Updated Infection Control Measures for the Prevention and Control of Influenza in Health-Care Facilities

January 20, 2005

Introduction

Influenza is a cause of respiratory illness that may require outpatient health-care visits and hospitalization. During the influenza season, outbreaks of health care-associated influenza affect both patients and personnel in long-term care facilities and hospitals. Although influenza vaccination of health-care personnel and long-term care facility residents can help prevent outbreaks, this year's shortfall in vaccine production may require increased reliance on other measures to prevent transmission. This document provides updated guidance for prevention and control of influenza transmission in health-care facilities. In addition, it provides electronic links to interim recommendations specific for the 2004-05 influenza season.

Transmission

Human influenza is transmitted from person-to-person primarily via virus-laden large droplets (particles >5 µm in diameter) that are generated when infected persons cough or sneeze; these large droplets can then be directly deposited onto the mucosal surfaces of the upper respiratory tracts of susceptible persons who are near (e.g., within 3 feet) the droplet source. Transmission may also occur through direct and indirect contact with respiratory secretions. Transmission from environmental surfaces has not been demonstrated by epidemiologic studies.

Prevention and Control Measures

Strategies for the prevention and control of influenza in health-care facilities include the following: influenza immunization for persons at high risk for complications, immunization for health-care personnel, respiratory hygiene/cough etiquette programs, Standard Precautions and Droplet Precautions, and restriction of ill visitors and personnel.

Vaccination

Health-care personnel and persons at high risk for complications of influenza should be encouraged to receive influenza vaccination according to [current national recommendations](#).

- **Vaccination is the primary measure to prevent infection or development of illness from influenza, and thereby limit transmission of influenza, and prevent complications from influenza.**
- **Inactivated influenza vaccine or live attenuated influenza vaccine may be used to vaccinate most health care personnel.**
 - **Inactivated vaccine may be used by all health-care personnel and is preferred for vaccinating health-care personnel who have close contact with severely immunosuppressed persons (e.g., patients with hematopoietic stem cell transplants) during those periods in which the immunosuppressed person requires care in a protective environment.**
 - **Live attenuated vaccine (LAIV) may be given to health-care personnel younger than 50 years of age who do not have contraindications to receiving the nasal vaccine. These health-care personnel include those who take care of immunocompromised patients who do not require care in a protective environment. If health-care personnel who care for severely immunocompromised patients in protected environments receive LAIV, then they should not care for these patients for 7 days following immunization.**

Infection Control Measures

In addition to influenza vaccination, the following infection control measures are recommended to prevent person-to-person transmission of influenza and to control influenza outbreaks in health-care facilities:

1. [Respiratory Hygiene/Cough Etiquette Programs](#)
Respiratory hygiene/cough etiquette should be implemented at the first point of contact with a potentially infected person to prevent the transmission of all respiratory tract infections in health-care settings. Respiratory hygiene/cough etiquette programs include:
 - Posting visual alerts instructing patients and persons who accompany them to inform health-care personnel if they have symptoms of respiratory infection.
 - Providing tissues or masks to patients and visitors who are coughing or sneezing so that they can cover their nose and mouth.
 - Ensuring that supplies for hand washing are available where sinks are located; providing dispensers of alcohol-based hand rubs.
 - Encouraging coughing persons to sit at least 3 feet away from others, if possible.

2. [Standard Precautions](#)
During the care of any patient with symptoms of a respiratory infection, health-care personnel should adhere to Standard Precautions:
 - Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.
 - Wear a gown if soiling of clothes with a patient's respiratory secretions is anticipated.
 - Change gloves and gowns after each patient encounter and perform hand hygiene.
 - Decontaminate hands before and after touching the patient, after touching the patient's environment, or after touching the patient's respiratory secretions, whether or not gloves are worn.
 - When hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either plain or antimicrobial) and water.
 - If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in clinical situations. Alternatively, wash hands with soap (either plain or antimicrobial) and water.

3. [Droplet Precautions](#)
In addition to Standard Precautions, health-care workers should adhere to Droplet Precautions during the care of a patient with suspected or confirmed influenza:
 - Place patient into a private room. If a private room is not available, place (cohort) suspected influenza patients with other patients suspected of having influenza; cohort confirmed influenza patients with other patients confirmed to have influenza.
 - Wear a surgical or procedure mask upon entering the patient's room or when working within 3 feet of the patient. Remove the mask when leaving the patient's room and dispose of the mask in a waste container.
 - If patient movement or transport is necessary, have the patient wear a surgical or procedure mask, if possible.

4. [Antiviral Prophylaxis](#)
Antiviral prophylaxis may be given to patients, residents, and health-care personnel in accordance with current recommendations.

5. Restrictions for Ill Visitors and Health-care Personnel

If there is no or only sporadic influenza activity occurring in the surrounding community:

- Discourage persons with symptoms of a respiratory infection from visiting patients. Inform the public about restricted visitation through educational activities.
- Evaluate health-care personnel with influenza-like illness and perform [rapid influenza tests](#) to confirm the causative agent is influenza; determine whether they should be removed from duties that involve direct patient contact, especially those who work in certain patient-care areas (e.g., intensive care units [ICUs], nurseries, organ-transplant [protective environment] units, and long-term care facilities). If excluded, they should not provide patient care for 5 days after the onset of symptoms.

If widespread influenza activity is in the surrounding community:

- Confirm that influenza is the cause of the outbreak by performing rapid or other [influenza tests](#) on a subset of ill persons.
- Actively communicate to the public at large (e.g., via public service announcements) and visitors (e.g., via posted notices) not to visit for 5 days following the onset of a respiratory illness.
- In high-risk areas (e.g., ICUs, nurseries, and organ-transplant [especially protective environment] units, and long-term care facilities), actively screen unvaccinated health-care personnel for symptoms of respiratory infection and exclude those with symptoms for 5 days following the onset of symptoms.

Control of Influenza Outbreaks in Health-care Settings

When influenza outbreaks occur in health-care settings, additional measures should be taken to limit transmission. These include:

- Identify influenza virus as the causative agent early in the outbreak by performing rapid [influenza virus testing](#) of patients with recent onset of symptoms suggestive of influenza. In addition, obtain viral cultures from a subset of patients to determine the infecting virus type and subtype.
- Implement [droplet precautions](#) for all patients with suspected or confirmed influenza.
- Separate suspected or confirmed influenza patients from asymptomatic patients.
- Restrict staff movement from areas with outbreaks to other units and buildings.
- If available, administer the current season's influenza vaccine to unvaccinated patients, residents, and health-care personnel. Follow [current vaccination recommendations](#) for nasal and intramuscular influenza vaccines.
- Administer [influenza antiviral prophylaxis and treatment](#) to patients, residents, and health-care personnel according to current recommendations.
- Consider antiviral prophylaxis for all health-care personnel, regardless of their vaccination status, if the outbreak is caused by a variant of influenza virus that is not well matched by the vaccine.
- Curtail or eliminate elective medical and surgical admissions and restrict cardiovascular and pulmonary surgery to emergency cases only, when influenza outbreaks, especially those characterized by high attack rates and severe illness, occur in the community or acute care facility.



DATE: September 30, 2005

SUBJECT: Long Term Care Provider Bulletin No. 12
Physician's Participation in Resident Care Planning

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Pennsylvania Department of Health

Attached is a copy of a directive received from Centers for Medicare Medicaid Services, which was originally posted in 1999. The letter provided clarification relative to physical presence of the attending physician during care plan meetings. The physician must provide input as part of the interdisciplinary team, but she/he may provide input via telephone or written communication, rather than attendance at the care plan meeting.

The attached directive reflects practice that continues to be acceptable per this update.

Re: Physician Involvement in Patient Planning Meetings –
(CFR 42 483.20 (d) (2) (ii), February 2, 1989)

Dear Director:

We recently received policy clarification from the Bureau of Policy Development, regarding the physicians' involvement in the patient planning meetings. A comprehensive care plan must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents needs.

The regulation requires the attending physician to participate in the preparation of a plan of care, but it does not require the attending physician to participate in a meeting. The attending physician can accomplish this participation in a number of other ways (e.g., written, telephone, or facsimile communications), but he or she does not actually have to attend a meeting of the interdisciplinary team. There may be occasions when the physician decides to meet with other health professionals to discuss a particular case, but this will be at the option of the physician.

A physician must, however, comply with section 483.20(a) which requires the residents, upon admission, to have physician orders for their immediate care. Noncompliance with this requirement is a serious threat to the health and safety of residents. It should also be noted that the attending physician must visit the resident at periodic intervals as specified in section 483.40 (c) and 483.40(c)(3). In these visits, the resident "must be seen" by the physician and/or the physician extender.

Sincerely,

Claudette V. Campbell, Chief
Survey and Certification
Review Branch
Health Standards and Quality



DATE: October 5, 2005

SUBJECT: Long Term Care Provider Bulletin No. 16
Methicillin-Resistant Staphylococcus Aureus (MRSA)
Guidelines for Long Term Care Facilities

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Pennsylvania Department of Health

The increasing incidence of MRSA in Pennsylvania long- term care facilities is of great concern. If accepted infection control procedures are followed, transmission of MRSA can be greatly reduced.

Attached, for your information, are guidelines regarding transmission, identification, and control of MRSA that were prepared by the Division of Nursing Care Facilities in conjunction with the Division of Acute Infectious Disease Epidemiology.

Thank you for your attention to this health care issue.

Attachments

Methicillin-Resistant Staphylococcus Aureus (MRSA) **Guidelines for Long Term Care Facilities (8/27/2001)**

Introduction

Methicillin-Resistant Staphylococcus Aureus (MRSA) is a gram-positive coccus, nosocomial pathogen, resistant to most commonly utilized antibiotics, including penicillins and cephalosporins.

Infected and colonized residents may serve as potential sources for the spread of MRSA in long-term care facilities. Elderly residents are at increased risk for colonization with MRSA, in addition to having the potential to carry MRSA for long periods of time.

Reports of MRSA infection have increased in the last two decades. Hospital patients, residents of long term care facilities, and even community residents are experiencing colonization and infection from MRSA. Reports of costly epidemics in hospitals and nursing homes are common.

Colonization v. Infection

Two significant states can occur: colonization or infection.

Colonization is the presence, growth, and multiplication of the organism without observable clinical symptoms or immune reaction. Colonization occurs on the skin surface, wound or decubitus ulcer surface, in the sputum, or urine. One of the most common sites of colonization in both residents and employees is the front of the nose (anterior nares). While personnel may become colonized with MRSA, they rarely develop infections.

Infection caused by MRSA is defined as isolation of the organism accompanied by clinical signs of illness such as fever, elevated white count, purulence (pus), pneumonia, inflammation, etc.

In other words, colonization refers to the presence of the micro-organisms in or on a host with growth and multiplication but without tissue invasion or damage. Infection implies invasive disease with resulting tissue damage. The distinction must be made regarding colonization versus infection to determine appropriate therapy.

Most persons with MRSA are colonized; only a few are infected.

Infectious Agent: A strain of *S. aureus* that is resistant to methicillin, oxacillin, nafcillin and other antibiotics

Reservoir: Colonized and infected patients. The anterior nares are a common colonization site. To a lesser degree, colonized healthcare workers may also serve as a reservoir.

Modes of Transmission: Person-to-person contact, for example via transiently colonized hands of staff. Fomites such as bed linens or environmental surfaces are not thought to play a major role in transmission except in special populations, such as patients in burn units or intensive care units. Cleaning and disinfection of these items is necessary, however, to reduce bacterial load and risk of

transmission. Hands of staff appear to be the most likely mode of transmission of MRSA from resident to resident. Droplet-borne transmission is less common but may be important in residents with tracheostomies who are not able to control their secretions. MRSA can be found on the skin, in the nose and in blood and urine.

Incubation Period: Variable

Risk Factors for MRSA

Identified risk factors for acquiring MRSA are:

1. Prolonged hospitalizations
2. Debilitated condition of patient
3. Age over 65
4. Invasive procedures (e.g. catheters, gastric/endotracheal tubes, etc)
5. Open Wounds
6. Severe underlying disease
7. Treatment with multiple broad-spectrum antibiotics
8. Close proximity to residents colonized or infected with MRSA

Diagnosis

A bacterial culture and antibiotic sensitivity of the suspected site of infection or colonization (e.g. blood, sputum, urine, respiratory secretions, wound exudate, decubitus material) is necessary for diagnosis. MRSA infection can be diagnosed by positive culture together with signs/symptoms of infection.

Treatment

The antibiotic of choice for MRSA infections is vancomycin given intravenously. Many minor MRSA infections can be successfully treated with trimethoprim-sulfamethoxazole, if susceptibility is established by testing. Avoid unnecessary use of antibiotics with all residents.

Goals

The goals of infection control measures for MRSA in long term care facilities are:

1. To prevent the transmission of the organism to residents and employees within the facility.
2. To facilitate appropriate transfer of patients from acute care to long term care facilities.

Admission Policies

Long term care facilities in Pennsylvania are capable of caring for any resident with MRSA colonization and some residents with MRSA infection. If there is no need for the resident to be hospitalized for treatment purposes, then there is no reason that the resident cannot be admitted

to a nursing home, as long as appropriate precautions are taken to prevent transmission. Cultures for MRSA need be obtained prior to or on admission only if MRSA is suspected.

It is the position of the Department of Health that a licensed nursing home has presented to the department infection control policies and procedures, which were accepted during the survey process.

Control Standards

Even in the absence of any known MRSA infection or colonization, certain minimum infection control standards must be adhered to. Much MRSA infection or colonization or colonization/infection by other organisms is unrecognized. Adherence to these minimum standards is extremely important in order to prevent transmission of these organisms.

Precautions: Isolation precautions (e.g. contact precautions) should be implemented according to the type of MRSA infection or colonization. Standard precautions should be practiced at all times, regardless of MRSA status. Transmission-based isolation precautions should be continued for as long as the resident continues to have secretions or excretions that cannot be contained. When the condition of a resident changes (e.g. wound drainage is contained), transmission-based isolation precautions can be modified or discontinued.

GLOVES: Gloves should be worn when providing care that involves substantial personal contact (e.g. changing clothes, toileting, bathing) or contact with items that may be contaminated by MRSA (e.g. bedding). If, during the course of resident care, gloves become soiled with potentially infectious material (e.g. urine, stool), they should be changed before further contact with clean surfaces, the resident or other staff. Remove the gloves after caring for the resident and wash hands with an antibacterial soap before leaving the room. Gloves alone do not guarantee prevention of transmission.

GOWNS: Gowns should be worn if the caregiver's clothing is likely to have substantial contact with a MRSA-positive resident in the course of care (e.g. bed baths, lifting). Gowns should be removed immediately after care and the caregiver's hands should be washed prior to leaving the resident's room. Gowns are not necessary for feeding or measuring vital signs.

Masks: MRSA is not known to be transmitted through the airborne route. However, masks are recommended when the resident has MRSA bronchitis or tracheitis, lower bronchial colonization or a tracheostomy, and during the care of MRSA-infected burns. If extensive splattering is expected, protective eyewear may be warranted.

Hand hygiene: Strict adherence to hand washing protocols must be maintained. Staff and visitors should wash their hands with an antibacterial soap after glove removal, after resident care, and prior to leaving the room of a MRSA-positive resident. Hands should be dried with a dry, disposable paper towel, and faucets should be turned off using a paper towel. Hands should be washed after touching body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Educate staff and residents about the

importance of hand washing. If residents cannot wash their own hands after bathroom use, their hands should be washed for them.

Linens: Minimal handling of soiled linens should be stressed. Staff involved with stripping beds or otherwise having direct contact with these materials should wear gloves and gowns. Soiled Linens should be bagged in the resident's room.

Environmental Cleaning: Routine cleaning of resident's surrounding should be done daily to reduce bacterial load. Sharing of non-critical equipment (such as thermometers, blood pressure cuffs and intravenous poles) should not be permitted. Cleaning supplies should be dedicated to the room. Discard all contaminated disposable supplies after the resident leaves the room, and keep disposable supplies in the room to a minimum. Only plastic, vinyl or leather-coated furniture that can be wiped down with a disinfectant should go in the room. Bath tubs, whirlpools, and hydrotherapy tubs should be cleaned and disinfected after each use. Refer to CDC Environmental Cleaning - http://www.cdc.gov/ncidod/hip/enviro/Enviro_guide_03.pdf

Room Placement: A private room is not necessary unless the patient has a condition that would increase the likelihood of transmission (e.g. eczema, a large MRSA-infection, colonized burn, or lower respiratory tract infection). However, when placing residents with MRSA in multiple-bed rooms, their roommates should not be severely immunocompromised or have indwelling lines or open wounds.

Group Activities: A long-term care facility is generally considered a resident's home. A MRSA-positive resident should be allowed to ambulate, socialize as usual, and participate in therapeutic and group activities, as long as contaminated body substances are contained. When residents leave their room, they should have their hands cleaned. In addition, they should have clean, dry dressings and wear clean clothes. Where appropriate, enhanced barrier protection to contain a contaminated body substance is preferred over restriction of residents.

Staff Education: All staff working in a long-term care facility should receive education and training regarding MRSA and the importance of control. Education should be provided on a regular basis, at least annually. Additionally, in-service training in infection control should be provided in response to any increase in MRSA frequency within the facility.

OUTBREAK CONTROL

An outbreak may be defined as the occurrence of a disease or condition in excess of what is normally expected. Each case of MRSA in a resident should be closely monitored as previously described. However, the following should be conducted in an outbreak situation:

1. Individual cases of MRSA in long-term care facilities are not presently reportable to Pennsylvania Department of Health. However, in outbreak situations, notify the Division of Nursing Care Facilities and your local public health office.
2. Reinforce infection control procedures throughout the facility (e.g. hand washing and isolation precautions).

3. Establish a cohort of MRSA-positive residents. Staff should be restricted to caring for only one cohort of residents. Restrict floating of staff.
4. Culture all residents in the affected unit(s). Staff with signs of staphylococcus infection should be cultured. Asymptomatic staff that has had contact with MRSA-positive residents should also be cultured. Culture-positive staff should be assessed on a case-by-case basis following the employee health guidelines of the institution.
5. Institute appropriate isolation precautions for the MRSA-positive cohort immediately.
6. Conduct an epidemiological investigation to the best of your ability. Focus on collecting the following information for each MRSA positive-resident:
 - a) the resident's location in the facility (before and after cohorting)
 - b) date(s) of the resident's original and most recent admission to the facility
 - c) date(s) of recent admission/discharges to/from other acute and long-term care facilities
 - d) which caregivers in the current facility had "hands-on" contact with the resident
 - e) body site(s) of infection/colonization of the resident
 - f) age, sex and ethnicity of the resident
 - g) diagnosis and underlying conditions of the resident
 - h) treatments given to the residents
7. Decolonization of residents or staff is not routinely recommended. This has not proven to be an effective control measure for large populations because recolonization occurs. However, in an outbreak situation, if an individual can be identified as the source of transmission (e.g. healthcare worker with several residents having identical strains of MRSA and phage typing of the outbreak strain and this healthcare worker's being identical), then s/he should be removed from work while efforts are made to achieve MRSA decolonization.
8. It is not necessary to restrict admissions or discharges to the facility unless it is determined that the facility is not following the proper protocols for those residents who are currently in the facility.

Communication

- Facilities should inform all physicians who admit persons to the facility when the facility is aware that MRSA transmission has occurred in the facility.
- Facilities should inform hospitals or other facilities if they are transferring a resident who is known to be colonized or infected with MRSA.
- A hospital or facility that is transferring a resident known to be colonized or infected with MRSA to a long term care facility, should inform the long term care facility that the resident has MRSA. Hospitals should also notify long term care facilities whether the resident being transferred was infected or colonized with MRSA during the

hospitalization.

- A hospital which finds that a patient admitted from a long term care facility is infected or colonized with MRSA within 48 hours of hospital admission, should notify the long term care facility of these results.
- Effective communication between acute and long term care facilities is vital. There must be a spirit of cooperation between hospitals and nursing homes.

Additional Guidelines

- MRSA colonization is not an indication for hospital admissions.
- Licensed facilities may admit and retain residents who are infected or colonized with MRSA.
- Overuse of antibiotics should be avoided. This will lower the survival advantage of this bacteria.
- Culturing of employees is indicated only if epidemiologically linked to an outbreak.
- Personnel with skin lesions should be removed from resident care. Personnel with respiratory infections with a cough should not be assigned to direct resident care.
- Routine culturing of asymptomatic residents is not indicated.
- A long term care facility must periodically present continuing education on handwashing, basic hygiene, and infection control procedures. When a resident with MRSA is admitted or identified, these procedures should be reviewed with all employees. Attention to proper infection control procedures is vital!
- MRSA colonization is not a contraindication to sending a resident home, if the resident can be cared for adequately at home.
- Above all, do not overreact. This leads to often harmful, costly, and labor intensive measures in terms of inappropriate antibiotics, random culturing, resident isolation, and to fear by family and personnel.

References

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). *Guideline for Environmental Infection Control in Health Care Facilities* 2003; 71-74

Massachusetts Department of Public Health. *Methicillin-Resistant Staphylococcus Aureus Infection Control Guidelines for Long-Term Care Facilities*. August 2001

Bischoff WE, Reynolds TM, Sessler CN et al. Handwashing compliance by HealthCare workers.
Archieve of Internal Medicine 2000; 160: 1017-1021

Glossary – The following definitions apply to these terms in the context of MRSA

Infection	The condition of a resident when MRSA has entered a body site, is multiplying and causing clinical consequences such as fever, a suppurative wound, and/or tissue destruction.
Colonization	The condition of a resident when MRSA is on or in the body, but no clinical consequences is occurring.
Cohort	Two or more or more residents in a facility physically separated from the other residents and cared for by staff that do not care for other residents.
Endemic	The situation in a facility when MRSA colonization and/or infections are occurring all or almost all the time, with relatively constant frequency.
Epidemic	The situation in a facility when MRSA colonization and/or infections are occurring at a significantly higher rate than usual for the facility.
Eradication	The complete removal of all MRSA from a colonized or infected person to a person previously free of the organism.
Transmission	The passage of MRSA from a colonized or infected person to a person previously free of the organism.
Segregation	The physical separation of a single of a single resident from others in the facility, with care for that resident assigned to one staff member per shift (that staff member limiting care for other residents as much as practicable)
Epidemiologic Investigations	The gathering of information on residents and staff of a facility regarding demographics, illness factor, and exposure factors, and the tabulation of that information in order to establish associations between illness and any antecedent risk factors for that illness.



DATE: October 13, 2005

SUBJECT: Long Term Care Provider Bulletin No. 18
Transmission of Physicians' Orders to Health Care
Facilities via Facsimile (Fax) Machine

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Pennsylvania Department of Health

The use of fax machines for the transmission of physicians' orders to nursing homes is an acceptable practice. Guidelines for this practice can be found in the State Operation Manual, Appendix PP, F386 F42 CFR 483.40(b) Physician Visits.

- Physician orders may be transmitted by facsimile machine if the following conditions are met:
- The physician should have signed and retained the original copy of the order from which the facsimile was transmitted and be able to provide it upon request.
- Alternatively, the original may be sent to the facility at a later time and substituted for the facsimile.
- The facility should photocopy the faxed order since some facsimiles fade over time.
- The facsimile copy can be discarded after facility photocopies it.
- A facility using such a system should establish adequate safeguards to assure that it is not subject to abuse.

It is not necessary for a physician to re-sign the facsimile order when he/she visits the facility.



DATE: **October 13, 2005**

SUBJECT: **Long Term Care Provider Bulletin #19
Use of the Minimum Data Set**

TO: **Nursing Home Administrators**

FROM: **William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816**

**Appendix R - Resident Assessment Instrument for Long-Term
Care Facilities - (Rev. 1, 05-21-04)**

Introduction

Sections 1819(f)(6) and 1919(f)(6) of the Social Security Act (the Act) require that the Secretary specify a minimum data set (MDS) of core elements and common definitions for use by long-term care facilities in conducting comprehensive assessments of residents residing in long-term care facilities. These sections also require the Secretary to establish guidelines for the use of these data elements.

These utilization guidelines consist of instructions for using the Resident Assessment Instrument (RAI) and include the resident assessment protocols (RAPs). Furthermore, the Secretary is required to designate one or more RAIs that are consistent with the MDS and common definitions. A State may specify the RAI designated by the Secretary for use in conducting assessments, or it may develop an alternate RAI provided it is approved by the Secretary as being consistent with the MDS of core elements, common definitions and utilization guidelines. CMS' original RAI was published in 1990 and implemented in all States by 1991.

CMS subsequently undertook a collaborative process to revise the RAI, which culminated in the release of version 2.0 of the RAI. CMS requires the use of the September 2000 update of version 2.0 of the RAI (or an approved alternate) by all States. Each State's RAI must consist of at least CMS' September, 2000 RAI.

Any State-specific items are included in an optional Section S; States may also specify the standardized, optional sections T and U as part of their RAI.

CMS' RAI consists of:

- MDS Version 2.0 (with or without optional Sections S, T, U)
 - Resident Assessment Protocols (RAPs)
- Utilization Guidelines

Under the SNF PPS requirements, facilities must complete Section T for residents in a Medicare Part A covered stay each time an MDS is required for Medicare payment purposes.

The revised Long-Term Care Resident Assessment Instrument User's Manual , Version 2.0, December 2002 including the June and August 2005 updates and Section W is located on **the CMS website**.

<http://www.cms.hhs.gov/quality/mds20/>



DATE: November 18, 2005

SUBJECT: Long Term Care Provider Bulletin #21
Admission and Treatment of Persons With AIDS or
AIDS-Related Conditions in Long Term Care Facilities

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

All health care facilities which are licensed by the department or certified to receive funding under the Medicare and Medical assistance programs must have a nondiscriminatory policy with respect to staff, patients, and persons seeking admission. Denial of admission or a service to a person based upon a diagnosis or suspicion that the person has AIDS or other HIV-related conditions, is prohibited when that person is otherwise qualified to be admitted or to receive the service.

All nursing homes in Pennsylvania are required to meet state rules and regulations for licensure. Included in the regulations are requirements for resident assessment and care planning, staffing to meet the needs of residents, staff education, professional services, and infection control practices. When in substantial compliance with these rules and regulations, a nursing home is capable of providing care to meet the needs of persons with most communicable diseases including AIDS and most HIV-related conditions.

Each facility's resident care policies and infection control program must include provisions for staff and resident education regarding the transmission of HIV and Centers for Disease Control standard precautions for the prevention of the spread of the virus .

http://www.cdc.gov/ncidod/publications/eid_plan/strategy.htm

The Department of Health, through the Bureau of HIV/AIDS, is available to help nursing homes design and conduct these staff and patient education efforts.

<http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=178&Q=231584&healthPNavCtr=#465>

Included is a web link to the Office of Civil Rights, Department of Health and Human Services, regarding HIPPA requirements for HIV/AIDS residents and Pennsylvania Act 148.

<http://www.hhs.gov/ocr/hipaa/>

<http://www.aidsandthelaw.com/issues/PA%20laws/PA%20Act%20148.htm>

Any health care provider who receives financial assistance through the Medicare, Medicaid, or other federal programs to assist your facility to formulate policies that ensure that persons with HIV and related conditions are not subject to unlawful discrimination.

It is the intent of the department to assure that services are made available to all persons with HIV/AIDS who require these services. The department will initiate a licensure action and recommend that action be taken against certification whenever it discovers that a facility has discriminated against an otherwise qualified person based upon a diagnosis of HIV, AIDS, or other HIV-related condition.

Please note attached list of AIDS related Hotlines.

INFORMATION HOTLINES

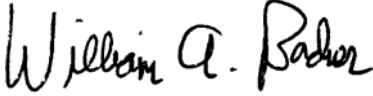
Pennsylvania Department of Health, State AIDS Factline	1-800-662-6080
Pennsylvania Department of Public Welfare Hotline	717-772-2525
U.S. Public Health Service AIDS Hotline	(English) 1-800-342-AIDS (Spanish) 1-800-344-SIDA
National AIDS Clinical Trials Hotline	1-800-TRIALS-A
Critical Path AIDS Project (Philadelphia)	215-985-2437
NAPWA (National Association of People with AIDS)	240-247-0880
AIDS Library of Philadelphia	215-985-4851
AIDS Law Project of Philadelphia	215-587-9377
American Civil Liberties Union	215-592-1513
Pennsylvania Human Relations Commission	717-787-4410
Pennsylvania Department of Health Bureau of HIV/AIDS Room 1010 Health & Welfare Building Harrisburg, Pa 17108	717-783-0572
Philadelphia AIDS Activities Coordinating Office	215-685-5600
Philadelphia AIDS Hotlines	215-985-AIDS 215-985-3300 215-732-AIDS



DATE: May 25, 2006

SUBJECT: Long Term Care Provider Bulletin No. 22, 7/1/91
Abuse, Neglect, Misappropriation of Property by Nurse Aides or Others

TO: Nursing Home Administrators



FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

This bulletin is notice of the Division of Nursing Care Facilities' (DNCF) revision of "Facility Report for Investigation of Abuse, Neglect, Misappropriation of Property" by any individual used by the facility to provide services to residents.

The revisions have been made to facilitate reporting to both the Department of Health and the Department of Aging. All areas of the form that are double underlined represent requirements of Act 13 of 1997 and must be reported to the Area Agency on Aging.

We have included as attachments:

- Instructions for Completion
- Revised Provider Bulletin -22 reporting form
- Guidelines for investigation of abuse, neglect and misappropriation of property
- Department of Health definitions
- Act 13 Mandatory Abuse Report Instruction Sheet.

Facility Responsibilities:

Each facility must develop and implement its own personnel policies to ensure the employment of qualified personnel. Appropriate reference checks must be made. For nurse aides, the Nurse Aide Registry must also be contacted to confirm the aides' enrollment and status on the registry.

Definitions of resident abuse, neglect, and misappropriation of resident property should be posted in a conspicuous place for staff and visitors' education.

The following procedure is to be implemented by the facility when an incident of resident abuse, neglect, or misappropriation of property is alleged or suspected:

1. Notify the appropriate Division of Nursing Care Facilities field office immediately, by fax or telephone, as to the nature of the allegation and the names of the resident(s) and individual(s) involved.

Notify the appropriate Area Agency on Aging immediately by telephone.

2. Conduct an investigation into the allegation and complete the PB -22 Reporting Form. UTILIZE THE DEFINITIONS AND GUIDELINES PROVIDED WHEN CONDUCTING THE INVESTIGATION AND COMPLETING THE FORM. Initiate contact with local authorities when warranted.

Complete all applicable sections of the PB-22 reporting form; merely stating "see attached" is unacceptable.

3. a. Submit the completed Provider Bulletin -22 reporting form with any required attachments to the field office within five working days of the incident.
b. Submit the completed Provider Bulletin #22 reporting form to the appropriate Area Agency on Aging within 48 hours of making the oral report.

In cases where more than one individual is implicated, use a separate PB #22 for each person. Where one individual is implicated in an allegation involving more than one resident, use only one form unless to do so limits ability to adequately address the issues.

4. Inform the individual(s) implicated that the facility is required to report the allegation and submit a written report of the investigation, whatever the outcome, to the field office.

State Agency Responsibilities:

1. Upon notification of an alleged incident, determine any need for an immediate on-site investigation.
2. If not indicated, conduct an administrative review of the facility's written report (PB-22) upon its receipt to insure that all applicable information is present, i.e., allegation is appropriate (meets the definition).
3. Initiate such follow-up activities as necessary to determine what action, if any, should be taken against the implicated individual(s).
4. Initiate referrals to local authorities, legal counsel, and the Nurse Aide Registry, as well as other state agencies as warranted.
5. Provide for appropriate notification of the accused, the facility or facilities, and Nurse Aide Registry.

Attachments: PB #22 Reporting Form
Definitions
Guidelines
Act 13 Mandatory Abuse Instructions
Instructions for completion.

SECTION IV – INVESTIGATIVE ACTIVITIES (How did the facility become aware of the incident?)

Who reported it?

To whom was it reported? _____ When?

Were there any witnesses? _____ If yes, provide names, addresses, social security numbers, and telephone numbers of all on separate sheet. Identify those willing to testify. Was/were witness(s) interviewed? _____. Written signed statements obtained? If yes, list names here and attach written statements. Specify if willing to appear as a witness or not, in the event of a hearing.

- 1. _____ 3. _____
- 2. _____ 4. _____

Is each witness felt to be a credible source? _____ If no, qualify response.

Was the resident (victim) interviewed? _____ Is there a signed statement from the resident? _____ Is he/she a credible source? Explain

Was the accused interviewed? _____ Was a signed statement obtained?

Were all the involved individuals interviewed? _____ Was a signed statement obtained?

What supportive documentation, other than an eye witness account, is available (i.e., x-ray reports, nursing or physician notes, photos)?

If physical or sexual abuse alleged, was resident seen by a physician? _____ Or require hospitalization?

Was/is another state agency involved in the investigation*?

Name/telephone of agency:

Name of contact person:

Outcome (if available):

Were local police notified? _____ Date: _____ Time: _____

Did police investigation occur? _____ If yes, give name of contact and telephone number:

*NOTE: This information is mandated under Act 13 reporting requirements for alleged abuse involving sexual abuse, serious bodily injury, serious physical injury, and suspicious death.

Investigation Status (i.e., ongoing, concluded):

SECTION V - FINDINGS OF FACILITY INVESTIGATION (Include description of mitigating circumstances surrounding the allegation/incident, if any (i.e., combative resident, dissention among coworkers involved).

SECTION VI – CONCLUSIONS

SECTION VII - ACTIONS TAKEN (Include referrals to licensing or certifying agencies, if any).

SECTION VIII - RELEVANT/SUPPORTIVE DOCUMENTATION ATTACHED

1. Witness statement (signed, dated)

2. Accused statement (signed, dated)

3. Nurses' notes, physicians' notes

4. Reports (x-ray, etc.)

Do not send photographs. Do indicate if they are available upon request.

ADDITIONAL DEPARTMENT OF AGING REPORTING REQUIREMENTS: NOTE: This section must be completed to meet Act 13 requirements

Oral Report to AAA:

Oral Report to PDA (if applicable):* 717-783-6207

Date: ____/____/____ Time: _____

Date: ____/____/____ Time: _____

Name AAA Contacted: _____

Name & Title of Person Initiating Report: _____

Signature of Person Initiating Report: _____

*NOTE: This information is mandated under Act 13 reporting requirements for alleged abuse involving sexual abuse, serious bodily injury, serious physical injury, and suspicious death

Completed by: _____ **Date:** _____ **Time:** _____
(print name)

Signature (person completing form): _____ **Date:** _____

Title: _____ **Phone number:** _____

(Note: All double underlined areas must be completed to meet Act 13 requirements)



PB-22 Instructions for Completion

SECTION I – General Information

Facility Type

Indicate: NH – Nursing Home
HH – Home Health
HP – Hospital
ICFMR – Intermediate Care Facility for the Mentally Retarded,
etc.

Facility Name Use the name under which your license was issued
Address Of the facility
County In which facility is located
Zip Code Of the facility
Telephone No. Of the facility

Date/Time of Alleged Incident: Be specific, if known. If not known, explain reason in narrative (Section III – Description of Incident)

Reported to DOH :

Name To whom was it reported in the Division of Nursing Care Facilities’ field office
Telephone No. Of the Field Office
Date/ Time Of the contact

Date/Time Investigation Initiated: By the facility

Date/Time Investigation Completed: By the facility

Date PB-22 Submitted to Field Office: By the facility

SECTION II – Allegations/Individual Involved

Name of Individual/Alleged Perpetrator Involved:

Indicate the name of the individual named or suspected

Address Of named individual
Telephone No. Of named individual
Age/Sex Of named individual
Relationship to Victim

Worker's Category Check, if appropriate
Other Specify job title (For example: direct care worker; dietary worker; housekeeping staff)
Date of Hire By the facility
Shift At the time of the incident
SS# Social Security Number
License/Registry # If applicable

Nature of Abuse (circle) See attached definitions

Name of Resident/Victim

Address If other than at the facility
Resident Date of Birth
Sex Check as appropriate
Telephone No. Indicate resident's personal phone number, if other than facility number

Family Member/Legal Guardian Notified Identify full name

Address Of family member/guardian
Telephone No. Of family member/guardian
Relationship If applicable

SECTION III – Description of Incident

Follow the directions as outlined on the form. Address each issue as is appropriate to the circumstances of the incident. Also reference attachment to the PB-22 entitled Guidelines for Investigation of Abuse, Neglect, and Misappropriation of Property.

Please indicate whether the act was believed to be intentional and the specific harm that was sustained by the resident. If a physical injury was not incurred, describe any physical reaction or emotional trauma suffered by the resident.

SECTION IV – Investigative Activities

Who reported it? Provide name and identify role (resident, staff member, visitor, etc.)
To whom was it reported? Provide name and position (Charge nurse, Supervisor, etc.)
When? Provide date

Witness information: For those identified as witnesses, they must have been a direct observer of the alleged incident or surrounding circumstances. Provide information as requested and note each person’s willingness to testify.

Resident/Accused: Indicate if the resident and accused were interviewed and if a signed statement was obtained. Note as requested whether the resident is credible, and willing to testify.

Supportive Documentation: Indicate information available and whether it is attached or retained at the facility.

Medical treatment: Indicate if, as a result of the physical or sexual abuse, the resident was seen by a physician and/or hospitalized.

State Agency referral: Indicate all agencies notified/involved: Protective Services, Department of Aging, Department of State, law enforcement. If known, indicate status of any investigation.

SECTION V – Findings of Facility Investigation

Provide narrative that describes all components that the facility determined to be relevant to the investigation. Include evaluations or disciplinary actions of the nurse aide if significant.

SECTION VI – Conclusions

Indicate whether the facility found the allegations to be substantiated or unsubstantiated.

SECTION VII – Actions Taken

Include actions taken with accused.

SECTION VIII – Attachments

This list of relevant/supportive documentation is a check prior to sending to the Field Office.

Department of Aging Additional Reporting Requirements

Indicate the Date and Time of the Oral Report to the Area Agency on Aging (Protective Services) and, if applicable, the report to the Department of Aging.

Include the name of the individual at AAA who received the report.
Indicate the facility person (name, title and signature) making the report.

Completion Section

This section is for the facility person completing the report.

Print and sign name

Provide title and phone number

Date and time of completion.

If the form is being completed manually, please ensure that the handwriting is legible.
Statements from witnesses should also be reviewed, prior to submission, to ensure they can easily be read.



**PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF FACILITY LICENSURE AND CERTIFICATION
DIVISION OF NURSING CARE FACILITIES**

DEFINITIONS

The following definitions should be applied for reporting purpose:

ABUSE--The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. The term includes the following:

Types of abuse include:

The following words and terms, when used in this subpart, have the following meanings, unless the context clearly indicates otherwise:

1. **Verbal abuse**--Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include:
 - (a) Threats of harm.
 - (b) Saying thing to frighten a resident, such as telling a resident that the resident will never be able to see his family again.
2. **Sexual abuse**--Includes sexual harassment, sexual coercion or sexual assault.
3. **Physical abuse**--Includes hitting, slapping, pinching and kicking. The term also includes controlling behavior through corporal punishment.
4. **Mental abuse**--Includes humiliation, harassment, threats of punishment or deprivation.

5. **Involuntary seclusion**--Separation of a resident from other residents or from his room or confinement to his room (with/without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.
6. **Neglect**—The deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.

The following definitions should be applied when determining whether resident abuse, neglect, or misappropriation of resident property has occurred:

ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical pain or mental anguish.

INTERPRETATION-This presumes that instances of abuse of any resident, whether cognizant or not, cause physical harm, pain, or mental anguish.

Types of abuse include:

1. **Verbal abuse**-Refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within hearing distance to describe residents, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.
2. **Sexual abuse**-Includes, but is not limited to: sexual harassment, sexual coercion, or sexual assault.
3. **Physical abuse**-Includes, but is not limited to: hitting, slapping, pinching, kicking, etc. It also includes control of resident's behavior through corporal punishment.
4. **Involuntary seclusion**-Mean separation of a resident from other residents, from his or her room, or confinement to his or her room (with or without roommates) against the resident's will or the will of the resident's legal representative. Temporary, monitored separation from others will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic measure until professional staff can develop a plan of care to meet the resident's needs.

5. **Mental abuse**-Includes, but not limited to: resident humiliation, intimidation, threatening demeanor, harassment, threats of punishment or deprivation, or denial of food or privileges.

NEGLECT means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces). [Neglect also occurs when a number of residents receive a lack of care in one or more regulatory groupings; a finding which reflects the facility's failure to have developed policies or implemented procedures to prohibit neglect.]

A finding of neglect must not be made if the accused individual demonstrates that such neglect was caused by factors beyond the control of the individual.

INTERPRETATION-Neglect refers to failure through inattentiveness, carelessness, or omission to provide timely, consistent, safety adequate, and appropriate services, treatment of care, including but not limited to: nutrition, medication, therapies, and activities to daily living. The absence of reasonable accommodations of individual needs and preferences may result in resident neglect.

MISAPPROPRIATION OF RESIDENT PROPERTY-Means the deliberate misplacement, exploitation, or wrongful (temporary or permanent) use of a resident's belongings or funds without the resident's consent.

Source: 28 PA Code, 201.3

Source: CFR488.301, 488.335
HCFA State Operations Manual Appendix P



**PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF FACILITY LICENSURE AND CERTIFICATION
DIVISION OF NURSING CARE FACILITIES
GUIDELINES FOR INVESTIGATION OF
ABUSE, NEGLECT, AND MISAPPROPRIATION OF PROPERTY**

Information Required From Providers When Reporting

A. Provide Chronology of the Investigation

Order of interviews or statements gathered include: list of persons working who could reasonably have knowledge of the incident, brief employment history of all employees interviewed or who have provided witness statements; include prior allegations or actions which resulted in discipline.

B. Witness/Accused Statements

Statement should be handwritten. If illegible, provide typed copy of exact words on statement and have the individual sign and date. Include both typed and handwritten copies with report.

Instruct the witness to describe the incident in full. Include the exact words if verbal abuse is suspected. Include a graphic description if physical abuse is suspected. Be sure to include a description of the scene, positioning of resident and staff, time, nature of injury, etc.

NOTE: If employees refuse to give a statement and management has reason to believe that the employee should have knowledge of an incident, require the employee to write a statement that he/she has no knowledge of the incident, sign, and date. Include with the report.

C. Descriptors Needed

1. Verbal Abuse

State exact words and describe circumstances surrounding the incident as well as responses from resident.

2. Physical Abuse

Describe nature, location, and size of injury (i.e., pear-shaped bruise on left-upper thigh, 5 cm long; scratch on right-upper cheek extending to ear, etc.). Obtain Polaroid photograph of injuries when possible. Be sure to maintain the dignity of the resident and obtain permission for pictures. Use other objects in photo as well as to show size relationships. Describe how resident manifested injury (i.e., posturing of injured limb, grimacing, moaning, or actual voice of pain).

NOTE: If an object or instrument was used to injure a resident, be sure to impound such object as appropriate and be able to produce for the police or the department's inspection if requested. Photographs of objects are permissible in cases where the object is too large to move or permanently affixed.

Pictures should NOT be submitted with report, but should be available upon request if taken as part of the investigation.

3. Misappropriation of Property

Include physical description of property or amounts of money. Photographs of personal property obtained upon admission are invaluable as are itemized lists of all personal property. Include a list of staff who would have access, when article was last seen, where it is usually kept, and estimate of approximate value. The report should reflect that the resident or residents' responsible party's permission was not given to use/remove said property.

ACT-13 OF 1997
Mandatory Abuse Report
Instruction Sheet

BACKGROUND AND PROCESS:

Act-13 of 1997 requires an employee or administrator of a facility who has reasonable cause to suspect that a recipient is a victim of abuse to immediately report the abuse. The effective date was December 10, 1997.

Employees and/or administrators who have reasonable cause to suspect that a recipient is a victim of any of the types of abuse described below shall immediately make an oral report to the Area Agency on Aging (AAA). In addition to reporting to the AAA, oral reports must be made to the Pennsylvania Department of Aging (PDA) and local law enforcement for suspected abuse involving sexual abuse, serious physical injury, serious bodily injury or if a death is suspicious.

Within 48 hours of making all oral reports, the employee or administrator shall make a written report (on forms prescribed by PDA as mandated by Act 13) to the AAA. The AAA will forward a copy of the written report to the Department of Aging within 48 hours for all reports involving sexual abuse (not including sexual harassment), serious physical injury, serious bodily injury and suspicious death.

NOTE: Sexual harassment is an abuse that requires reporting to the AAA; however, it is not sexual abuse that requires reporting to PDA and local law enforcement.

DEFINITIONS:

Act-13 mandates the following facilities to report: domiciliary care homes; home health care agencies; long-term care nursing facilities; older adult daily living centers; personal care homes. In addition, the Department of Public Welfare (DPW) has concluded that Act-13 reporting is applicable to all DPW-licensed and DPW-operated residential facilities for adults. The additional DPW facilities include: community residential rehabilitation services, 55 Pa. Code Ch. 5310; community homes for individuals with mental retardation, 55 Pa. Code 6400; family living homes, 55 Pa. Code Ch. 6500; ICFs/MR (private and state), 55 Pa. Code 6600; state mental hospitals and state nursing facilities.

Recipient: An individual who receives care, services or treatment in or from a facility. (regardless of age)

Abuse: The occurrence of one or more of the following acts: (1) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish; (2) the willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health; (3) sexual harassment; and/or (4) sexual abuse which is intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault or incest.

Serious Bodily Injury: An injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ.

Serious Physical Injury: An injury that causes a person severe pain or significantly impairs a person's physical functioning, either permanently or temporarily.

Sexual Harassment: Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Sexual Abuse: Intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest.

Rape: A person commits rape when he or she engages in sexual intercourse with a complainant: (1)by forcible compulsion; (2)by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; (3)who is unconscious or where the person knows that the complainant is unaware that the sexual intercourse is occurring; (4)where the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance; (5)who suffers from a mental disability which renders the complainant incapable of consent; (6)who is less than 13 years of age.

Statutory Sexual Assault: Except as provided under the definition of Rape, a person commits statutory sexual assault when that person engages in sexual intercourse with a complainant under the age of 16 years and that person is four or more years older than the complainant and the complainant and the person are not married to each other.

Involuntary Deviate Sexual Intercourse: A person commits involuntary deviate sexual intercourse when he or she engages in deviate sexual intercourse with a complainant: (1)by forcible compulsion [forcible compulsion includes but is not limited to compulsion resulting in another person's death, whether the death occurred before, during or after sexual intercourse]; (2)by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; (3)who is unconscious or where the person knows that the complainant is unaware that the sexual intercourse is occurring; (4)where the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance; (5)who suffers from a mental disability which renders him or her incapable of consent; (6)who is less than 13 years or age, or (7)who is less than 16 years of age and the person is four or more years older than the complainant and the complainant and person are not married to each other.

Sexual Assault: Except as provided under the definitions relating to Rape and Involuntary Deviate Sexual Intercourse, a person commits sexual assault when that person engages in sexual intercourse or deviate sexual intercourse with a complainant without the complainant's consent.

Aggravated Indecent Assault: Except as provided under the definitions relating to Rape, Statutory Sexual Assault, Involuntary Deviate Sexual Intercourse, and Sexual Assault, a person who engages in penetration, however slight, of the genitals or anus of a complainant with a part of the person's body for any purpose other than good faith medical hygienic or law enforcement procedures commits aggravated indecent assault if: (1)the person does so without the complainant's consent; (2)the person does so by forcible compulsion; (3)the person does so by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; (4)the complainant is unconscious or the person knows that the complainant is unaware that the penetration is occurring; (5)the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing without the knowledge of the complainant, drugs, intoxicants or other means for the purposes of preventing resistance; (6)the complainant suffers from a mental disability which renders him or her incapable of consent; (7)the complainant is less

than 13 years of age; or (8)the complainant is less than 16 years of age and the person is four or more years older than the complainant and the complainant and the person are not married to each other.

Indecent Assault: A person who has indecent contact with the complainant or causes the complainant to have indecent contact with the person commits indecent assault if: (1)the person does so without the complainant's consent; (2)the person does so by forcible compulsion; (3)the person does so by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; (4)the complainant is unconscious or the person knows that the complainant is unaware that the indecent contact is occurring; (5)the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance; (6)the complainant suffers from a mental disability which renders him or her incapable of consent; (7)the complainant is less than 13 years of age; or (8)the complainant is less than 16 years of age and the person is four or more years older than the complainant and the complainant and the person are not married to each other.

Incest: A person commits incest if he or she knowingly marries or cohabits or has sexual intercourse with an ancestor or descendant, brother or sister of the whole or half blood or an uncle, aunt, nephew or niece of the whole blood. The relationships referred to include blood relationships without regard to legitimacy, and relationship of parent and child by adoption.

DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

DATE: December 20, 2005

SUBJECT: Long Term Care Provider Bulletin No. 24
Securing Copies of Nurse Aide Notices of Enrollment

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Long Term Care
Pennsylvania Department of Health

Promissor is the state contracted agency responsible for Nurse Aide Activities in Pennsylvania. Information relative to Nurse Aide requirements can be obtained via Promissor Website or by calling Promissor at 1-800-852-0518.

Weblink – www.health.state.pa.us
Click on Topics A-Z
Click on Nursing Home Information
Click on Nurse Aide Registry

The following procedure is to be used to secure copies of Notices of Enrollment for all current and prospective employees working as nurse aides:

Access the "**Pennsylvania Nurse Aide Handbook**", **Appendix C, page 54.**

Complete the form and mail to Promissor at the address indicated, with required documentation or call Promissor at the above telephone number to request the form.

All prospective new hires for nurse aide positions must be verified through the registry. Contact the Pennsylvania Nurse Aide Registry with aide's name, social security number and, if available, registration number.

Contact the registry at 1-800-852-0518 if you are presented with what may appear to be a falsified notice. Presenting a false notice may constitute Theft by Deception under the Pennsylvania Crimes Codes, 18 Pa. C.S. §3922.



Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

DATE: November 18, 2005

SUBJECT: Long Term Care Provider Bulletin No. 28
Potential Hazards of Protective Restraint Devices

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

Attached is a Food and Drug Administration Alert regarding the use of bedrails. This FDA alert is specific to the dangers and not to any manufacturer or type of bed rails.

Additional information about the use of restraints and available options can be found at the following website or by contacting the following organization:

<http://www.parri.kendal.org/>

or

Kendal Outreach, LLC
PO Box 100
Kennett Square, PA 19348
610-388-5586

Attachment:

FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails

(We encourage you to copy and distribute this Alert)

August 23, 1995

TO: Biomedical/Clinical Engineers Hospital Administrators
 Directors of Nursing Nursing Associations
 Home Healthcare Agencies Nursing Homes
 Hospices Risk Managers

This Safety Alert concerns entrapment hazards associated with the use of hospital bed side rails in a small, identifiable patient population, and recommends certain actions to prevent such hazards. The Alert is not specific to any manufacturer or product; it is part of a cooperative effort between FDA, the healthcare industry, and manufacturers to resolve the problem. Currently, no universal standards exist for design of hospital bed side rails.

Since January 1990, FDA has received 102 reports of head and body entrapment incidents involving hospital bed side rails. The 68 deaths, 22 injuries, and 12 entrapments without injury occurred in hospitals, long-term care facilities, and private homes. The U.S. Consumer Product Safety Commission, the United Kingdom Department of Health, and the Canadian Health Protection Branch have also received similar reports of entrapment.(1,2,3) Although the number of reported incidents is small relative to the large number of patients who use hospital beds, we believe appropriate precautions can reduce further incidents.

All reported entrapments occurred in one of the following ways (numbered 1-4 in the diagram below):

1. through the bars of an individual side rail;
2. through the space between split side rails;
3. between the side rail and mattress; or
4. between the headboard or footboard, side rail, and mattress.

All deaths involved entrapment of the head, neck, or thorax, while most injuries involved fractures, cuts, and abrasions to the extremities. Although an entrapment did occur in a patient two years of age, the majority of the deaths and injuries involved elderly patients. Patients at high risk for entrapment include those with pre-existing conditions such as confusion, restlessness, lack of muscle control, or a combination of these factors.

FDA recommends the following actions to prevent deaths and injuries from entrapment in hospital bed side rails:

Inspect all hospital bed frames, bed side rails, and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. Be aware that gaps

can be created by movement or compression of the mattress which may be caused by patient weight, patient movement, or bed position.

Be alert to replacement mattresses and bed side rails with dimensions different than the original equipment supplied or specified by the bed frame manufacturer.(4) Not all bed side rails, mattresses, and bed frames are interchangeable. Variation in bed side rail design and thickness and/or density of the mattress may affect the potential for entrapment. When bed side rails and mattresses are purchased separately from the bed frame, check with the manufacturer(s) to make sure the bed side rails, mattress, and bed frame are compatible.

Check bed side rails for proper installation using the manufacturer's instructions to ensure a proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard).

Additional safety measures should be considered for patients identified as high risk for entrapment. Such patients include those with altered mental status (organic or medication related) or general restlessness. Increased risk also occurs when the patient's size and/or weight are inappropriate for the bed's dimensions. Bed side rail protective barriers may be used to close off open spaces in which these patients might accidentally become entrapped. Follow the healthcare facility's procedures and/or manufacturers' recommendations/specifications for installing and maintaining bed side rail protective barriers for the particular bed frame and bedside rails used.

Bed side rails should not be used as a substitute for patient protective restraints. Patients who need a protective restraint, such as a vest or wrist/leg device, must be monitored frequently while wearing it.(5) If a protective restraint is used, follow your facility's protocol and the restraint manufacturer's instructions for proper use, in addition to the federal, state, and local regulations regarding the use of protective restraints.

FDA is interested in receiving reports concerning problems with hospital bed frames, bed side rails, mattresses, and any other medical device. The Safe Medical Devices Act of 1990 (SMDA) requires hospitals and other user facilities to report deaths, serious illnesses, and injuries associated with the use of medical devices. Healthcare workers should follow the procedures established by their healthcare facility for such mandatory reporting. Practitioners who become aware of any adverse event (i.e., death, serious illness, or injury) that may be related to a medical device product problem or malfunction should report it to their facility's contact person who is responsible for reporting these events to the FDA.

If an adverse event or device problem or malfunction is not reportable under SMDA, or if you do not work in a user facility that is required to report under SMDA, we encourage you to report directly to MedWatch, the FDA's voluntary reporting program.

Write to: Medical Product Reporting Program
MedWatch, HF-2
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20857

Phone: Medical Product Reporting Program
at 1-800-FDA-1088
(also call for MedWatch information)

Modem: 1-800-FDA-7737 (9600 baud rate)

Getting more information:

If you have questions regarding this publication, please contact the Issues Management Staff, Office of Surveillance and Biometrics (HFZ-510), 1350 Piccard Drive, Rockville, Maryland, 20850, by fax at 301-594-2968, or by e-mail at phann@cdrh.fda.gov . Additionally, a voice mail message may be left at 301-594-0650 and your call will be returned as soon as possible.

Sincerely yours,

D. Bruce Burlington, M.D.
Director
Center for Devices and



DATE: January 16, 2002

SUBJECT: Long Term Care Provider Bulletin No. 29
Nurse Aide Registry

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

The following information is being provided to assist in interpreting the final federal regulations as they relate to the Nurse Aide Registry. These regulations were published in Federal Register, Vol. 58, No. 187, Thursday, September 26, 1991; and were effective on April 1, 1992.

Multi-State Registry Verification - 42 CFR §483.75(e)(6)

Facilities are required to contact any state registry that may contain information on an individual presenting for hire as a nurse aide. To assist in this, attached is a list of registry contacts for all states. Following verification of a current enrollment with another state, the nurse aide must complete an Application For Enrollment By Reciprocity (copies attached) and forward it to the out-of-state registry for verification. The out-of-state registry must then return the application directly to the Pennsylvania registry.

In-service Education - 42 CFR §483.75(e)(8)

Facilities are required to provide a minimum of 12 hours of in-service education annually. The topics should be determined by the needs of the nurse aides and should address areas of weakness. Topics related to the care of the cognitively impaired resident must be included in the in-service training. Mandatory in-service education programs listed in the Pennsylvania Long Term Care Facilities Licensure Regulations may be included as part of the 12 hours annually.

Definition of a Nurse Aide - 42 CFR §483.75(e)(1)

A nurse aide may provide any nurse-related service that is assigned if they are properly trained and are competent to do so, except for services that are within the scope of practice of a licensed health professional.

1-800-852-0518
Pa Department of Health website:
www.health.state.pa.us

NOTICE TO ALL NURSE AIDES ENROLLED ON THE PENNSYLVANIA NURSE AIDE REGISTRY

The following information is being provided to clarify questions regarding enrollment on the Nurse Aide Registry.

CONTINUED ENROLLMENT APPLICATION

An application to continue enrollment on the Nurse Aide Registry will be sent approximately 90 days before the expiration date of the current Notice of Enrollment. After a completed application is submitted a new Notice of Enrollment will be sent to the nurse aide, as long as the nurse aide is qualified for continued enrollment.

FOR ALL APPLICANTS

Individuals are required to submit an application once every two years to continue enrollment on the registry. This application will be sent automatically approximately 90 days before the end of the two-year enrollment period. The application for reenrollment (renewal) should be completed and returned to the registry as soon as possible.

Applicants should contact the registry if a renewal application is not received by mail.

The Nurse Aide Registry is unable to assist nurse aides that seek assistance at the Division of Nursing Care Facilities (walk-ins).

EMPLOYMENT REQUIREMENT

Nurse aides must work a minimum of one full documented day of paid nursing or nursing-related services within each two-year (24 month) period in order to retain current status on the Nurse Aide Registry. These services may be provided in any health care setting (e.g., nursing home, hospital, nursing/home health agency, licensed personal care home.)

IN-SERVICE EDUCATION

Federal regulations require that the facility of employment must provide a minimum of 12 hours of in-service education per year. If the nurse aides are currently employed in a nursing home, the topics of this in-service education will be determined by that facility.

COPYING THE NOTICE OF ENROLLMENT

When applying for employment, the nurse aide should have the original display portion of the Notice of Enrollment so that the facility may copy it for their records. Once hired, it is not a requirement that the facility keep the original on file; HOWEVER, it may be the facility policy to do so. Should the nurse aide cease to work at that facility, the original should be returned to them.

CPR

Performing CPR is not a federal requirement; HOWEVER, it is not prohibited. If a facility requires that nurse aides perform CPR, they must be properly trained and be competent to do so.

REPORTING CHANGES/REQUESTING DUPLICATE NOTICES

If there is a change of address, a name change, or if the card is lost and needs to be replaced, contact the Nurse Aide Registry and provide registration number. A new notice will be issued in 2-3 weeks. There is no fee for a duplicate notice.

A photocopy of a marriage certificate or a divorce decree must be submitted for a name change. The request for a name change must be in writing and include the registration number. **BE SURE TO INCLUDE THE REGISTRATION NUMBER ON ALL CORRESPONDENCE.**

RECIPROCITY

If moving to another state, contact that state's nurse aide registry for information on registering as a nurse aide. Pennsylvania enrollment may be continued if all requirements are met and prompt notification to the department of a change in address will aid in expediting the process.

ABUSE, NEGLECT, AND MISAPPROPRIATION OF RESIDENT PROPERTY

All incidents of suspected abuse, neglect, and misappropriation of property against a nursing home resident are reported to the Division of Nursing Care Facilities for investigation. In the event that a nurse aide is reported for such an allegation, the aide will be notified by letter and contacted by an investigator from the division for a statement regarding the allegation(s). If the allegation is determined to be unsubstantiated, the aide will be notified in writing.

The Division of Nursing Care Facilities will accept requests for removal from the Nurse Aide Registry an annotation for neglect, as outlined in Title 42, Chapter 7, Social Security Act, Title XIX, §1396r. The request may be submitted no sooner than one year after the annotation has been added, providing that the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect, and the neglect involved in the original finding was a singular occurrence.

RIGHT TO APPEAL

If upon investigation an allegation is found to be substantiated, the nurse aide will be notified in writing of their right to a hearing to dispute the findings.

During the state's investigation or if an appeal has been made to a substantiated hearing, the nurse aide is not prohibited from working in a nursing home; however, it may be a facility policy to discontinue

employment until the final ruling by the hearing examiner.

If the hearing officer finds in favor of the nurse aide, no entry will be placed on the aide's registry record and they will be considered in good standing. If the hearing examiner finds for the Department of

-3-

Health, the aide's registry record will contain information regarding the substantiated finding, and the individual will be considered ineligible for hire by a nursing care facility.

If an action is taken against the nurse aide disallowing employment in a nursing care facility as a nurse aide, the registry is required by law to place an annotation on the file which permanently bars them from working as an aide in any licensed nursing home which participates in the Medicare or Medicaid programs. Information regarding a substantiated finding will remain on the record permanently. Lists of persons who are not permitted employment in the capacity of a nurse aide are sent to all nursing homes. This list is also shared with other states.

If you have further questions, please contact the employer or the Pennsylvania Nurse Aide Registry:

Pennsylvania Nurse Aide Registry
C/O Assessment Systems, Inc.
P.O. Box 13785
Philadelphia, PA 19101-3785
1-800-852-0518

NURSE AIDE REGISTRY TELEPHONE HOURS ARE:

8:00 a.m.–5:00 p.m.
Monday--Friday

**NURSE AIDE REGISTRY INTERACTIVE VOICE RESPONSE IS AVAILABLE
SEVEN DAYS A WEEKS AT:**

1-877-224-0231

Attachment



DATE: November 18, 2005

SUBJECT: Long Term Care Provider Bulletin #31
Training of Companions/Sitters in Medicare and/or Medicaid Certified
Long Term Care Facilities

TO: Nursing Home Administrators

FROM: William A. Borden, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

Federal Long Term Care Regulation 42 CFR 483.75(e) Administration stipulates that "Volunteers are not nurse aides and do not come under the nurse aide training provisions of these requirements" and "private duty nurse aides who are not employed or utilized by the facility on a contract, per diem, leased or other basis, do not come under the nurse aide training provisions."

Since Companions/Sitters are not employed by the facility they are not considered to be nurse aides and the requirements for nurse aide training and competency evaluation are not applicable.

However, facilities are responsible for the care that is provided and may establish policies regarding the utilization of companions/sitters.



DATE: November 21, 2005

SUBJECT: Long Term Care Provider Bulletin No. 34
Fee Schedule For Licensure

TO: Nursing Home Administrators

FROM: *William A. Bordner*
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

This bulletin is to advise you of the current fee schedule for licensure. The fees are as follows:

Regular or Special License

\$250.00 plus per each long-term care bed in excess of 75 beds—\$2.00.

Provisional License

Provisional I	\$400.00
Plus per each bed	4.00
Provisional II	\$600.00
Plus per each bed	6.00
Provisional III	\$800.00
Plus per each bed	8.00
Provisional IV	\$1,000.00
Plus per each bed	10.00



DATE: November 21, 2005

SUBJECT: Long Term Care Provider Bulletin No. 35
Disposition of Resident Medications

TO: Nursing Home Administrators

FROM: *William A. Bordner*
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

The purpose of this bulletin is to clarify the department's position regarding the disposition of resident medications.

Pennsylvania Long Term Care Regulation §211.9(j) states:

...Disposition of discontinued and unused medications and medications of discharged or deceased patients shall be handled by facility policy, which has been developed in cooperation with the consultant pharmacist. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart. The disposition procedures shall be done at least quarterly under Commonwealth and Federal statutes.

It should not be the practice of facilities to dispose of medications when a resident is hospitalized and charge for refills once the resident returns.

Facility policies and practices should not allow wastefulness or promote repurchasing of drugs irrespective of consultant pharmacist/pharmacy relationships or payment source.

Storing of a resident's medication(s) until his or her return from a hospital stay, is not in violation of state or federal regulations.

Medications, once dispensed, are the property of the resident. The facility acts as the custodian of them during the resident's stay. Therefore, medications should not automatically be destroyed/discarded when a resident is transferred to a hospital for treatment. Upon transfer to another facility, or discharge the medications may be given to the patient or responsible party in accordance with the attending physicians recommendations.

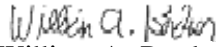
Also, the routine disposition of medications when potential for reuse by the same patient exists is considered by the department to be an unacceptable practice.



DATE: November 21, 2005

SUBJECT: Long Term Care Provider Bulletin No. 36
Advance Directives for Health Care/Durable Power of Attorney/
Do Not Resuscitate Orders

TO: Nursing Home Administrators

FROM: 
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

The purpose of this bulletin is to clarify the department's position with respect to transfer of information to health care facilities regarding advance directives, durable power of attorney, and/or do not resuscitate orders. Pennsylvania Long Term Care Facilities Licensure Regulations §201.31(b)(2) Stipulates that there shall be a written transfer agreement between a hospital and a facility “for the exchange of medical and other information necessary to the appropriate care and treatment of residents to be transferred.” Medicare and Medicaid requirements for long-term care facilities at §483.75(n), Transfer Agreement, also require an exchange of medical and other information needed in the treatment of the individual.

Therefore, all long-term care facilities are required to provide information regarding advance directives, durable powers of attorney, and/or do not resuscitate orders in the event of transfer to hospital. Facilities must ensure that the required transfer agreement with local hospitals addresses the sharing of essential information.



DATE: November 21, 2005

SUBJECT: Long Term Care Provider Bulletin #37
Exception/Waiver Requests

TO: Nursing Home Administrators

FROM: William A. Bordner
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

Rules and regulations regarding health facility licensure requirements were published in the Pennsylvania Bulletin volume 28, No. 23 on June 6, 1998. This publication addresses exceptions to the licensure requirements for long-term care nursing facilities.

EXPLANATION OF THE PROCESS:

Federal and state terminology for waiving of requirements differs. "**Waiver**" is the federal term, while "**exception**" refers to the waiving of a licensure requirement and constitutes a state action.

Exceptions are granted by the department at the division level. Approval of a waiver request from a medicare certified facility is given at the federal regional office level, or in the case of a medicaid facility, by the state agency. Waiver requests are referred to the appropriate state or federal agency following review at the division level.

In order for a regulatory requirement to be set aside or waived, it must be determined that such action would not endanger the health and safety of individuals and/or failure to waive would result in unreasonable hardship to the facility.

Requests for exception or waivers must be made in writing by the provider and include sufficient justification for the request. The amount and type of documentation required varies with the nature of the request (e.g., a physical environment versus a staffing request). Delays in responses can be avoided by preliminary contact with the facility's field office.

Exceptions and/or waivers are approved for a fixed period of time and usually subject to annual renewal. Exceptions that are granted are reflected on the facility's license. The facility receives written notification of the approval or denial of its request and is expected to maintain the federal and/or state response on file. In instances when a request is denied, a

deficiency statement will be issued and a plan of correction required

The **purpose** of a waiver or exception is not to avoid complying with a regulatory requirement. New or renovated construction projects should meet all regulatory requirements.

Exceptions

Based on review of information submitted by the facility as well as input from the field office, a decision to grant or deny the exceptions will be made with consideration to the requirements outlined in the Pennsylvania Bulletin published on June 6, 1998. On-site inspections and/or meetings with the facility representatives may be necessary.

Exceptions are not granted as a remedy for a situation for which a provisional license would be appropriate or for violations of resident rights.

Exceptions and/or waivers are approved for a fixed period of time and usually subject to annual renewal. Exceptions that are granted are reflected on the facility's license. The facility receives written notification of the approval or denial of its request and is expected to maintain the federal and/or state response on file. In instances when a request is denied, a deficiency statement will be issued and a plan of correction required.

Copies of federal and state letters approving or denying a facility's request are forwarded to the respective field office and placed on file.

In 1975 when the licensing authority for long term care facilities was transferred from the Department of Welfare to the Department of Health, provision was made for existing facilities to be "grandfathered" in under the new regulations. The exceptions that were realized as a result of that "grandfathering" were not put in writing. Because it is not the department's intent to allow the existence of substandard facilities indefinitely, "exceptions" that exist in these facilities are subject to review and reconsideration. Deficiencies will be cited in a facility whose physical plant is so outdated as to negatively impact on residents or on staff in the performance of their duties.

Exceptions/Waivers

GENERAL INSTRUCTIONS:

1. Requests for waiver of fire safety code requirements must be made through the Division of Safety Inspection.
2. Requests for physical plant exceptions not of a fire/safety nature are to be made through the Division of Long Term Care NOT the Division of Safety Inspection, although, the request may originate during a plans review.
3. Written justification must be submitted in sufficient detail to support the exception being requested. As a minimum cost factors influencing the request; alternative(s) to meeting the intent

of regulation; impact on resident care, delivery of services, safety, and quality of life should be included as applicable.

4. When an exception/waiver request is made on the HCFA 2567 in response to a deficiency, it must be accompanied by appropriate written justification. (Request through field office supervisors).
5. When part of the building is to be used for a purpose other than health care, special authorization must be obtained from the Division. An exception to Pennsylvania Long Term Care Regulation 205.6(a) Function of building must be obtained. (Request through Regional Managers).
6. Physical plant exceptions for new facilities under construction or existing facilities undergoing alteration, renovation, or expansion, should be made by an authorized facility representative. (Request through regional manager).

Regional Offices of the Pennsylvania Department of Health		
Harrisburg Field Office 132 Kline Plaza, Suite B Harrisburg, PA 17101-2424 (717) 783-3790 (717) 772-3641 (fax)	Jackson Center Field Office 19 McQuiston Drive Jackson Center, PA 16133 (724) 662-6050 (724) 662-6067 (fax)	Lehigh Valley Field Office 4520 Bath Pike Bethlehem, PA 18107 (610) 861-2117 (610) 861-2123 (fax)
Pittsburgh Field Office 300 Liberty Avenue Pittsburgh State Office Bldg. Room 505 Pittsburgh, PA 15222 (412) 565-2836 (412) 565-2893 (fax)	Williamsport Field Office 1000 Commerce Park Drive Suite 112 Williamsport, Pa 17701 (570) 651-1040 (570) 651-1043 (fax)	Norristown Field Office 1937 New Hope Street Norristown, PA 19401 (610) 270-3475 (610) 270-1152 (fax)
Scranton Field Office 100 Lackawanna Avenue Scranton Sate Office Room 111 Scranton, PA 18503 (570) 963-4331 (570) 963-3415 (fax)	Johnstown Field Office 184 Donald Lane, Suite 3 Johnstown, PA 15904 (814) 248-3125 (814) 248-3058 (fax)	Lionville Field Office P.O. Box 500-110 Pickering Way Exton, PA 19341-0500 (610) 594-8041 (610) 594-9267 (fax)



DATE: December 13, 2005

SUBJECT: Long Term Care Provider Bulletin No. 41
Incident/Accident Reporting Procedures

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

The Division of Nursing Care Facilities' requires that all reporting of incidents and accidents should be made through the Department of Health Electronic reporting system (www.health.state.pa.us/facility). This should not serve as an absolute prohibition on follow-up data via telephone. Division of Nursing Care Facilities' managers/supervisors can provide guidance on specific situations. Facility administrators must also exercise prudent judgment in determining whether an occurrence would warrant both a telephone call for immediate notification, as well as the electronic filing.

Please refer to the June 6, 1998, Pennsylvania Bulletin, Vol. 28, No., 23, regarding information that must be reported to the Division of Nursing Care Facilities in the event of an incident, accident, disaster, or other significant occurrence.

Section 51.3(e)(f)(g)(h) requires **immediate written** reports of events, which seriously compromise quality assurance or patient safety.

The facility shall provide this information to the director of the Division of Nursing Care Facilities through the respective field office.

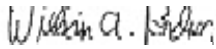
Notice requirement, as outlined in Chapter 51.3(e)(f)(g), shall be adhered to during instances where reporting is necessary.



DATE: January 2, 2007

SUBJECT: Long Term Care Provider Bulletin No. 42
Taping of Exit Conference

TO: Nursing Home Administrators

FROM: 
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

Due to recent inquiries, this bulletin is provided as a reiteration of the Department of Health's long standing policy regarding taping of the exit conference in nursing homes. The department's policy stipulates that Taping of the exit conference is **not** permitted.

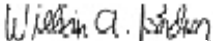
The exit conference is not the final conclusion to the inspection. The survey team concludes its inspection findings in the statement of deficiencies (CMS 2567) forwarded to you usually within 12 days after the exit conference. This deficiency list is the official document that concludes the on-site survey review process. It is encouraged that providers take notes during the survey process.



DATE: December 13, 2005

SUBJECT: Long Term Care Provider Bulletin No. 43
Precautions for Excessive Temperatures

TO: Nursing Home Administrators

FROM: 
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

This bulletin is to reinforce to facility administrators the importance of monitoring residents for the effects of excessive heat. Facilities should address excessive temperatures in the disaster plan developed for the facility. Problems with excessive temperatures should be reported to the Division of Nursing Care Facilities field office via the Electronic Reporting System as any other serious problem that may interrupt operation of the facility.

Guidelines for consideration include:

- * Provide air-conditioning if possible. Facilities initially certified for medicare or medicaid after October 1, 1990, must maintain a temperature range of 71-81 degrees Fahrenheit. Where air-conditioning is unavailable, or is inadequate to provide acceptable temperatures, fans should be used to provide air circulation.
- * Encourage fluid intake to maintain hydration.
- * Close window blinds or curtains to block out the sun.
- * Use light-weight, loose-fitting clothing. To the greatest extent possible, avoid use of synthetic materials that do not "breathe".
- * Chill food supplements and other fluids.
- * Monitor temperatures in various locations. Identify cooler areas to which residents who are at high risk for heat-related conditions, or exacerbation of compromised health status, may be moved.

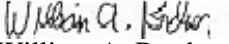
- * Closely monitor residents for hydration and adverse effects of heat. Pay particular attention to residents having respiratory difficulties, i.e., residents with chronic obstructive pulmonary disorder, asthma, congestive heart failure, lung cancer, and other conditions. If necessary, transfer residents to hospitals or other nursing homes that are capable of providing care for those residents who are highly compromised and at great risk due to excessive heat.
- * Administer cool sponge baths as needed.
- * Monitor skin condition for effects of excessive heat.
- * Use other common sense approaches to minimize health risks due to heat.



DATE: December 14, 2005

SUBJECT: Long Term Care Provider Bulletin No. 44
Informal Dispute Resolution Process

TO: Nursing Home Administrators

FROM: 
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

In accordance with 42 CFR §488.331, the state must offer an opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies (Form HCFA 2567).

The attached procedure entitled "Pennsylvania's Informal Dispute Resolution Process for Nursing Facility Providers," has been reviewed and update to ensure compliance with Federal Survey and Certification letter 05-10, dated December 16, 2004. It outlines the responsibilities of the Department of Health (state survey agency) and provides the procedure that is to be followed when a facility exercises this option.

It is essential that the procedure given be followed as outlined. Failure to do so will impede the process and impact on the promptness with which a decision may be reached. **HOWEVER**, failure of the Department of Health to complete the process prior to the effective date of an enforcement action will **NOT** result in a delay of the enforcement action. (See 42 CFR §488.331(b)(1)).

Informal Dispute Resolution is a federal process. If a facility wishes to exercise their rights to appeal any state licensure action, the facility must file the "Notice of Appeal" within 30 days of the date of the notice with the Health Policy Board at P.O. Box 90, Harrisburg, Pennsylvania 17108.

Attachment

PENNSYLVANIA'S INFORMAL DISPUTE RESOLUTION ("IDR") PROCESS
FOR NURSING FACILITY PROVIDERS

GENERAL INFORMATION

1. Upon transmission of the official HCFA-2567, facilities will be offered one opportunity to informally dispute deficiencies continued therein with the State Survey Agency, the Department

of Health. The facility must request IDR within the same 10-calendar day period the facility has for submitting an acceptable plan of correction in response to a HFCA-2567.

2. The purpose of the IDR process is to allow a facility to present information, which indicates that one or more deficiencies on the HCFA-2567 should not have been cited.
3. Facilities may not use the IDR process to delay the formal imposition of remedies. Failure of the state to complete the IDR timely cannot delay the effective date of any enforcement action against the facility
4. Facilities may **not use** the IDR process to challenge any other aspect of the survey process, including the:
 - c. Failure of the survey team to comply with a requirement of the survey process.
 - d. Alleged inconsistency of the survey team in citing one or more deficiencies among facilities; or the
7. Alleged inadequacy or inaccuracy of the IDR process.
8. IDR decisions will not be made by persons directly involved in the survey.
9. A facility may request an IDR for each survey that cites deficiencies. The following table indicates when an IDR may be requested based on the results of a revisit or as a result of previous IDR outcome.

SITUATION	ELIGIBILITY FOR IDR
Continuation of same deficiency at revisit	Yes
New deficiency (i.e., new or changed facts, new tag) at a revisit or as a result of an IDR	Yes
New examples of deficiency (i.e., new facts, same tag) at revisit or as a result of an IDR	Yes
Different tag but same facts at revisit or as a result of an IDR	No

A second IDR is not offered on the existence of the deficiencies as of the date of the first survey.

PROCEDURES FOR FACILITIES TO FOLLOW:

1. Facilities who wish to avail themselves of the opportunity for IDR must provide a written submission to the applicable field offices. The Division of Nursing Care Facilities Field Offices are as follows:

Regional Offices of the Pennsylvania Department of Health		
<p>Harrisburg Field Office 132 Kline Plaza Suite B Harrisburg, PA 17104 (717) 783-3790 (717) 772-3641 (fax)</p>	<p>Jackson Center Field Office 19 McQuiston Drive Jackson Center, PA 16133 (724) 662-6050 (724) 662-6067 (fax)</p>	<p>Lehigh Valley Field Office 4520 Bath Pike Bethlehem, PA 18107 (610) 861-2117 (610) 861-2123 (fax)</p>
<p>Pittsburgh Field Office 300 Liberty Avenue Pittsburgh State Office Bldg. Room 505 Pittsburgh, PA 15222 (412) 565-2836 (412) 565-2893 (fax)</p>	<p>Williamsport Field Office 1000 Commerce Park Drive Suite 112, 2nd Floor Williamsport, PA 17701 (570) 651-1045 (570) 327-3547 (fax)</p>	<p>Norristown Field Office 1937 New Hope Street Norristown, PA 19401 (610) 270-3475 (610) 270-1152 (fax)</p>
<p>Scranton Field Office 100 Lackawanna Avenue Scranton Sate Office Room 111 Scranton, PA 18503 (570) 963-4331 (570) 963-3415 (fax)</p>	<p>Johnstown Field Office 184 Donald Lane, Suite 2 Johnstown, PA 15904 (814) 248-3129 (814) 248-2058 (fax)</p>	<p>Lionville Field Office P.O. Box 500-110 Pickering Way Exton, PA 19341-0500 (610) 594-8041 (610) 594-9267 (fax)</p>

2. The written submission must:
 - a. be received in the applicable field office within the same 10 calendar day period in which the Plan of Correction (POC) for the HCFA-2567 is due.
 - b. clearly state that it is being submitted for the purpose of IDR.
 - c. specifically identify by Tag number(s) and regulation(s) which deficiencies are being disputed.
 - d. identify the date of the exit conference of the relevant survey, which is the subject of the IDR.
 - e. provide all information and documentation in support of the facility's contention that the deficiencies were erroneously cited.

DEPARTMENT OF HEALTH ACTION IN INFORMAL DISPUTE RESOLUTION

1. Once the Department of Health receives a written submission for an IDR, it may:
 - a. Issue a decision based on the written submission
 - b. Request additional information or clarification, if necessary; or
 - c. Initiate a telephone conference or meeting at its discretion or in consultation with the Department of Public Welfare.
2. The Department of Health will notify the facility, in writing, of the outcome of the IDR.
3. Failure of the Department of Health to complete IDR prior to the effective date of any enforcement action cannot result in a delay of that enforcement action.

INFORMAL DISPUTE RESOLUTION OUTCOMES AND IMPACT ON HCFA-2567

1. If the IDR results in the elimination of one or more deficiencies, the following applies:
 - a. The facility will receive a “clean” (new) copy of the HCFA-2567. The “clean” copy will be disclosable pursuant to 42 CFR §488.325. The “clean” HCFA-2567 POC must be signed and submitted to the field office by the facility within 5 days of receipt.
 - b. Any enforcement action imposed solely as a result of one or more deficiencies, which were eliminated through IDR, will be rescinded.

Status of Deficiencies during the IDR Process

Deficiencies pending IDR will not be posted to the federal Nursing Home Compare website until the IDR process has been completed.

CMS Authority

While states may have the option to involve outside persons or entities they believe to be qualified to participate in the IDR process, it is the states, not the outside individuals or entities that are responsible for the IDR decisions. CMS will look to the states to assure the viability of these decision-making processes, and hold states accountable for them.



Date: December 16, 2005

Subject: Long Term Care Provider Bulletin No. 46
Ban on use of Egg Breaking Centrifuges

To: Nursing Home Administrators

From: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

Pennsylvania Food Act (31 P.S. §§ 20.3 (3)), revised February 22, 2005, "Prohibits any Adulteration or misbranding of food." Section §§ 20.8(12) stipulates eggs are considered to be adulterated "if it bears or contains eggs processed by or egg products derived from a manufacturing, processing or preparing method wherein whole eggs are broken using a centrifuge-type egg breaking machine that separates the egg's liquid interior from the shell."

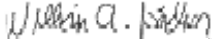
Therefore, usage of egg breaking centrifuges or products processed in the making of the product are prohibited from usage in nursing homes. Pennsylvania Food Act 31 P.S. §20.5 (a) and (b) address both civil and criminal penalties assigned for violation of the above noted act.



DATE: December 21, 2005

SUBJECT: Long Term Care Provider Bulletin No. 48
Surety Bond Requirements

TO: Nursing Home Administrators

FROM: 
William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Quality Assurance

The purpose of this bulletin to provide information regarding **42 CFR 483.10(c)(7) Assurance of financial security** to nursing homes in Pennsylvania.

Based on federal law nursing homes are required to purchase a surety bond to assure the security of all personal funds of residents deposited with the facility.

A surety bond is an agreement between the facility, the insurance company and the resident (the obligee). The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring from any failure by the facility to hold, safeguard, manage, and account for the residents' funds.

Although the federal statute allows for the state to be named as the obligee; there is no state law directing the state to serve as obligee and no law prohibiting residents from serving as same.

Essential points relative to security bonds:

- The resident or the residents, either named individually or in a group is the obligee
- The facility cannot be named the beneficiary
- Self-insurance is not an acceptable alternative to a surety bond

- Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation, or other similar entities, is not an acceptable alternative to a security bond.



DATE: December 29, 2005

SUBJECT: Long Term Care Provider Bulletin No. 49
Department Access to Records at Nursing Homes Pursuant to 35 P. S. §448.813

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Quality Assurance

THIS INFORMATION SHOULD BE SHARED WITH ALL FACILITY STAFF AND MANAGEMENT.

During a complaint investigation to determine facility action on numerous repeated resident injuries (skin tears, bruises, fractures of unknown origin), survey staff were denied access to the incident and accident reports maintained by the facility, even though facility personnel upon interview repeatedly referred to these documents as evidence that all incidents were properly investigated.

Subsequently, the licensed facility not only refused to turn over the records, for which a \$500 per day fine was ordered, but removed the records from the facility to the corporate office. As a result of the latter action, the department filed a Complaint in Equity and a Motion for Preliminary Injunction in Commonwealth Court to restrain further violation of the Health Care Facilities Act. After a full evidentiary hearing, Senior Judge Eunice Ross issued the injunction. After an unsuccessful appeal for reconsideration and an emergency application to the Supreme Court to stay, the injunction was denied, the records were turned over to the department, and the full fine for \$5,000 was paid. The entire matter lasted ten days. The department was fully prepared to seek Civil Contempt sanctions if the court order was not complied with in a timely fashion.

The facility maintained that incident and accident reports are quality assurance records and part of their quality assurance programs. They further alleged that the records cannot be turned over to the Commonwealth because to do so would violate confidentiality mandates of federal law. The administrator/operator of the facility maintained that the incident and accident reports fall into the category of quality assurance records of its Quality Assessment and Assurance Committee established in accordance with 42 V.S.C. §1395 i 3 (b)(1)(B). The committee meets quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements plans of action to correct identified quality deficiencies.

The department's position in this situation is that no federal statute or rule mandates that incident and accident reports are part of a quality assurance file. In the Briarcliff situation, following surveyor review of other pertinent medical records and files which did not provide conclusive evidence of adequate facility action with reference to the identification of cause of resident injury, and repeated reference by facility staff that the cause of resident injury is recorded on the incident and accident reports, the surveyor requested access to the reports. The department acted pursuant to the authority in the Health Care Facilities Act which allows any authorized agent of the Department of Health to "enter, visit, and inspect. . .any health care facility licensed. . .under this act and shall have full and free access to the records of the facility and to the patients and employees therein and their records and shall have full opportunity to interview, impact, and examine such employer." See 35 P.S. 3448.813.

A copy of the opinion and orders in Commonwealth of Pennsylvania Department of Health v Penn Med Consultants, Inc.: Briarcliff Nursing Home Associates & Richard Slazinski, NHA, (Docket No. 423 M.D. 97, May 9, 1997) is available upon request from this office.

Questions regarding the legal issues involved should be addressed to Office of Legal Counsel; Department of Health; P.O. Box 90; Harrisburg, Pennsylvania 17120; telephone (717) 783-2500.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF HEALTH,

Plaintiff

v,

No. 423 M.D. 1997

RI.CHARD SLAZINSKI, N.H.A., AND
BRIARCLIFF NURSING CENTER
ASSOCIATES, A PENNSYLVANIA
LIKITED PARTNERSHIP, D/B/A
BRIARCLIFF PAVILION FOR
SPECIALIZED CARZ, AND PENN
MED CONSULTANTS, INC.,
Defendants

HEARD: MAY 7 & 8, 1997

BEFORE: HONORABLE EUNICE ROSS, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
SENIOR JUDGE ROSS

FILED: MAY 9. 1997

Plaintiff, the Commonwealth of Pennsylvania, Department of Health, moves for the issuance of a preliminary injunction against defendants, Richard Slazinski, N.H.A., Briarcliff Pavilion for Specialized Care, Briarcliff Nursing Center Associates, a Pennsylvania limited partnership doing business as Briarcliff Pavilion for Specialized Care, and Penn Med Consultants, Inc. Penn Med became a party defendant by oral motion made at trial on the preliminary injunction. The relief sought by the Commonwealth is a (1) direction by this Court that defendants produce all incident and accident reports from Briarcliff Pavilion for January 1, 1996 to date and continuing as events occur in the future: (2) an injunction barring defendant, their officers, agents servants and employees from violations of the Health Care Facilities Act, 35 P.S. § 448.103 et seg; and (3) the award of costs and other interim relief as the Court deems appropriate.

Defendants filed at trial a counter motion for preliminary injunction praying the Court to enjoin the survey by the Department of

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Health of Audubon Villa, a facility like defendant Briarcliff and managed by the same corporation, Penn Med, as Briarcliff. Defendants allege that the survey was a retaliatory act by reason of the refusal by defendants to turn incident and accident reports of Briarcliff over to the plaintiff.

THE FACTS

The credible facts adduced at hearing follow.

Defendant Slazinski is the administrator of Briarcliff Pavilion for Specialized Care, located at 249 Maus Drive, North Huntingdon Township, Westmoreland County, Pennsylvania. Briarcliff is licensed by the plaintiff under the Pennsylvania Health Care Facilities Act, 35 P.S. 448.101 No. 423 M.D. 1997 et seq., to operate a long-term care facility or nursing home. It is certified to participate in the Medicare and Medicaid programs.

On April 22, 1997, the Division of Nursing Care Facilities of plaintiff based in Ebensburg, Pennsylvania began an investigation of two formal complaints made by relatives of residents against defendants for possible physical abuse of Briarcliff patients as manifested by skin tears, bone fractures and bruises. Josephine Bobik, a department surveyor, presented herself to defendants on April 22, 1997, properly identified herself and requested access to facility documents recording the causation of the residents' skin tears, bruises and fractures which she observed as part of her survey investigation that day. The director of nursing informed Ms. Bobik that the incident and accident reports record causation of resident injury. When a request was made to Mr. Slazinski to view the reports, he refused basing his denial on a corporate policy.

Aside from medical or financial records, defendants made available to Ms. Bobik incident logs which identified the resident only by room number, something not fixed. Causation is shown on the log only when another resident caused the injury or when under the heading "Description of Injury" a fall is noted. Other causation then appears only on the incident and accident report.

The facility in the past on November 7, 1996, prepared a written form PB-22 which recorded investigations of abuse, neglect or

misappropriation of property by a facility employee. The facility reported abuse allegedly inflicted upon a resident by a staff member. An incident and accident report was attached to the PB-22 form.

The department in performing surveys of other facilities has never been denied access to incident and accident reports which show specific causation.

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On May 5 and 6, 1997, Ms. Bobik returned to Briarcliff as part of a licensure investigation which also may result in certification for Federal Medicare and Medicaid and asked to see the incident and accident reports. Again she was refused on May 5, 1997 and was told on May 6, 1997, that the records had been removed from the facility to corporate headquarters (Penn Med).

Defendants plead that incident and accident reports at Briarcliff and at any other facility run by Penn Med are quality assurance records and part of their quality assurance programs. They allege that the records cannot be turned over to the Commonwealth because to do so would violate confidentiality mandates of Federal law. The administrators/operators of Briarcliff contend that the incident and accident reports fall into the category of quality assurance records of its quality assessment and assurance committee established in accordance with 42 U. S. C. §1395 (i) (3) (B). The committee meets quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develops and implements plans of action to correct identified quality deficiencies.

No Federal statute or rule mandates that incident and accident reports are part of the quality assurance file. Defendants made that determination themselves before denying plaintiff access.

Defendants also assert that plaintiff could learn the facts of causation through staff and resident interviews and other open records kept at the facility.

THE LAW APPLIED TO
THE FACTS

(1) THE PETITION OF THE COMMONWEALTH

Under the Health Care Facilities Act, 35 P. S. § 448,813 for the purpose of "determining . . . the adequacy of the care and treatment provided or the continuing conformity of the licensees to this act and to applicable local, state and Federal regulations, any authorized agent" of the Department of Health may "enter, visit and inspect . . . any health care facility licenses . . . under this act and shall have full and free access to the records of the facility and

to the patients and employees therein and their records and shall have full opportunity to interview, inspect and examine such employees. Upon entering a health care facility, the inspector shall properly identify themselves" to the person in charge of the facility: 35 P.S. § 448.813. See also 28 Pa. Code § 201.14(a); 201.18(f) (1); 210.19(d) and 210.30(a).

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Under Federal rules and regulations governing licensure of defendant's facility, Briarcliff must be and is licensed under applicable state law and must operate in compliance with all pertinent Federal, state and local laws, regulations and codes: v.36 Federal Register, No. 137 September 26, 1991, § 483.75.

Defendant bases its refusal to turn over the incident reports (which it rather than the Federal or state government have designated as quality assurance documents) in 42 U.S.C. § 1395 (i) - 3(b) (1) (B) which forbids disclosure of records of the quality assurance committee to the state or the secretary "except insofar as such disclosure is related to the compliance of the Committee . . ." The committee is directed in that section to identify issues of quality assessment and to develop appropriate plans to correct quality deficiencies.

Since the incident and accident reports are not documents which are generated by the committee to identify quality deficiencies or which develop and implement plans for appropriate action, the reports do not fall within the aegis of documents protected from disclosure by Federal law. It is the facility not the committee which prepares the documents and identifies them as quality assurance documents.

The State Operations Manual generated by the Health Care Financing Administration, Tag number F521, P.202, emphasizes that the committee produces plans of action to identify and correct quality deficiencies and that committee attempts to do so cannot be the basis for governmental sanctions. Committee generated documents are not the same as documents furnished the committee by the facility. Neither the statute nor the manual provides for confidentiality for any document beyond those concerned with the identification and proposed remedy of quality deficiencies.

Defendant, however, further urges the Court to rely on a Health Care Financing Administrative seminar training manual which, without a citation of authority, tells seminar participants not to ask for a record of accident and incident reports but rather to "ask for

evidence of how they routinely monitor accident and incident reports, record them and have in place a system to prevent and/or minimize further accidents of incidents." This manual provision taken out of context can have no authority to overcome the fact that neither Federal statute nor Health Care Facility regulations oust state authority to investigate complaints about abuse at health care facilities. An intent to pre-empt state authority to investigate and sanction facilities when issues of health and safety are involved must be set forth expressly: Hillsborough County v. Automated Medical Laboratories, 471 U.S. 707, 717-718, 85 L. Ed. 2d 714, 105 S.Ct. 2371, 2375, 2377 (1985); Jones v. Rath Packing Company, 430 U.S. 519, 525, 51 L.Ed.2d 604, 97 S.Ct. 1305, 1309 (1977).

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Indeed, Federal Health Care Facilities regulations found in 42 C.F.R. ch. IV, § 483.75(a)(b) require state licensure and compliance by facilities with Federal, state and local law. The regulations at 42 C.F.R. ch. IV, § 448.332 mandate that the state survey agency establish procedures and adequate staff to investigate complaints of violations: 42 C.F.R. ch. IV, § 448.332. The regulations expressly authorize the state to investigate whether "an identifiable individual neglected or abused a resident, or misappropriated a resident's property." See 42 C.F.R. ch. IV, § 448.332 and § 488.335.

The power of the state to license coupled with the power of the state to investigate resident abuse clearly manifested in the Federal regulations make it clear that there has been no pre-emption by the Federal government of the right of the state to investigate allegations of resident abuse and to impose sanctions therefore including the denial of future licensure.

Thus, the confidentiality issue falls as to the incident and accident reports and with it the other argument that the department might retrieve the same information as to causation by interviewing staff and residents and perusal of other documents. The incident and accident report is the only report documenting the cause of resident injury.

The Court may enter a preliminary injunction after notice and hearing only if the relief is necessary to prevent immediate injury, there is a clear right to the requested relief, the injury would be irreparable or incapable of adequate compensation by an award of damages, the defendant's wrong is manifest, greater injury would result from refusal than from the grant of the relief, plaintiff's remedy at law is inadequate, general equity jurisdiction is warranted, the action to be restrained is actionable, injunctive relief is reasonable equitable to abate the activity and the injunction will restore the status quo: Lewis v. City of Harrisburg, 631 A. 2d 807, 810 (1993).

All the prongs of this test have been met. In light of the large number of injuries observed by the department's investigator and the two formal complaints filed in this case and the fact that the health and safety of residents is an issue of first importance, there is a need for immediate action on the part of the Court. The return of the incident and accident reports to open files will restore the status quo without any disruption of the daily work at the facility or the quarterly work of the committee.

The prayer of the department's petition will be granted. Since an agency of the Commonwealth requests the preliminary injunction, no bond will be required: Pa.R.C.P. 1531 (b).

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(2) THE DEFENDANT'S COUNTER-MOTION
FOR PRELIMINARY INJUNCTION

Defendants' counter-motion for preliminary injunction will be dismissed since it relates to a different party, Audubon Villa, and alleges a different set of facts from the underlying case. The dismissal is without prejudice to defendants' right to file an appropriate underlying case setting forth the new factual situation and requesting appropriate relief.

Eunice Ross, Senior Judge

Eunice Ross, Senior Judge

Associates, a Pennsylvania limited partnership, d/b/a/ Briarcliff Pavilion for Specialized Care and Penn Med Consultants, Inc., defendants, for preliminary injunction is denied without prejudice to the right of defendants to file an appropriate underlying action and to request appropriate relief as an incident thereto.

Eunice Ross, Senior Judge

praying for a preliminary injunction directed to defendants Richard Slazinski, N.H.A., Briarcliff Nursing Center Associates, a Pennsylvania limited partnership, d/b/a/ Briarcliff Pavilion for Specialized Care and Penn Med Consultants, Inc., in accordance with the opinion contemporaneously entered.

It is ordered, adjudged and decreed that a preliminary injunction will issue and defendants, Richard Slazinski, N.H.A., Briarcliff Nursing Center Associates, a Pennsylvania limited partnership, d/b/a/ Briarcliff Pavilion for Specialized Care and Penn Med Consultants, Inc., are directed within five days to produce all incident and accident reports of Briarcliff Pavilion covering all incidents and accidents occurring at the Briarcliff Pavilion from January 1, 1996, through May 6, 1997, for inspection and copying by the Commonwealth of Pennsylvania, Department of Health; defendants are further directed to comply with all requirements of 35 P.S. § 448.813 to enable the Department of Health upon proper identification of its inspectors to the person in charge of the facility to enter Briarcliff to visit and inspect the facility for any appropriate department function with full and free access to all facility records, employees and patients.

No bond shall be required of plaintiff.

Eunice Ross, Senior Judge



DATE: May 3, 2005

SUBJECT: Long Term Care Provider Bulletin No. 50,
Consumer Hotline

TO: Nursing Home Administrators

A handwritten signature in black ink that reads "William A. Bordner".

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

Please note that the Department of Health has a toll free grievance and complaint consumer hotline accessible 24 hours a day, seven days a week. The number is **1-800-254-5164**. Please make this number available to residents, their guardians and families, and post in public areas of your facility.

As a reminder to your employees, attached is a listing of the numbers for each of the Department of Health's Nursing Care Facilities field offices. Staff in these offices are available to assist you on all quality of care issues.

Attachment

FIELD OFFICES OF THE PENNSYLVANIA DEPARTMENT OF HEALTH

Harrisburg Field Office
 132 Kline Plaza, Suite B
 Harrisburg, PA 17104
 (717) 783-3790
 (717) 772-3641 (fax)

Jackson Center Field Office
 19 McQuiston Drive
 Jackson Center, PA 16133
 (724) 662-6050
 (724) 662-6067 (fax)

Johnstown Field Office
 184 Donald Lane, Suite 3
 Johnstown, PA 15904
 (814) 248-3125
 (814) 248-3058 (fax)

Lehigh Valley Field Office
 4520 Bath Pike
 Bethlehem, PA 18017
 (610) 861-2117
 (610) 861-2123 (fax)

Lionville Field Office
 110 Pickering Way, PO Box 500
 Exton, PA 19341-0500
 (610) 594-8041
 (610) 594-9267 (fax)

Norristown Field Office
 1937 New Hope Street
 Norristown, PA 19401
 (610) 270-3475
 (610) 270-1152 (fax)

Pittsburgh Field Office
 300 Liberty Avenue
 Pittsburgh State Office Building, Room 505
 Pittsburgh, PA 15222
 (412) 565-2836
 (412) 565-2893 (fax)

Scranton Field Office
 100 Lackawanna Avenue
 Scranton State Office Building, Room 111
 Scranton, PA 18503
 (570) 963-4331
 (570) 963-3415 (fax)

Williamsport Field Office
 1000 Commerce Park Drive
 Suite 112
 Williamsport, PA 17701
 (570) 651-1040
 (570) 651-1043 (fax)



DATE: December 29, 2005

SUBJECT: Long Term Care Provider Bulletin No. 51
Notification Requirements for Changes in Ownership, Structure, or Name

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

The Division of Nursing Care Facilities is issuing this Provider Bulletin to remind all facilities of the 30-day advance notice requirements for changes in ownership, structure, or name. This requirement is specified in Title 28 Health and Safety, Part IV Health Facility, Subpart A General Provisions, Chapter 51 General Information, Subsection 51.4 Change of Ownership, Change in Management which states:

- a. A health care facility shall notify the department in writing **at least 30 days prior** to transfer involving five-percent or more of the stock or equity of the health care facility.
- b. A health care facility shall notify the department in writing **at least 30 days prior** to a change in **ownership** or a change in the **form of ownership** or **name** of the facility. A change in ownership shall mean any transfer of the controlling interest in a health care facility.
- c. A health care facility shall notify the department in writing within 30 days **after** a change of management of a health care facility. A change in management occurs when the person responsible for the day-to-day operations of the health care facility changes.

The license is not transferable without prior approval of the Department. Failure of facilities to adhere to this notice requirement may result in civil monetary penalties and the revocation of license.



DATE: January 3, 2006

SUBJECT: Long Term Care Provider Bulletin No. 54
Microorganisms Resistant to Anti-microbial Drugs in Non-Hospital Settings

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

The original Provider Bulletin posted in 1997 focused on Vancomycin Resistant Enterococci. However, current information provided by Centers for Disease Control addresses additional organisms that have acquired drug resistant status. The following provides some basic information and guidance in dealing with these organisms.

What are “non-hospital settings”?

Non-hospital settings refer to long-term care, skilled nursing homes, home care, hemodialysis centers and physicians’ offices.

What are “multidrug-resistant organisms”?

Multidrug-resistant organisms are bacteria and other microorganisms that have developed resistance to anti-microbial drugs. Common examples include:

- **MRSA**-methicillin/oxacillin-resistant *Staphylococcus aureus*
- **VRE** – vancomycin-resistant enterococci
- **ESBLs**-extended-spectrum beta-lactamases (which are resistant to cephalosporins and monobactams)
- **PRSP** –penicillin-resistant *Streptococcus pneumoniae*

Which Multidrug-resistant organisms are most commonly seen in nursing homes and other long-term care facilities?

MRSA and VRE are the multi-drug resistant organisms most commonly encountered in **nursing homes**. **PRSP** are more commonly seen in patients seeking care in outpatient settings such as physicians’ offices and clinics, especially in pediatric settings.

What is the difference between colonization and infection?

Colonization means that the organism is present in or on the body but is not causing illness. Infection means that the organism is present and is causing illness.

What conditions increase the risk of acquiring these organisms?

There are several risk factors for both colonization and infection:

of by a multi-drug-resistant organism

- Advanced age
- Severity of illness
- Previous exposure to antimicrobial agents
- Underlying diseases or conditions, particularly:
 - Chronic renal disease
 - Insulin-dependent diabetes mellitus
 - Peripheral vascular disease
 - Dermatitis or skin lesions
- Invasive procedures, such as:
 - Dialysis
 - Presence of invasive devices
 - Urinary catheterization
- Repeat contact with the healthcare system
- Previous colonization of by a multi-drug-resistant organism
- Advanced age

Should residents colonized or infected with these organisms be admitted to a nursing home?

Nursing homes can safely care for and manage these residents by following appropriate infection control practices. In addition, nursing homes should be aware that persons with MRSA, VRE and other infections may be protected by the Americans with Disabilities Act.

What can be done to prevent or control transmission of these pathogens in a facility?

Resident placement – Place the resident in a private room, if possible. When a private room is not available, place the resident in a room with a resident who is colonized or infected with the same organism, but does not have any other infection (cohorting). Another option is to place and infected resident with a resident who does not have risk factors for infection.

Group activities – It is extremely important to maintain the residents' ability to socialize and have access to rehabilitation opportunities. Infected or colonized residents should be permitted to participate in group meals and activities if draining wounds are contained, and the resident observe good hygienic practices.

The following recommendations for prevention of VRE/MRSA in hospitals maybe adapted to us in nursing home settings:

- Obtain stool cultures or rectal swab cultures of roommates of resident newly found to be infected or colonized with VRE, and nasal swabs for MRSA
- Adopt a policy for deciding when residents can be removed from isolation, e.g. VRE-negative results on at least three consecutive occasions, one or more weeks apart.

Are there any recommendations for pre-admission screening in nursing homes?

CDC does not have recommendations for pre-admission screening.

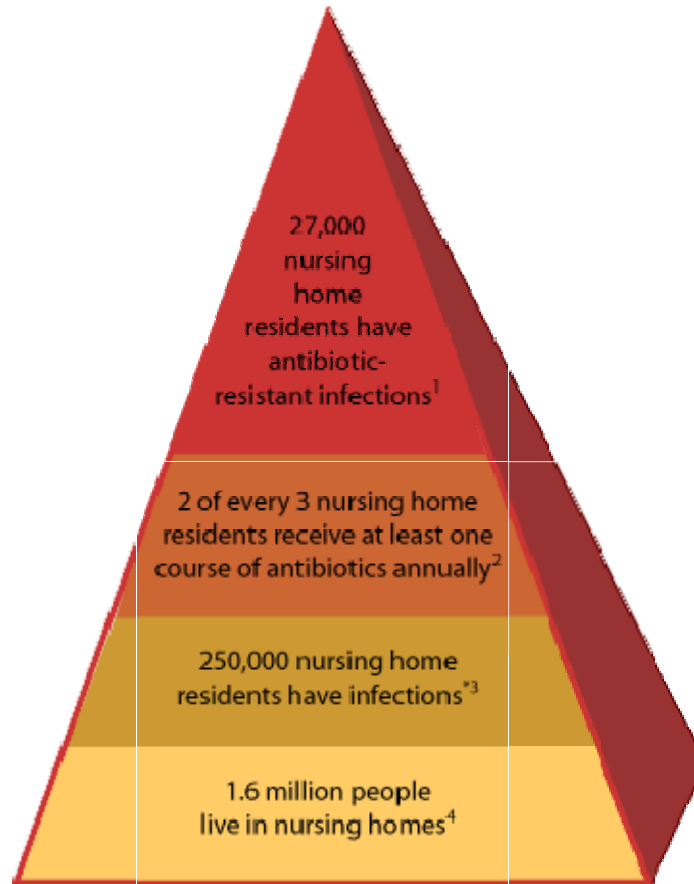
Handling of clusters or outbreaks of infection

- Consult with state or local health officials or an experienced infection control professional as needed.
- Nursing Homes must have policies and procedures for dealing with clusters and/or outbreaks, which include, involvement of the facilities Medical Director.
- Report outbreaks as required by regulations

If a resident in a facility is colonized or infected with MRSA or VRE, what do their visitors/family members need to know?

In general, healthy people are at low risk of getting infected with MRSA or VRE. Therefore, casual contact-such as kissing, hugging and touching-is acceptable. Visitors should wash their hands before leaving an infected person's room. Also, disposable gloves should be worn (if excessive contact with body fluids is excepted, gowns should be worn.) It is also acceptable for infants and children to have casual contact with these residents.

Burden of Infections Among U.S. Nursing Home Residents



* wound infections, respiratory infections, urinary tract infections, or pneumonia

<http://www.cdc.gov/drugresistance/healthcare/ltc.htm>

References:

1. Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident Profile Table as of 05/02/2005. Baltimore, MD.
2. Loeb, M et.al. Antibiotic use in Ontario facilities that provide chronic care. J Gen Intern Med 2001; 16: 376-383.
3. Centers for Medicare and Medicaid Services, Long Term Care Minimum Data Set, Resident Profile Table as of 05/02/2005. Baltimore, MD.
4. Centers for Disease Control and Prevention, National Center for Health Statistics, 1999 National Nursing Home Survey. Nursing Home Residents, number, percent distribution, and rate per 10,000, by age at interview, according to sex, race, and region: United States, 1999.
5. Centers for Disease Control and Prevention, Preventing Infection and Antimicrobial Resistance among Nursing Home Residents, Posted 12/28/2005
6. Centers for Disease Control and Prevention, Multidrug Resistant Microorganisms in Non-Hospital Settings

DEPARTMENT OF HEALTH

*Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health*

DATE: January 9, 2006

SUBJECT: Long Term Care Provider Bulletin No. 55
Nursing Hours

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification
(717) 787-1816

This provider bulletin is being issued to clarify the method to be used for the calculation of nursing hours for long-term care facilities.

The procedure for calculating general nursing care hours is as follows:

Add up the actual number of direct-care personnel and multiply by the hours worked (usually eight). This will reflect the actual hours provided. Multiply the resident census for each day times 2.7 (current required nursing hours per resident); this will reflect the required nursing staff. Divide the actual hours provided by the daily census; this number indicates the actual number of contact hours and should be 2.7 hours or above.

Points to Ponder:

Pennsylvania State Regulation 28 PA Code § 211.2(g) requires one nursing staff employee on duty per 20 residents. "On duty" means to physically present and to personally provide nursing care when needed. When computing staff time, a person is considered to be on duty during lunch and break times.

Pennsylvania State Regulation §211.12(h) guidelines stipulate that Private duty nurses should not be counted as part of the staffing pattern.

Pennsylvania State Regulation §211.12(i) stipulates “be a minimum of 2.7 hours of **direct** resident care for each resident...”. Administrative and supervisory nursing employees are not counted as part of the direct staff unless they have provided direct care to the residents. When there is a need for administrative/supervisory staff to provide direct care only the time actually spent providing the care should be included in the general nursing hours.

Examples for calculating nursing hours

Example 1: Staffing over three shifts/24 hours = 35 (RNs, LPNs, CNAs); facility census is 102 residents

35 Nursing staff	102 Residents
<u>x8</u> hours worked per staff	<u>x2.7</u> Nursing hours required per 24 hrs.
280 nursing hours provided*	275.4 Nursing hours needed**

*The facility has met and exceeded the nursing hours required

Example 2: Staff over three shift/24 hours = 34 (RNs, LPNs, CNAs); facility census is 102 residents

34 Nursing Staff	** Nursing Hours needed remains at
<u>x8</u> hours worked per staff	275.4 *
272 Nursing Hours provided	

* The facility has failed to provided the needed nursing hours to meet the regulatory requirement



DATE: January 6, 2006

SUBJECT: Long Term Care Provider Bulletin No. 57
Nurse Aide Registry -Overview

TO: Nursing Home Administrators

FROM: William Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

On October 11, 2001, the Pennsylvania Department of Health Nurse Aide Registry entered into a contract with Promissor (previously Assessment Systems Incorporated or ASI) to handle all Nurse Aid Registry functions. Promissor has sufficient trained registry personnel available to address all Nurse Aide Registry business matters regarding nurse aide registrations, including verifications, continued enrollment, address/name changes, reciprocity. Information can be obtained by going to the Promissor website -www.promissor.com or by calling Promissor's Customer Service Department at **1-800-852-0518**, Monday through Friday, 8:00 A.M. to 5:00 P.M.

Questions related to scheduling an **examination**, reservations, and testing should be directed to the **American Red Cross at 1-800-795-2350**.

Once the nurse aide has passed both the written (or oral) examination and the skills evaluation, the nurse aides name will be placed on the Pennsylvania Nurse Aide Registry. A Registry Card (Notice of Enrollment) will be mailed to the nurse aide and will arrive within three (3) weeks of successfully completing the testing.

Promissor mails (to the address listed on the Registry) continued enrollment applications to nurse aides 90 days prior to the expiration date. Applications for renewal can also be down loaded from the Promissor website. Once renewal has been finalized the nurse aide will receive a new Registry Card (Notice of Enrollment), which is good for 24 months.

Nurse aides will still need to contact Promissor within 10 days regarding any change in name and/or address. This contact will ensure that nurse aides receive any documents mailed to them.

We look forward to providing a better consumer friendly service for everyone involved.

Please share this information with all nurse aides on your staff.



DATE: January 6, 2006

SUBJECT: Long Term Care Provider Bulletin No. 58
Advance Directives Requirements

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

This bulletin is notice of the Division of Nursing Care Facility's (DNCF) position with regard to the performance of Cardiopulmonary Resuscitation (CPR) in nursing care facilities and facility policies with regard to advance directives for health care.

DNCF recognizes and acknowledges that there are no state or federal regulations that require nursing care facility staff to provide CPR to residents who require such services. However, DNCF also believes that many residents and their responsible parties do not understand that some facilities' staff will not perform CPR when appropriate. Accordingly, nursing facilities whose staff will not perform CPR when needed and when there is no Do Not Resuscitate (DNR) order or an effective Advance Directive requiring CPR in place, are required to provide notice of this policy in clear and understandable language to residents and/or the resident's responsible party prior to admission.

Such notice must explain that the facility staff will not perform CPR and that it is the facility's policy to call emergency medical services when CPR is needed.

DNCF also reiterates that a nursing facility may NOT require a resident to execute an advance directive for health care as a condition for being admitted or receiving nursing care services. The opportunity to execute an advance directive may be given to residents at any time, but there may be no condition attached to such offers.

DNCF does recommend that nursing facilities have staff members who are certified in CPR and that those staff members be permitted to perform CPR when appropriate.



*Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health*

DATE: January 6, 2006

SUBJECT: Long Term Care Provider Bulletin No. 59
Elopement, Resident Smoking and Water Temperatures

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

The Department of Health (DOH) continues to investigate incidents regarding resident health and safety issues involving elopements, resident smoking and water temperatures. In order to improve the quality of health care for nursing home residents, we have compiled some thoughts regarding these issues that merit consideration for all facilities.

Elopements:

- Confused, wandering residents make up a significant part of our nursing home population.
- Wandering residents require a great amount of supervision. The facility needs to utilize the least restrictive chemical and physical restraints and maintain the resident's at their highest functional ability.
- An elopement can place the resident at risk for serious harm and even death; depending on the physical condition of the resident, the amount of time that the resident is missing, the weather, the way that the resident is dressed, and the area where the resident has wandered.
- Facilities often seek permission from the department to install a special locking arrangement (SLA) to ensure the safety of residents. SLA's can be installed for a variety of reasons and, in areas where if exited, could pose a safety hazard to residents. SLA's are not to be installed and utilized to physically restrain residents to a specific area. **They are not meant to be a replacement for staff's supervision of resident.** Facilities often assume that once an SLA is installed,

that the system will be error free. The system is only successful if utilized as intended and maintained in operating condition. The SLA is not to be utilized in lieu of staff supervision and programming for the residents.

- Once a resident is admitted or exhibits a change in condition and determined to be a wanderer, a full and comprehensive assessment should take place. Families should be a part of the ongoing assessment to reflect the resident's behavioral and customary patterns for the development of a safe environment.
- Once the assessment is completed and interventions developed to ensure the resident's safety, staff must be aware of the needs of the resident and the interventions that should be consistently implemented. Consistent implementation of the care plan that addresses the resident's need for supervision is key in the prevention of unassisted attempts to exit the facility.
- If the resident has attempted on several occasions to elope from the facility but has not been successful, the facility should periodically re-evaluate the care plan interventions to determine that they are continuing to ensure the resident's safety. During our investigations of elopements, in many cases, the facilities were aware that the resident was at risk of elopement.
- If elopements do occur, a complete and thorough investigation should take place immediately to determine how the resident was able to exit the facility. The investigation should be comprehensive and include other residents that may be at risk as a result of this failure. If during the investigation of the elopement, it is determined that the facility's lack of action has not corrected the identified situation or that other residents remain at risk, the facility may be assessed to be in an immediate jeopardy situation.
- Elopement is immediately reportable to the Department of Health as required under Chapter 51 [(51.3(f)(4)], of the Health Care Facilities Act.

Elevated Water Temperatures:

- Pennsylvania LTC Regulations require hot water outlets accessible to residents to be controlled so that the water temperature of the outlets does not exceed 110 degrees Fahrenheit.
- A system must be in place to monitor the temperatures at the water outlets (sink, tub, shower) in resident areas.
- If elevated water temperature is identified and an investigation is in progress until a permanent solution is maintained the facility should implement measures to protect the health and safety of the residents, such as: communicating to all staff the concern

regarding elevated water temperatures, provide thermometers to measure water temperatures at the water outlets and any other precautionary measures to ensure the safety of the residents.

Resident Smoking:

- Pennsylvania LTC Regulations require that policies regarding resident smoking be developed. These policies shall include provisions to protect the rights of the nonsmoking residents as well as the health and safety of all residents residing in the facility.
- Residents that smoke should be assessed for their ability to safely smoke independently.
- Residents found to be incapable of smoking safely should have interventions developed to ensure that the resident smokes in a manner and environment that ensure their safety. Adequate supervision while smoking should be provided for those residents that require it.
- Staff must be aware of the needs of the resident and must consistently implement the care plan interventions developed to prevent unsupervised smoking to ensure the safety of the residents.
- If a resident that has been assessed as requiring supervised smoking is found smoking without supervision, **a complete and thorough investigation should take place** immediately to determine how the resident was able to obtain smoking paraphernalia. The investigation should be comprehensive and include other residents that may be at risk as a result of this failure. If during the investigation, it is determined that the facility's lack of action has not corrected the identified situation or that other residents remain at risk, the facility may be assessed to be in an immediate jeopardy situation.
- If a resident that smokes requires oxygen therapy, precautions must be implemented so the oxygen which is highly combustible is not a factor. Weighing the residents rights with a safety hazard in communal living must be considered.
- Facilities may establish smoke free policies, however, residents who smoke and have resided in the facility prior to the implementation of the smoke free policy can not be prohibited from smoking after the policy is implemented.

The administrator and the medical director should monitor these issues. Facilities need to be proactive in identifying issues, identifying patterns and implementing measures to ensure resident safety.

“Please note that Provider Bulletins are the means by which the Division of Nursing Care Facilities (DNCF) provides technical interpretations and guidance on various issues. The DNCF Message Board is the method for the majority of communication between the DNCF and Providers. The DNCF Message Board must be accessed on a regular basis by Providers to insure they are current with DNCF communications.”

DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

DATE: January 6, 2006

SUBJECT: Long Term Care Provider Bulletin No. 60
Federal Requirements Regarding Use of the Medicare Prospective Payment System (PPS) Assessment Form (MPAF)

TO: Nursing Home Administrators

FROM: William A. Bordner, Director
Division of Nursing Care Facilities
Bureau of Facility Licensure and Certification

Effective July 1, 2002, long-term care facilities participating in Medicare and Medicaid programs have been afforded the opportunity to utilize the new Minimum Data Set Medicare Prospective Payment System Assessment Form (MPAF) as of the first day of your new fiscal year. **Assessments affecting Medical Assistance payment (Admission, Annual, and Significant change) will not change.**

The OBRA assessment requirements supersede the use of the abbreviated form, which is used only for the prospective payment system assessments (PPS).

The facility may *choose* to complete and submit the shorter MPAF form in conjunction with portions of the PA-Specific Minimum Data Set Section S for the following assessments (see attachments):

- Medicare PPS only assessments
- PPS assessment combined with an OBRA quarterly assessment

Use of the MPAF form is ***completely optional***. PPS only assessments completed and submitted as full assessments are still acceptable. If a full assessment is submitted only for PPS, the MDS full assessment items that are not on the MPAF form will be ignored and will not be stored in the state MDS data repository. If you choose to utilize a full MDS assessment in place of the MPAF form for Medicare PPS assessments, no errors or warnings will occur with data submission. Your software will need updated to support the use of the MPAF form. The RAVEN grouper and MDS transmission software will support the use of the MPAF form. Information on the RAVEN software package can be viewed at <http://www.hcfa.gov/medicaid/mds20/raven.htm>. If you choose not to utilize the MPAF form, no software updating will be necessary and you will not have difficulty submitting the full MDS assessment form for your Medicare PPS assessments to the state data repository.

If you have any questions please call (717) 787-1816.