Knudsen, Berkheimer, Richardson
& Endacott, LLP
3800 VerMaas Place, Suite 200
Lincoln, NE 68502

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Knudsen, Berkheimer, Richardson &
Endacott, LLP
3800 VerMaas Place, Suite 200
Lincoln, NE 68502

Toll Free: 800-714-3439
Phone: 402-475-7011
Fax: 402-475-8912
E-mail: tschroeder@knudsenlaw.com

Visit our website

www.knudsenlaw.com

Volume 3, Issue 4

KNUDSEN, BERKHEIMER, RICHARDSON & ENDACOTT, LLP

October 31, 2010

Long-Term Care Newsletter

Contributors:

- **Laura Essay**
- **Michael Khalili**
- **Jeanelle Lust**
- **Kevin McManaman**
- **Tammy Schroeder**
- **Shirley Williams**

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MDS 3.0 By Kevin R. McManaman

The long-awaited MDS 3.0 brings specific requirements and interpretive guidance, but because the MDS frequently is used in disputed matters, many are predicting the new requirements will also bring increased complaints and litigation. A few of the most concerning interpretive guidelines include Quality of Care, Pressure Sores and Accidents.

Quality of Care (F309)

Section 483.25 of the CFRs correlates to F309, and states that: "Each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care." The "highest practicable" status for an individual varies with specific pathologies, the right to refuse care, and normal aging, and declines not related to those three factors are not "unavoidable." This broad provision appears likely to be used by surveyors for anything that is not specifically found elsewhere, and likely will impact complaints and litigation, particularly given the new resident interviews in MDS 3.0. The Brief Interview for Mental Status (BIMS), for example, is a quarterly interview to establish cognitive status trends. Lawyers are likely to argue over the meaning of the BIMS results, not only over the trends, but also about competency, such as whether a resident with mild dementia is competent to make particular decisions related to their care. Similarly, the Patient Health Questionnaire 9 (PHQ9) is an interview designed to identify a decline in patient health, including possible depression. Experts will be expected to use such data in litigation. Finally, the pain interview in MDS 3.0 may have a very obvious impact on litigation since pain and suffering are a part of many lawsuits.

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DEA Lays Out New Policy Allowing Some Nurses to Relay Pain Medication Prescriptions to Pharmacies by Tammy Schroeder

On October 6, 2010, the DEA made a surprise announcement that it would now allow nurses working in long-term care facilities to act as agents of the prescriber. This change in the DEA's policy allows the agent nurse to call or fax the pharmacy and relay the prescribers verbal orders for Schedule III, IV and V controlled substances. In addition, the agent nurse is now allowed to fax Schedule II prescriber signed orders to the pharmacist for hospice patients and long-term care facility residents.

The American Society of Consultant Pharmacists is one of many long-term care and pharmacy groups that has opposed the DEA's restrictions on prescribing in long-term care facilities, stating that it only leads to unnecessary delays in residents receiving their pain medications. An article in the October 3, 2010 edition of the New York Times described nursing home residents as the unintended casualties of the DEA's war on drugs. The DEA had increased the level of enforcement to keep narcotics from getting in the wrong hands to such an extent that care was delayed for long-term residents. The American Pharmacists Association had suggested a short-term solution to the issue could be to have the DEA allow nurses in long-term care facilities to act as agents for the prescribers in order to relay those Schedule II through V prescriptions via fax to the pharmacy and to expand the definition of prescription orders to include chart orders.

Under this new policy, one way a nurse may be designated an agent for a physician would be to have a written agreement. A copy of the written agreement should be maintained by the practitioner, the provider, the pharmacy and any other party involved. Once the agency status is established, the nurse is able to relay medication orders to the pharmacy. A facility should contact an attorney to help develop this written agreement based on DEA's suggested

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We would like to wish everyone a Happy and Safe Holiday Season

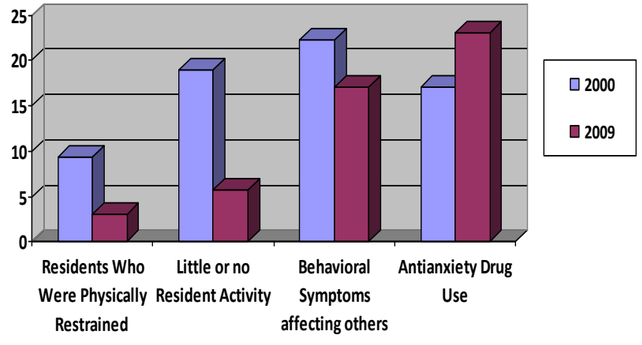
The Happy Medium

By Michael W. Khalili

According to the Centers for Medicare and Medicaid Services (CMS) Quality Indicator Report, nursing home resident activity is up, emotional and behavioral symptoms that affect other residents fell, and there was a reduction in falls and symptoms of depression. Also, residents who were physically restrained fell from 9.3% in 2000 to 3.1% in 2009. One statistic that seems to jump out is the increase in activity of the residents. The prevalence of little or no activity in residents has decreased from 18.9% to 5.7%.

It would be difficult, if not impossible, to determine the chief reason for these favorable outcomes but one presumable ingredient is the increase in anti-anxiety drug use. According to CMS, the prevalence of anti-anxiety and hypnotic drug use has increased from 17% to 23.1% and the percentage of resident patients taking nine or more medications increased from 42.8% to 70.6% over the last 10 years.

Is the balance between the increased amounts of anti-anxiety drugs to quality of life of all residents reasonable in long term health care? That happy medium is unique to each resident and difficult to assess across the board but the recent statistics seem to validate the increased anti-anxiety drug use.



DEA's New Policy (continued from pg. 1)

wording.

With an agreement in place, a nurse will be able to take a verbal order from a prescriber, call a pharmacist and relay that order. The pharmacist is to then write down the order, being sure that all the information required for a valid prescription other than the prescriber's signature is captured. This procedure will only be valid for Schedule III through V controlled substances.

In the case of a Schedule II narcotic, the agent is able to fax the prescriber signed order to the pharmacist but only if they are in the hospice or long-term care setting and in no other circumstance may they do that. The fax will then serve as the original prescription.

Some provider groups feel this new policy still doesn't go far enough. First, Schedule II narcotics which are excluded for the most part from the nurse relay rules, are some of the most common pain killers used for end-of-life nursing home residents and recent surgery patients. Second, the new policy allows written agreements to apply to individuals only rather than a nursing position, such as director of nursing or charge nurse, which may cause logistical and tracking issues and delays.

These groups are suggesting that facilities be allowed to create a blanket position within the nursing home to act as an agent of a prescriber. They also feel legislation should be passed allowing nurses to relay orders for Schedule II narcotics.

For the DEA's part, the agency sees the role of agents being reduced over time as the use of electronic prescribing by practitioners increases.

MDS 3.0 by Kevin R. McManaman (continued from pg. 1)

Pressure Sores (F314)

Section 483.25(c) requires a facility to ensure: (1) a resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The accompanying interpretive guideline now provides a definition for avoidable and unavoidable pressure sore development, which will continue to be a much litigated area. MDS 3.0 also has a new Section M to document the current number of unhealed pressure ulcers and how many of those were present on admission or re-entry to the facility. Facilities will want to be careful that Section M assessments are accurate and not inconsistent with other clinical record terminology. Finally, facilities should be able to show that: (1) they recognized and assessed the risk; (2) they defined and implemented interventions related to the risk; (3) they monitored and evaluated interventions; (4) they revised the approach as appropriate.

Accidents (F-323)

Section 483.25 (h) of the CFR requires a facility to ensure "(1) the resident environment remains as free of accident hazards as is possible; and (2) each resident receives adequate supervision as assistance devices to prevent accidents." As with the other guidelines, above, avoidable and unavoidable accidents are defined. This section also defines "supervision," which is often a disputed issue in survey citations, complaint investigations, and lawsuits. This guidance provides the expectations of assessment, risk factors, mitigation, interventions, and an investigation protocol, all of which can also be critical in the litigation setting. Finally, MDS 3.0, Section J, entitled "Health Conditions" may be important with regard to accident litigation because it contains information about balance, and range of motion effects on function. As always, the most important aspect will be the implementation of appropriate care plan interventions, and documentation.

In summary, the new MDS 3.0 and the interpretive guidelines will impact surveys, complaints, and litigation. Only time will tell, but it appears likely that these three areas of MDS 3.0 will be of particular significance.

Good Night, Sleep Tight, and...

By Jeanelle R. Lust

Bed bugs are everywhere, in dirty and clean homes, in movie theaters and public libraries, on buses and in schools, as well as in nursing homes. Once eradicated to the point that whole generations of Americans thought they were a myth, bedbugs began coming back in urban apartment buildings in recent years and then started traveling. Bed bugs will attach to luggage, to purses, and bags, and will cause an infestation if not killed right away.

Bed bugs are parasitic insects, active mainly at night, and so tiny they're difficult to spot. Their bites are usually painless, allowing them to dine to their tiny hearts' content while their victims sleep. Many people are allergic to the bites, however, and about 30 percent of victims have a reaction after being bitten, according to the Environmental Protection Agency. Bed bugs can cause illnesses if the bite becomes infected. The bites look like mosquito stings or flea bites, often causing red inflamed markings on lower legs, arms, and sometimes on the face. Since bed bugs feed in the early morning hours, some people never witness being bit by the bug because they are asleep. Bed bugs will become dormant after they feed, often giving the illusion that they have died.

In nursing homes, bed bugs may spread through shared laundry facilities, common sitting areas, or by staying in a room near someone who may have bed bugs. The bugs will travel through the plumbing, they live in wood, and they hide in magazines and books. The bugs hid in cracks and crevices during the day, and typically come out at night, usually between midnight and 5 a.m., for feeding. One of the places they hide and lay eggs is in the folds of mattresses—thus the name.

The currently recognized best methods of exterminating bed bugs are through extreme heat or extreme cold. Bed bugs have become highly resistant to chemical eradication techniques and since the early 1970's, DDT, the most effective chemical used in combating bed bugs has been banned globally.

If you suspect that your nursing home has bed bugs, call an exterminator immediately. Wash all fabrics in extremely hot water, and dry them on high heat in the clothes dryer. You may have to throw out mattresses and pillows. You may also have to move residents around while their rooms are being cleaned and exterminated.