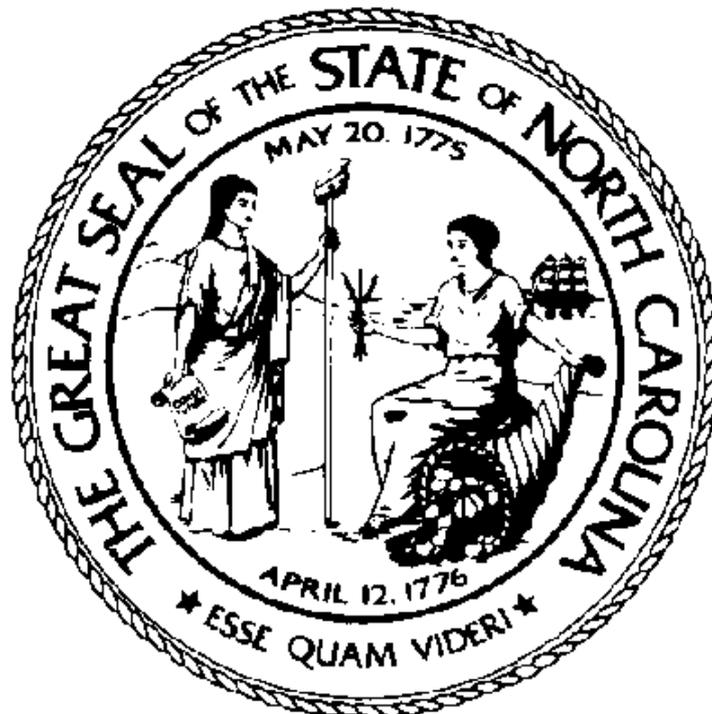


Basic Orientation Manual



NC Department of Health and Human Services
Division of Health Service Regulation
Adult Care Licensure Section

Basic Orientation Manual

Introduction

This Basic Orientation Training Manual contains all training material for the Adult Care Licensure Section (ACLS) Basic Orientation Training Workshop, including presentations, approved forms, and other training resources. Training participants are responsible for printing a copy of this manual to bring with them to the training workshop. Please bring your [licensure rule books](#) as well.

The ACLS offers Basic Orientation Training at least twice per year for new ACLS staff, County Department of Social Services (DSS) adult home specialists, and county DSS supervisors. The primary goal of Basic Orientation Training is to enhance the knowledge and skills of new staff in the inspection and monitoring of adult care homes. Topic areas include: survey/monitoring protocol; compliance tools; principals of documentation; medication management; food service; staff competency; health care; personal care; and licensed health professional support.

Pre/Post Requisites: Prior to attending Basic Orientation Training, staff should be familiar with their roles in surveying and monitoring adult care homes. Opportunities for state mandated pre-basic and post-basic orientation training are offered in the form of state survey activity. Please contact your [regional team survey supervisor](#) for scheduling information.

If you have any questions, please contact: DHSR.AdultCare.Training@dhhs.nc.gov.

Basic Orientation Manual

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Chapter 1

Monitoring and Inspection Protocol

Adult Care Home Monitoring and Inspection Protocol

Adult Care Licensure Section

Inspection and Monitoring Objectives

- ▶ Identify the Purpose
- ▶ Identify the Types
- ▶ Utilize General Protocols
- ▶ Utilize a 6-Step Process

Purpose

- ▶ Evaluate, determine, and promote rule compliance
- ▶ Protect the health, safety, and welfare of North Carolina adult care home residents

Monitoring Types

- Quarterly Monitoring
- Complaint Investigations
- Entity-Reported Death Investigations
- Follow-ups

General Protocols

- Interpersonal Skills and Attitude
- Planned Visits
- Resident Interactions
- Staff Interactions

Interpersonal Skills and Attitude

- Professional
- Respectful
- Friendly
- Open and Direct
- Objective and Helpful

Planned Visits

- Unannounced
- During established business hours
- Have a specific purpose and a detailed plan

Resident Interactions

Respect Rights and Confidentiality

- Knock before entering room
- Obtain consent to speak to or observe resident or belongings
- Request staff presence with physical interventions
- Ensure private discussions are not overheard

Staff Interactions

Respect Needs and Confidentiality

- Initiate contact and explain purpose of visit
- Be considerate of need to serve residents and facility
- Ensure private discussions are not overheard

Staff Interactions

Respect Needs and Confidentiality (cont.)

- Seek understanding
- Share, clarify, and validate findings
- Intervene only to prevent serious errors or provide technical assistance
- Acknowledge good work and problem-solving efforts

6-Step Monitoring Process

Step 1: Plan and Prepare

Monitoring Type:	Plan Based on:
Quarterly (routine)	Annual Survey Findings
Complaint Investigation	Potential Rule/Rights Non-Compliance
Follow-Up	Previous Rule/Rights Non-Compliance

Step 2: Conduct Entrance Conference

Meet with Administrator or Designee

- Explain purpose of visit (rule area)
- Review information/assistance required including staff involvement
- Provide notice of exit conference and time if known

Step 3: Collect and Evaluate Specific Data

- Conduct facility tour
- Select appropriate sample size
- Take the lead and stay focused
- Keep designated person informed
- Request information unable to find

Step 4: Pre-Exit Conference Planning

- Take notes on what to tell Administrator/Designee
- Start/Complete Reports:
 - ✓ Monitoring Report
 - ✓ Corrective Action Report?
 - ✓ Do you have a Violation?
 - ✓ Do you need a Plan of Protection?
 - ✓ Do you need to write a Penalty Proposal?

Step 5: Conduct Exit Conference

No Surprises...

- Present findings before leaving facility
- Explain/clarify positive and negative findings
- Show how findings are rule-based and supported by evidence
- Leave copy of Monitoring Report

Step 6: Complete Follow-Up

- Provide Monitoring Report
- Provide additional reports within required time frames
- Repeat steps for each follow-up visit

Division of Health Service Regulation Adult Care Licensure Section

2708 Mail Service Center
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Fax: (919) 733-9379



Questions may be sent to:
DHSR.AdultCare.Questions@lists.ncmail.net

Chapter 2

Principles of Documentation

PRINCIPLES OF REGULATORY DOCUMENTATION AND COMPLIANCE TOOLS

Adult Care Licensure Section
Division of Health Service Regulation

Objectives

- Understanding the importance of legal aspects of regulatory documentation
- Understanding the principles of documentation and how to use them to accurately to communicate findings

What is expected of us as regulators?

Integrity - Our reputations as professional investigators rest on our ability to be honest and “above board” in our conduct.

Mature Judgment - Because of our positions of public trust that we hold, our judgment must be guided by known facts and reasonable assumptions based on those facts.

Adopted from NCIT Basic Program

Principles of Documentation

The survey process determines the compliance or noncompliance of providers.

The documentation (SOD or CAR) records the compliance or noncompliance.

Statement of Deficiency or Corrective Action Report

The Importance of **Effective** Documentation

- Licensors and investigators cannot rely on memory.
- We must record in detail what is heard, seen or read during site visits and interviews.
- Is necessary to form the basis for record and decision-making.
- Becomes part of subsequent legal proceedings arising from contested decisions.
- Provides the facility with the information necessary to analyze and correct it's problems.

3 Sources of Evidence

- 1. Observation:** source, date, time, and location of observations
- 2. Interview:** date and time of interviews, titles of interviewed person or identifiers if not confidential
- 3. Record Review:** types and dates of all documents reviewed

Observations

- Information gathered based on input from the senses
- Must answer the who, what, where, when and how questions
- **Avoid** terms such as “throughout the monitoring visit” – be specific
- Goals of observation are to gather resident-specific information, observe the environment for features that impact residents’ quality of life, and to be alert to the way care is provided, and how staff and residents interact.

Interview

- Talking to individuals (residents, staff, family, visitors, physicians, etc.) to collect information regarding **rule compliance**.
- Information obtained can support a deficiency.
- To the extent possible, interview information is **verified** through **observation** and **record review**.
- If this is not possible, information can be verified through **multiple interview sources**.

Record Review

- Process of reviewing and analyzing administrative and **clinical** documents.
- To determine the needs of the resident and if the provider has addressed those needs.
- Identify the record that contained or failed to contain the documentation.
- If documentation is lacking, **ask** a staff member if further documentation is available.

Outcomes

- If at all possible, outcomes should be included in the findings.
- Include the **specific results** or **consequences** of the provider's deficient practice for individual cases.

"Principles of Documentation"

1. Use Plain Language
2. Components of a Citation
3. Onsite Correction
4. Interpretations
5. Adverse Actions

Principle #1 Use Plain Language

Exclude use of consultation, advice, comments or directions aimed at the provider.

Each **deficiency citation** relates to a **rule requirement** in 10A NCAC 13F/13G or General Statute.

Inclusion of extraneous information or consultative remarks may lead to confusion.

Writing Clearly

**Minimizes misunderstanding
and legal problems**

Write

- For the reader
- In a way that can be understood by all
- As you speak
- To inform----not to impress

Best Practice is to...

DO

- Keep sentences short.
- Avoid undefined abbreviations, initials, and jargon.
- Write in laymen's terms.
- Ensure the accuracy of quoted material.
- Put all relevant facts in **chronological order**.

DON'T

- Ramble on losing sight of the focus of the sentence.
- Res. With dx of HVA, CVA and HTN.
- Cardiac arrest vs heart attack.

Best Practice is to...

Use active voice:

The resident was approached by the personal care aide.

The personal care aide approached the resident.

Avoid unnecessary words:

The dining room was yellow in color.

The dining room was yellow.

Best Practice is to...

Avoid vague words or phrases:

The resident had a large ulcer on the ankle.

- ✓ The resident was observed to have an ulcer on the left inner ankle. The wound was open with yellow drainage and measured approximately one inch in diameter and ¼ inch deep.

Use descriptions:

There was mold on the wall.

- ✓ There are spots on the wall.

Best Practice is to...

Avoid words that imply:

The personal care aide was rude to the resident.

The personal care aide told the resident to "shut up."

Principles #2 Components of a Citation

Regulatory Reference

Statement of Deficient Practice

Relevant Findings

Concern vs Deficiency

Concern - scope and/or severity **not present**
Documented on a monitoring report

Deficiency - scope and/or severity **present**
*Documented on a corrective action report (CAR)
or statement of deficiency (SOD)*

What is a Deficiency?

A **failure to comply** with a licensure **rule**
and/or law 10A NCAC 13F/13G or residents'
rights as specified in G.S. 131D-21

Based on what you see, hear, and read.

*Information gathered is **evaluated for**
scope and severity.*

Scope and Severity

- Scope is the **number** of residents **potentially** or **actually affected**.
- Severity is the **effect** on resident outcomes.
- Expressed in numerical format.
- When the deficient practice does NOT apply to all residents, determine the **relevant universe**.

The "relevant universe" is **the total number**
of residents affected by the failed practice.

Documentation Tools

- **Monitoring Report**
- **Corrective Action Report (CAR)**
- **Statement of Deficiency (SOD)**
- **Plan of Protection**
- **Penalty Proposals**

Monitoring Report

WHAT

Form used to document routine or follow-up monitoring visit.

Should include:

- purpose of visit
- sample size
- monitoring activities
- follow-up to previous concerns
- provider comments & signature

WHEN

- Completed if problems noted do not have scope & severity for deficiency.
- Should be completed prior to exit or during exit conference.

Corrective Action Report Statement of Deficiency

WHAT

Form used to document substantial non-compliance.

A **written enforceable agreement** between the facility and the regulatory agency.

The official document on which deficiencies are recorded.

WHEN

Anytime there is rule-based or statutory-based non-compliance that rises to a **standard level deficiency or violation**.

The Regulatory Reference

Examine the language of the regulation
What does it say? What does it require?

**Determine the regulation the provider
may have violated.**

10A NCAC 13G. 0507 Training on CPR

Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management.

The Regulatory Reference is composed of...

- 10A NCAC 13F
- General Statute

An explicit statement that the requirement was **"NOT MET"** (Deficient Practice Statement)

Deficient Practice Statement

- Written specifically to allow the reader to understand the part of the requirement not met (summary of problem).
- **Source** from which evidence was obtained: **observation, record review and interview.**
- Identifies scope and severity.
- Includes what the provider did or did not do to cause the non-compliance.

Deficient Practice Statement

- Specific action(s), error(s), lack of action.
- Resultant outcome (when possible).
- Extent of deficient practice (**# of deficient cases relative to total in the sample**).
- Identifiers of individuals.
- *Based on record reviews and staff interviews, it was determined that 4 of 6 resident records did not have complete medication orders (#1, 2, 3 and 6).*

Deficient Practice Statement

Example

Based on observation, record review, and staff and resident interviews, the facility failed to ensure licensed health professional support reviews were done for 3 of 5 sampled residents (# 4,13, and 18). Sampled residents required reviews due to insulin administration, oxygen, and nebulizer treatments.

Findings... What to include?

- How*** - source of evidence.
- What*** - the facility did or failed to do.
- What*** - was the impact on the Resident?
- Who*** - were the staff or resident(s) involved?
- Where*** - it occurred.
- When*** - the problem occurred & how long it lasted.

Findings

Record review for Resident #3 revealed an FL-2 dated 01/28/08 with a diagnoses of diabetes and an order for a no concentrated sweets diet. During observation of the 04/01/08 lunch meal at 12:15 PM, Resident #3 was observed to receive a frosted cake square and iced tea.

Interview with the dietary staff at 1:00 PM on 04/02/08 verified that the cake and iced tea contained sugar. The cook stated that he thought "all the residents were on regular diets and that's how I cook".

Identifiers

- Use resident roster to assign identifier numbers.
- When referencing **confidential interview, do not use a date or time** of interview.
- If an interviewee does not wish the provider to know the source of information **DO NOT USE** an identifier, date or time.

Confidential Interviews

"During a confidential interview with....."

- Assure interviewee their name will not be disclosed to the facility.
- Explain to interviewee that all information obtained during the course of an investigation or survey **could potentially be subpoenaed**.

Examples of Identifiers

- For 2 of 5 residents sampled (#3 and 4).
- For 5 of 5 Personal Care Aides (C,D,E,F and G).
- During dining room observations on Jan 21, 2008 at 12:30 p.m., 2 non-sampled **random** residents were observed asking for second helpings and being told “no” by facility kitchen staff. In addition, a confidential interview revealed “there is never enough food here.”

Organize Your Findings

- Findings are facts that allow the provider to compare what it did or failed to do with what is required.
- Findings should be organized in a chronological and logical order, not necessarily the order in which you found them.
- **Findings** with the most **compelling scope and severity should be first**.
- When including a series of facts and events, begin with relevant background facts.

Principle # 3 Onsite Correction

What if the provider corrects the deficiency during a survey?

- The deficiency is **still documented**.
- Correction of the finding reported does not eliminate the presence of the problem.
- Fixing the problem for the identified resident does not necessarily mean the underlying cause of the problem of system failure has been identified and corrected for all residents.

Principle #4 Interpretations

- The deficiency demonstrated **how the provider failed to comply with rule requirements, NOT** interpretations.
- Interpretations are designed to assist both DSS/DHSR and providers in understanding the requirements.
- Interpretive guidelines **DO NOT** replace or supersede regulatory requirements.

Principle #5 Adverse Actions

The findings explain **how** the scope and/or severity of the deficient practice **justifies** a Type A1, A2 or Type B violation (impact to resident).

Type A1 Violation

- Results in death, serious physical harm, abuse, neglect or exploitation.
- Requires a written plan of protection regarding how the facility will immediately abate the violation in order to protect residents from further risk or additional harm.

Type A2 Violation

- Results in **substantial risk** that death or serious physical harm, abuse, neglect or exploitation will occur.
- Requires a written plan of protection regarding how the facility will immediately abate the violation in order to protect residents from further risk or additional harm.

Defining Abuse, Neglect, and Exploitation

§ 131D-2.1. Definitions.

- (1) Abuse. – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.
- (8) Exploitation. – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.
- (11) Neglect. – The failure to provide the services necessary to maintain a resident's physical or mental health.

Type A2 Violations & Penalties

Department may or may not assess a penalty taking into consideration the following:

- Preventative Measures
- Compliance History
- Response to Previous Violations

Type B Violation

- **Detrimental to health, safety or welfare of any resident.**
- **Does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.**
- **Requires a written plan of protection regarding how the facility will immediately abate the violation in order to protect residents from further risk or additional harm.**

Unabated Type B Penalty Proposal

- **If the violation is not corrected by the date specified, the Type B violation will then be forwarded to DHSR as a penalty proposal.**
- **The proposal is based on the failure to correct by the time frame specified and the findings from the follow-up visit.**

Conclusions

Correct documentation is the key to success of the survey/monitoring and licensure process

- **It is the knowledge of the regulations and how to apply them in a consistent manner that produces a clear description of the problem.**
- **When the provider resolves these cited problems, quality of care and quality of life can be a reality in the adult care home.**

Principles of Documentation Exercises

ACLS BASIC ORIENTATION TRAINING

Is This a Deficiency?

During a routine visit to a Family Care Home you determine that 3 of 5 residents did not receive their therapeutic diets as ordered.

YES

NO

Is This a Deficiency?

During a routine monitoring of a 40 bed Adult Care Home it is determined that the residents' weights are not being documented monthly.

YES

NO

Is This a Deficiency?

During a routine monitoring of a 12 bed Adult Care Home it is determined that a resident is transported to dialysis by his mother rather than the facility.

YES

NO

Record Review

Revealed an order dated 01/21/15 for Lasix daily.

Is this a complete order?

Regulatory Reference

- Part of the rule that was NOT met: Medication Orders **10A NCAC 13F/G .1002 (a)(2)** physician contact for clarification if orders not clear or complete.
- **(c)(2)** The medication orders shall be complete and include the strength of the medication.
- Cite the rule that most clearly and specifically addresses the identified problem.

Summary Statement

- Summary of problem
- Source from which evidence obtained (observation, record review, interview)
- Identifies scope and severity
- Based on record reviews and interview with the Medication Aide, it was determined that 4 of 6 resident records did not have complete medication orders (#1, 2, 3 and 6).



Writing a Summary Statement

- During a probe visit of Nutrition and Food Service to a Family Care Home you determine that 3 of 5 residents did not receive their NCS diet as ordered.
- What information would you include in your summary statement?



Summary Statement

- Based on record review, interview with the cook, and observation of the lunch meal, 3 of 5 residents did not receive their therapeutic diets as ordered by their physician(#2, 3 and 4).



Summary Statement

Based on record review, interview with the cook, and observation of the lunch meal,

3 of 5 residents did not receive their therapeutic diets as ordered by their physician(#2, 3 and 4).



AHS Facility Report

Purpose of Visit:		
<input type="checkbox"/> Monitoring <input type="checkbox"/> Complaint Investigation <input type="checkbox"/> Complaint Investigation Summary <i>(see Attachment B)</i>		
<input type="checkbox"/> Deliver CAR <input type="checkbox"/> Follow Up to CAR issued on: _____ <input type="checkbox"/> Technical Assistance		
<input type="checkbox"/> Deliver Correspondence <input type="checkbox"/> Death Investigation <input type="checkbox"/> Other: _____		
Date Onsite: _____ Time: _____ Previous Onsite Date: _____		
County:	Facility:	License #:
Address:		
Administrator/Designee:		
Section A:	Current Census:	Sample Size: _____ <input type="checkbox"/> Unannounced Visit
Section B:	<i>Complete this section during onsite visit</i>	
Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews	
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued	
	<input type="checkbox"/> Plan _____	
Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews	
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued	
	<input type="checkbox"/> Plan _____	
Rule Number:	<input type="checkbox"/> Observations <input type="checkbox"/> Interviews <input type="checkbox"/> Record Reviews	
Description:	<input type="checkbox"/> No Deficiency <input type="checkbox"/> Deficiency <input type="checkbox"/> CAR to be Issued	
	<input type="checkbox"/> Plan _____	
Section C:	<i>Brief Description of Visit/Discussion With Staff in Charge</i>	
Section D:	<i>Signatures</i>	
Administrator/Designee:	Date:	
Adult Home Specialist:	Date:	

County:		Facility:		License #:	
Address:					
Administrator/Designee:					
Section A:		<i>Complete this section upon initiating and when completing a Complaint Investigation</i>			
Date(s) onsite: _____					
Date Received: _____		Date Initiated: _____		Date Completed: _____	
Complaint #: _____		Rule(s)/Description: _____			
Section B:		<i>Upon Completion of a Complaint Investigation</i>			
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Rule Number:		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description:		<input type="checkbox"/> Unsubstantiated	<input type="checkbox"/> Substantiated	<input type="checkbox"/> CAR to be Issued	
Section C:		<i>Complete this section when any Report of Abuse, Neglect or Exploitation of a Resident(s) has been made</i>			
Rule Number: 10A NCAC 13F .1205/G.1206		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Investigation and Reporting Health Care Personnel		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Section D:		<i>Complete with initial monitoring of facility, when new hire(s), and as appropriate</i>			
Rule Number: 13F .0407 (a)(5)/G.0406(a)(5)		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Facility compliance with Health Care Personnel Registry for negative findings (G.S. 131E-256)		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Rule Number: 13F.0407 (a)(7)/G.0406(a)(7)		<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews		
Description: Facility compliance with criminal history background checks (G.S. 114-19.3)		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Rule Number(s):		<input type="checkbox"/> Observations	<input type="checkbox"/> Interviews	<input type="checkbox"/> Record Reviews	
Description: Rules in Sections .0400 Staff Qualifications & Section .0500 Staff Orientation, Training, and Competency		<input type="checkbox"/> No Deficiency	<input type="checkbox"/> Deficiency	<input type="checkbox"/> CAR to be Issued	
Adult Home Specialist:					Date:

COMPLAINT INVESTIGATION SUMMARY

Facility Name:

Facility Address

License Number:

County:

Date of Visit(s):

I. Complaint Intake Number:

II. Participants:

III. Allegations:

IV. Method of Investigation: An unannounced visit was made to the facility on _____ at _____. The investigation included a tour of the facility, direct observations, interviews with staff and residents, and a review of resident records.

V. Findings (Allegation Substantiated or Unsubstantiated):

VI. Action Plan:

AHS Signature

Date

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: _____

Address: _____

II. Date(s) of Visit(s): _____

County: _____

License Number: _____

Purpose of Visit(s): _____

Exit/Report Date: _____

Instructions to the Provider (please read carefully):

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to \$400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the violation(s). Please submit any additional information within **5 days** to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to \$1000.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified <i>For each citation/violation cited, document the following four components:</i>	III (b). Facility plans to correct/prevent: <i>(Each Corrective Action should be cross-referenced to the appropriate citation/violation)</i>	III (c). Date plan to be completed
<ul style="list-style-type: none"> Rule/Statute violated (rule/statute number cited) Rule/Statutory Reference (text of the rule/statute cited) Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation) Findings of non-compliance 	<input type="checkbox"/> POC Accepted <div style="text-align: right; margin-top: 20px;"><i>DSS Initials</i></div>	
Rule/Statute Number:	<input type="checkbox"/> POC Accepted <i>DSS Initials</i>	
Rule/Statutory Reference:		
Level of Non-Compliance:		
Findings:		

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	Date:
	Signature:	
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	Date:
	Signature:	

VII. Agency's Review of Facility's Plan of Correction (POC)		
<input type="checkbox"/> POC Not Accepted	By:	Date:
Comments:		
<input type="checkbox"/> POC Accepted	By:	Date:
Comments:		

**NC Division of Health Service Regulation ---Adult Care Licensure Section
Plan of Protection**

To be completed by DHSR/DSS Staff

Facility Name: _____ License #: _____

Rule Violation Cited: _____

(Complete separate form for each Rule Violation)

PLAN OF PROTECTION

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Describe your plans to ensure residents are protected from further risk or additional harm?

Regarding A1 or A2 Violations - if you believe this to be a Past Corrected Violation, please answer the questions below.

Describe the preventative measures in place prior to the violation.

Describe how and when the violation was corrected.

Describe the corrective measures the facility implemented to achieve and maintain compliance.

Describe the facility's system to ensure compliance is maintained and how the system will continue to be implemented.

For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:

Please provide a date by which the facility will be in compliance with the rule area cited (*required*). Date: _____

Facility staff completing this form:

Name/Title
DHSR/AC 4659 NCDHHS (2011/08)

Date

DHSR/DSS staff
Keep copy for facility file

Date

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

FACILITY INFORMATION

Facility Name: _____
 Site Address: _____

 County: _____ License #: _____ FID #: _____ Facility Type: HA FCH
 Licensed Bed Capacity: _____ Census (at time of violation): _____
 Administrator: _____ Email Address: _____

LICENSEE INFORMATION

Licensee: _____ Email Address: _____
 Name of Officer: _____
 Correspondence Mailing Address: _____

PENALTY INFORMATION

Proposal Submitted by: DSS DHSR
 VIOLATION: Type A1 Type A2
 Rule: _____
 Regulatory Area: _____ Correction Date: _____
 Rule: _____
 Regulatory Area: _____ Correction Date: _____
 Statute(s): _____
 Statutory Area: _____ Correction Date: _____
 Description of Events: CAR Attached SOD Attached Supporting documents attached Exit Date: _____

SEVERITY *Select only one*

Outcome to Affected Resident(s)	
<input type="checkbox"/>	Substantial risk that serious harm, abuse, neglect, or exploitation will occur
<input type="checkbox"/>	Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur
<input type="checkbox"/>	Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur
<input type="checkbox"/>	Resident died
<input type="checkbox"/>	Resident died & there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation
<input type="checkbox"/>	Resident died, there is substantial risk further resident death

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

COMPLIANCE STATUS

G.S. 131E-256 (d2) (HCPR Verification)	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G.S. 131E-256 (g) (HCPR Investigation of Allegations)	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA
G.S. 131D-40 Criminal Record Check	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G.S. 131D-34.1 (a) Death Report to DHHS within 3 days of death of any resident resulting from violence, accident, suicide, or homicide	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA
G.S. 131D-34.1 (a) Death Report to DHHS immediately when physical restraint or physical hold was used within seven days of resident death	Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA

FACILITY'S EFFORT TO CORRECT *Select only one*

<input type="checkbox"/>	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action will not result in correcting the violation(s).
<input type="checkbox"/>	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action did not result in correcting the violation(s) and/or furthered noncompliance and serious outcomes occurred.
<input type="checkbox"/>	Prior to the initiation of the survey, the facility had identified the specific violations but had not responded with corrective actions.
<input type="checkbox"/>	The facility was unaware or denies the existence of a violation(s). The survey team identified the violation(s).

COMPLIANCE HISTORY FOR THE PAST 36 MONTHS

Date	<i>Rule Number Violation</i>	<i>Brief Rule Area Description</i>	<i>Select Appropriate Violation(s)</i>			
	Rule	Rule Area	Type B	Unabated B	Type A	Unabated A

NUMBER OF RESIDENTS PUT AT RISK *Select Only One*

One More than one All

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Type A1 and Type A2 Violations**

INTERVENTION TIMELINE

Date(s) of Survey/Investigation	
Specified Time for Correction	
Dates(s) Follow-up/Revisit for Violation(s)	
Date Licensee Received Violation & Written Intent of Penalty Proposal	
Date Facility Received Violation & Written Intent of Penalty Proposal	
Date of Receipt of Additional Information	
Date of Penalty Proposal to Licensee	
Date of Penalty Conference/Additional Information Submitted	
Date Violation Abated	
Date Proposal Submitted to DHSR	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Affected Resident(s) FL-2s				
Specific Information Supporting Violations				
Other Documentation				

Completed by: _____
DHSR/DSS Staff Signature
Date

Submitted by: _____
DHSR/DSS Staff Signature
Date

Recommended Penalty Amount \$ _____

Branch Manager Signature
Date

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION - Unabated Violation**

FACILITY INFORMATION

Facility Name: _____

Site Address: _____

County: _____ License#: _____ FID#: _____ Facility Type: HA FCH

Licensed Bed Capacity: _____ Census (at time of violation): _____

Administrator: _____ Email Address: _____

LICENSEE INFORMATION

Licensee: _____ Email Address: _____

Name of Officer: _____

Corresponding Mailing Address: _____

PENALTY INFORMATION

Proposal Submitted by: DSS DHSR

VIOLATION: Unabated A1 Unabated A2 Unabated B

Rule: _____

Regulatory Area: _____ Correction Date: _____

Rule: _____

Regulatory Area: _____ Correction Date: _____

Statute(s): _____

Statutory Area: _____ Correction Date: _____

Description of Events: CAR Attached SOD Attached Supporting documents attached Exit Date: _____

Date Violation was Corrected: _____

Number of days Violation continued beyond date specified for correction: _____

**ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Unabated Violation**

INTERVENTION TIMELINE

Date(s) of Survey/Investigation	
Date(s) of Original Citation	
Specified Time for Correction	
Dates(s) Follow-up/Revisit for Violation(s)	
Date Licensee Received Violation & Written Intent of Penalty Proposal	
Date Facility Received Violation & Written Intent of Penalty Proposal	
Date of Receipt of Additional Information	
Date of Penalty Proposal to Licensee	
Date Violation Abated	
Date Proposal Submitted to DHSR	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Affected Resident(s) FL-2s				
Specific Information Supporting Violations				
Other Documentation				

Completed by: _____
DHSR/DSS Staff Signature
Date

Submitted by: _____
DHSR/DSS Staff Signature
Date

Recommended Penalty Amount \$ _____

Branch Manager Signature
Date



North Carolina Department of Health & Human Services
 Division of Health Service Regulation
 Adult Care Licensure Section

CONTACT INFORMATION

Affected Resident Name:	CAR/SOD Resident Identifier Number:
Address:	
Date of Birth:	
Facility Name:	
Resident has a Legal Representative?	
<input type="checkbox"/> No <input type="checkbox"/> Yes (check one and complete next section): <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Legal guardian	

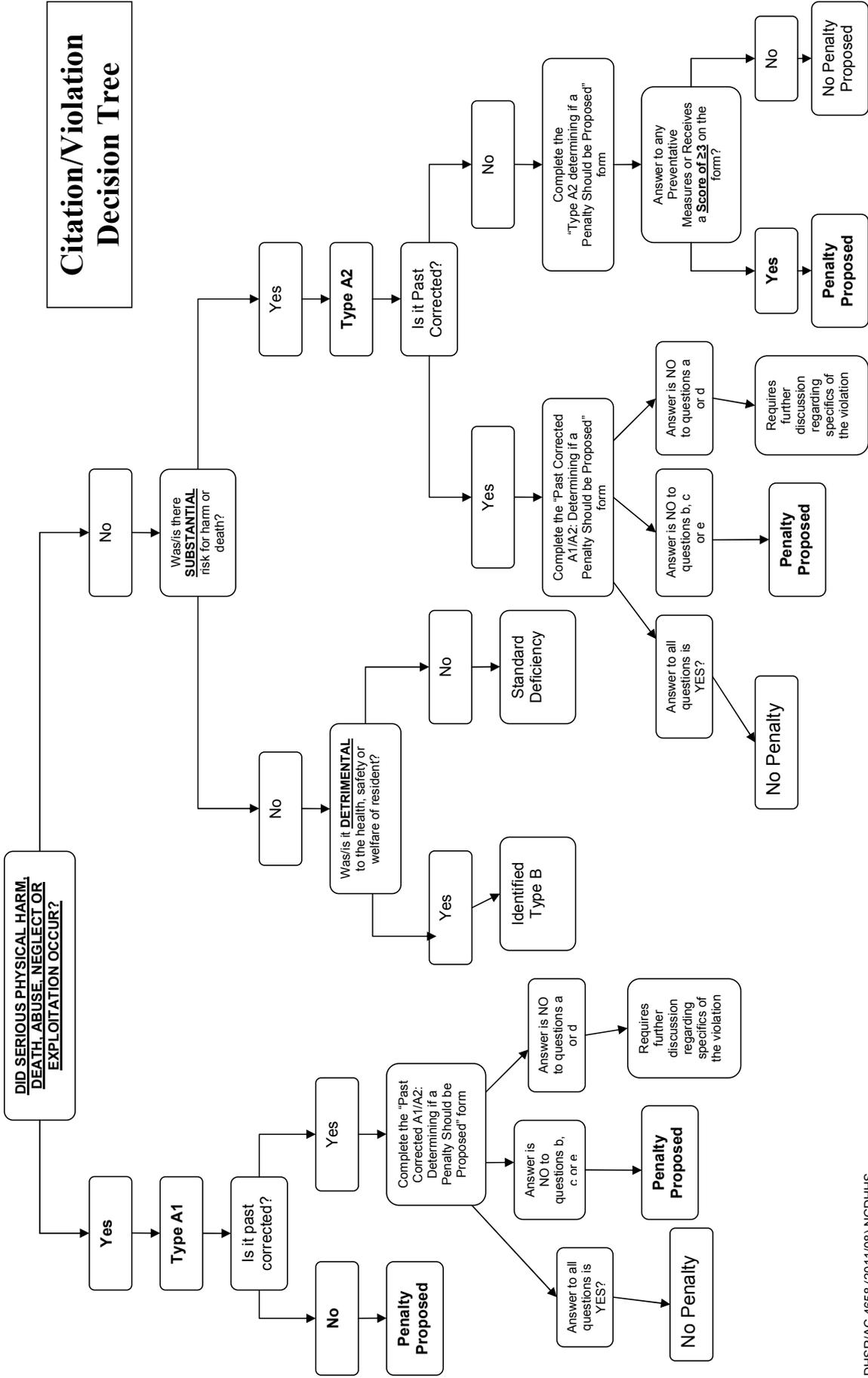
POWER OF ATTORNEY OR LEGAL GUARDIAN CONTACT INFORMATION

Name:		
Street Address:		
City:	State:	Zip:
Phone #:		

Information is to be disclosed as required by NC GS 131D-34 for **Type A1 and Type A2 Violations and Unabated Type A1, Type A2 and Type B Violations**. The requirements include direct notification of the scheduled penalty review committee (PRC) meeting to **affected residents** and their **powers of attorney or guardians** regarding the penalties to be considered by the PRC.

Date: _____ Surveyor Signature: _____





ADULT CARE LICENSURE RESIDENT RECORD REVIEW

Surveyor's Initials: _____

Resident: _____ **Date:** _____ **Facility:** _____

Diagnoses: _____

Date of Birth: _____

Date of Adm: _____

Check appropriate: <input type="checkbox"/> POA <input type="checkbox"/> Guardian <input type="checkbox"/> Resp. Person	Name: _____ Address: _____
--	-------------------------------

FL-2 Date:		TB Testing		Diet Order		Health Care	
ambulation: <input type="checkbox"/> non-amb <input type="checkbox"/> semi-amb <input type="checkbox"/> ambulatory	assistive device: <input type="checkbox"/> none <input type="checkbox"/> cane <input type="checkbox"/> walker <input type="checkbox"/> w/c <input type="checkbox"/> other: _____	bladder: <input type="checkbox"/> continent <input type="checkbox"/> incontinent <input type="checkbox"/> int catheter <input type="checkbox"/> ext catheter	2-Step / Chest X-Ray _____ STEP 1 given: _____ read as: _____ on: _____	Date: _____ Diet Order _____ supplements: <input type="checkbox"/> Y <input type="checkbox"/> N thickener: <input type="checkbox"/> Y <input type="checkbox"/> N	Date: _____ Orders / TX: <input type="checkbox"/> BS: <input type="checkbox"/> BIP: <input type="checkbox"/> HR: <input type="checkbox"/> WT: <input type="checkbox"/> O ₂ : <input type="checkbox"/> TED: <input type="checkbox"/> ROM: <input type="checkbox"/> DSG:	Referral / FU: <input type="checkbox"/> PT/OT/SLP: <input type="checkbox"/> HH: <input type="checkbox"/> POD: <input type="checkbox"/> MD: <input type="checkbox"/> LAB:	

Medication Review		LHPS Review		Weight Management		Assessment & Care Plan		Mental Health	
Quarterly: <input type="checkbox"/> Y <input type="checkbox"/> N Complete: <input type="checkbox"/> Y <input type="checkbox"/> N	Quarterly: <input type="checkbox"/> Y <input type="checkbox"/> N Complete: <input type="checkbox"/> Y <input type="checkbox"/> N	Date of Review: _____ recommendations: <input type="checkbox"/> none <input type="checkbox"/> yes: _____ follow-up: <input type="checkbox"/> none <input type="checkbox"/> yes: _____	Quarterly: <input type="checkbox"/> Y <input type="checkbox"/> N Complete: <input type="checkbox"/> Y <input type="checkbox"/> N Date Task Ordered: _____ Tasks: _____ Phys. Assess. _____ Date of Review: _____ recommendations: <input type="checkbox"/> none <input type="checkbox"/> yes: _____ follow-up: _____	Date: _____ Significant Δ: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> reassessment: <input type="checkbox"/> MD notified: <input type="checkbox"/> order: <input type="checkbox"/> wt. policy: weights: _____	Assessment Date: _____ <input type="checkbox"/> MD signed annual <input type="checkbox"/> significant Δ <input type="checkbox"/> 72-hour: (Res. Reg) _____	CP Date: _____ ADLs eating _____ toileting _____ ambulation _____ bathing _____ dressing _____ grooming _____ transfer _____	seen by MH _____ behaviors documented _____ facility addressed: _____	Restraints <input type="checkbox"/> Order: _____ <input type="checkbox"/> Assessment: _____ <input type="checkbox"/> Consent: _____	

TYPE A2 - Determining if a Penalty Should be Proposed

Facility Name: _____ **License #:** _____

Date of Violation: _____ **Rule Area:** _____

PREVENTATIVE MEASURES

Did the facility have policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had staff been trained in the policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had staff implemented the policies/procedures specific to the violation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(If "No" is checked for any question above, a Penalty Proposal is to be completed)

COMPLIANCE HISTORY

Were there any previous violations in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number/brief description)</i>	Date	Type	Points		
			Subtotal =		

Were there standard deficiencies in the same rule area as the current violation in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number)</i>	Date	Points			
		Subtotal =			

RESPONSE TO PREVIOUS VIOLATIONS BY THE FACILITY

Were there any unabated Type A or B Violations in the past 36 months?				<input type="checkbox"/> Yes <i>(list below)</i>	<input type="checkbox"/> No
<i>Rule Area (number)</i>	Date	Type	Points		
			Subtotal =		

Criteria to propose a penalty: 3 points or greater	Total Points =	
--	-----------------------	--

Points Assessed Per Citation/Violation

Standard Deficiency	Type B Violation	Unabated Type B Violation	Type A Violation	Unabated Type A Violation
.25	0.5	1	2	3

Completed by: _____

Date: _____

PLAN OF CORRECTION

Basic Training

- The Facility's plan of correction should identify how the deficiency/violation has/will be corrected and how compliance will be maintained.
 1. Must address the rule(s) cited
 2. State the action already taken or action which will be taken to ensure correction and maintain compliance.
 3. Address methods that will be used to monitor and evaluate the corrective action (who, what, when)
 4. Give a date for facility to be in compliance if a violation cited, facility will give a date of compliance for deficiencies cited.

- The plan of correction should:
 1. Be legible
 2. Avoid vague words or terms
 3. Avoid excuses
 4. Correction plans and end results should be measurable
 5. Address the overall problem or rule violation(s) and not just the specific examples on the Corrective Action Report(CAR)/Statement of Deficiencies(SOD)
 6. Include the action already taken and/or action which will be taken to ensure correction and maintain compliance, i.e., monitoring, in services, staff validations etc.
 7. Include who (title of person) i.e., Administrator, SIC, Director of Resident Services, will be responsible for monitoring, what will be monitored, and how often the area will be monitored.
 8. Include any resources to be utilized, i.e., nurse, pharmacist, dietitian, ombudsman, etc.
 9. Have a realistic time frame for correction
 10. Alternative plans and possible sources of delay, if applicable, should be discussed with the facility upon reviewing the facility's' plan of correction.
 11. Failure to receive a POC or an acceptable POC does not delay your follow up to the facility.

Chapter 3

Medication Monitoring

MEDICATION MONITORING IN ADULT CARE HOMES

Presented by
NC Division of Health Service Regulation
Adult Care Licensure Section



Drug Management

Objectives:

- Access and utilize the medication administration and pharmaceutical care regulations for Adult Care Homes
- Monitor and encourage medication administration rule compliance in Adult Care Homes using a systematic approach

Preparation

Materials needed:

- Licensure Rules and General Statutes
- Monitoring Report
- Corrective Action Report
- Medication Aide Qualifications Worksheet
- Medication Monitoring Work Sheet
- Resources

Resources

- **ACLS Consultants:** Nurse, Pharmacist, Social Worker, or Dietician
- **Drug Reference Manuals:** PDR, Drug Information Handbook, Complete Guide to Prescription and Non-Prescription Drugs, The Pill Book, etc.



Monitoring Medication Administration

- 10A NCAC 13F / 13G .0403
- 10A NCAC 13F / 13G .0503
- 10A NCAC 13F / 13G .0505
- 10A NCAC 13F / 13G .1000
- 10A NCAC 13F / 13G .1211
- G.S. 131D-4.5B and 4.5C

Medication Aides and Supervisors

Who must meet these qualifications?

- Staff who administer medications, including staff who only prepare the medications
- Staff who directly supervise the administration of medications
- Exemption: Persons authorized by state occupational licensure laws to administer medications (e.g., registered nurses)

Medication Administration
10/15-Hour Training Course for
Adult Care Homes

Instructor Manual



 
North Carolina Department of Health and Human Services
Division of Health Service Regulation
Center for Aide Regulation and Education
Adult Care Licensure Section

G.S. 131D-4.5B

Who does it apply to?

- All licensed adult care homes under 131D
- New staff hired on or after 10/01/2013 to perform medication duties (unless staff can verify prior employment per 131D-4.5b and passed written medication exam)
- Any current staff with new responsibilities of medication duties on or after 10/01/2013

What changed on October 1, 2013?

Prior to 10/01/2013:

- Competency validation by a RN or RPh prior to administration of medications (non-transferable)
- Pass written State medication exam for unlicensed staff in adult care homes within 90 days of competency validation

Effective 10/01/2013:

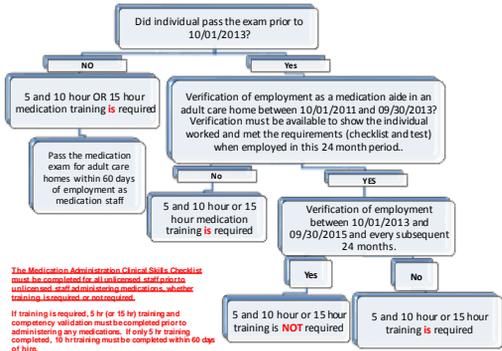
- Verification of employment as a medication aide in an adult care home within past 24 months; competency validation prior to administration of medications, and passed State written exam prior to 10/01/2013 **OR**

- 5-hour training developed by DHHS
- Competency validation by a RN or RPh

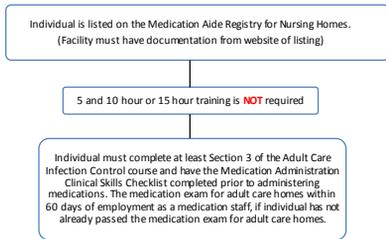
Within 60 days of hire:

- 10-hour training developed by DHHS
- Pass written State medication exam for unlicensed staff in a dult care homes

Guide to Determine if Medication Training is Required



Guide to Determine Training Requirements for Staff listed on the Medication Aide Registry for Nursing Homes



Competency Evaluation

<p>Clinical Skills Validation:</p> <ul style="list-style-type: none"> Completed prior to staff being assigned to administer medications Medication Administration Skills Validation Form Non-transferable between licensed facilities 	<p>Written Exam:</p> <ul style="list-style-type: none"> Administered by DHHS Completed within 60 days of hire as medication staff Passing score of at least 90% Transferable
---	---

Medication Administration Clinical Skills Checklist



- Validation by RN or RPh
- Only form used for competency validation
- Certain tasks may only be validated by RN
- Complete checklist for all tasks employee will be responsible for performing
- Required for all new staff regardless of whether or not staff was required to complete training
- Maintain in the facility for review

Revalidation of Medication Staff

- No revalidation required of employees:
 - Who remain employed by new ownership
 - Are rehired by facility
- Facility is responsible for assuring that staff is competent to administer medications and oriented to facility's policies and procedures

Medication Testing Questions and Materials

- Center for Aide Regulation and Education (CARE) Medication Testing Unit: 919-855-3793
- DHSR Website:
<http://www.ncdhhs.gov/dhsr/acls/index.html>
- Medication Testing Website:
<https://mats.dhhs.state.nc.us:8598/default2.aspx>

**Infection Control
for Adult Care Homes
Instructor's Manual**



North Carolina Department of Health and Human Services
Division of Health Service Regulation • Division of Public Health
Center for Aids Regulation and Education
Adult Care Licensure Section

EXERCISE



Data Collection

- Documentation / Resident Records
- Observations of Staff and Residents
- Interviews with Staff and Residents

Resident Record Review

- Sample size based on survey protocol
- Target new admissions, re-admissions, residents receiving insulin, Coumadin or multiple changes in medication orders
- Medication Monitoring Form: Begin with FL-2 form or discharge summary and follow subsequently dated medication orders

Observation and Interview of Residents

- Sometimes necessary to confirm how / if medication was / is given
- Helpful in determining staff procedures within the facility
- Use open-ended questions during interviews

Observation and Interview of Staff

- Indirectly observe staff during medication passes
- Ask staff to tell you about facility procedures
- Determine if staff is following proper procedures for:
 - ✓ Pre-pouring and infection control
 - ✓ Reordering of medications
 - ✓ Medication administration techniques
 - ✓ Administering within 1 hour grace period
 - ✓ Documentation on the MAR

Policies and Procedures

- Individualized procedures in the facility
 - Who is responsible for doing what?
 - How is it done?
 - When is it done?
 - Where is it done?
- If there are inconsistencies among staff, refer to policy and procedure manual (e.g., MAR documentation, reordering of meds, etc.)

Medication Orders

- FL-2 or Discharge Summary
- Report of Health Services Form
- Telephone Order Slips
- Prescriptions
- Physician's Order Sheet
- Other: Lab Reports, DRR

Medication Orders



To be complete:

- Medication name and strength
- Dosage of medication to be administered
- Route of administration
- Specific directions for use including frequency
- If ordered PRN, an indication for use
- If an order is incomplete, staff should clarify the order with doctor and document the clarification

Medication Administration Record (MAR)



Current and Accurate:

- Resident's name
- Each medication dose administered
- Name, strength, and dosage administered
- Instructions for administering
- Date and time medication is administered
- Reason for omissions
- Reason and resulting effect of PRN medications
- Name / initials and equivalent signature

Monitoring MARs



- Are there omissions or blanks?
- Is the reason / effect documented for administration of PRN's?
- Is the medication scheduled for administration at appropriate times?
- Is staff documenting immediately after administration to each resident prior to administering medications to the next resident?

Drug Storage

- Drugs should be stored in a clean, orderly, well-lit, and well-ventilated area
- External / internal drugs stored separately
- Refrigerated agents: 36 - 46°F
- Expired / discontinued drugs
- Security



Labeling

- Prescription medications
- Non-prescription medications (OTCs)
- Direction changes
- Samples
- Leave of absence

Prescription Label Requirements

- Resident's name
- Dispense date
- Prescriber's name
- Name / strength of medication
- Instructions for administration
- Generic equivalency statement
- Expiration date
- Name of dispensing pharmacist and pharmacy

Controlled Substances

- Accountability / retrievable record
 - Receipt
 - Administration
 - Disposition
- Storage
- Disposition / destruction
- Is the MAR documentation sufficient as a controlled substance record, too?

Medication Errors

- Error = an act or belief that unintentionally deviates from what is correct, right or true
- Medication error occurs when a medication is not administered as prescribed
- ALL errors, including documentation errors, should be entered on appropriate form
- Omissions and unavailability of medications are errors!

Pharmaceutical Care and Services

- **Components of medication review:**
 - On-site
 - At least quarterly
- **Responsibilities of Licensed Health Professional and follow-up by facility:**
 - Summary report
 - Maintain on file in facility (not necessarily in resident's record)
- Adult Care Homes (7+) vs. Family Care Homes (<7)

Evaluating Scope and Severity

- Pre-exit
- Scope of the deficiency
 - How many residents were affected?
- Severity of the deficiency
 - How serious was it?
- Monitoring report, corrective action, or penalty?



EXERCISES



**Instructions for Completing the
Medication Administration Clinical Skills Checklist**
Developed by the Division of Health Service Regulation, Adult Care Licensure Section
2708 Mail Center, Raleigh, NC 27699-2708 (919) 855-3793

TO ALL INSTRUCTORS:

Unlicensed staff who administer medications and supervisors of staff responsible for administering medications in adult care homes must have a registered pharmacist or registered nurse validate the staff's competency for tasks or skills that will be performed in the facility prior to the unlicensed staff administering medications. Competency validation for **all** unlicensed staff must be completed using this checklist, prior to staff administering medications. Staff is required to also have documentation of successfully completing the required medication aide training for adult care homes or verification of employment **and** pass a written competency test approved by the Department of Health and Human Services within 60 days of hire date as a medication aide in accordance with NCGS 131D-4.5B. The Medication Administration Clinical Skills Checklist is a standardized checklist and the **only one to be used for validating staff**. Refer to regulations 10A NCAC 13F/13G .0503 and NCGS 131D-4.5B.

The guidelines and attachments are provided to assist with training and validation, as well as, provide the minimum standards for staff administering medications in adult care homes. Tasks listed in the left column of the guidelines match the tasks on Medication Administration Clinical Skills Checklist and the right column of the guidelines provides information for training and validation. It will be the instructor's responsibility to determine that the employee has demonstrated competency in performing the tasks or skills by using the guidelines and checklist.

The instructor needs to be knowledgeable of the regulations and interpretations of regulations related to medication administration for adult care homes. As indicated on the checklist, the instructor is to review the guidelines and checklist prior to the observation of the tasks or skills.

Directions for completing checklist

1. The name of the employee and adult care home are to be written on each page of the checklist. The checklist is not transferable.
2. All documentation on the checklist is to be in ink. Items that have an (*) by the tasks or skills must be checked off only by a registered nurse.
3. When the employee has demonstrated competency for a task or skill, the instructor is to complete the "Satisfactory Completion Date" block and the "Inst. Initials/Signature" block to the right next to the completion block. The "Needs More Training" and "Inst. Initials/Signature" is to be completed if the employee needs further training in an area or needs to be observed again.
4. **Sections 1 through 14** - Must be completed for each unlicensed staff person, unless otherwise indicated on the checklist or guidelines. **** Section 13 K through P – tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504, .0505 and .0903 and the instructions on the Guidelines for Completing the Medication Administration Clinical Skills Checklist.**
5. **Section 1**- Competency may be determined by asking the employees questions or by a written test.
6. **Sections 2 through 13** - The employee is to be observed actually performing the task or skill or at least be able to verbalize and demonstrate competency to perform the task or skill. Further instructions are provided in the guidelines for the tasks or skills in Section 13.
7. The employee and instructor are to sign and date the checklist after the completion of tasks.
8. If competency validation for additional tasks on the Medication Administration Clinical Skills Checklist is needed after the employee and instructor have signed the checklist, then the additional tasks/skills may be checked off, initialed and dated by the instructor on the original checklist and signed and dated by the instructor and employee again in the "Comment" section or a new checklist may be used and attached to the original checklist.
9. The "Comment" section may be used to document any additional information, including signatures.
10. The checklist must be maintained on file in the facility.

**If you have any questions about completing the checklist or comments, please call the
Adult Care Licensure Section at the above phone number.**

Medication Administration Clinical Skills Checklist

The unlicensed staff must (without prompting or error) demonstrate the following skills or tasks in accordance with the guidelines on the attachments with 100% accuracy to a registered nurse or pharmacist. Competency validation by the registered nurse or pharmacist is to be in accordance with their occupational licensing laws. Items that are (*) must be checked off **only** by a registered nurse.

Instructor – Refer to attachment on instructions and guidelines for completing this checklist prior to beginning observation of skills or tasks.

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
1. Basic Medication Administration Information and Medical Terminology (Refer to attachment)				
A. Matched common medical abbreviations with their meaning				
B. Listed/Described common dosage forms of medications and routes of administration				
C. Listed the 6 rights of medication administration				
D. Described what constitutes a medication error and actions to take when a medication error is made or detected				
E. Described resident's rights regarding medications, i.e., refusal, privacy, respect				
F. Defined medication "allergy"				
G. Demonstrated the use medication resources or references				
2. Medication Orders (Refer to attachment)				
A. Listed or Recognized the components of a complete medication order				
B. Transcribed orders onto the MAR 1. Used proper abbreviations 2. Calculated stop dates correctly 3. Transcribed PRN orders appropriately 4. Copied orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinued orders properly				
C. Described responsibility in relation to telephone orders				
D. Described responsibility in relation to admission and readmission orders and FL-2				
E. Described or Demonstrated the process for ordering medications and receiving medications from pharmacy				
F. Identified required information on the medication label				
3. Demonstrated appropriate technique to obtain and record the following: (Refer to Attachment)				
A. * Blood Pressure				
B. * Temperature				
C. * Pulse				
D. * Respirations				
E. Fingersticks/Monitoring Devices such as glucose monitoring (Only required to be validated if the employee will be performing this task.)				

EMPLOYEE NAME : _____

ADULT CARE HOME NAME: _____

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
4. If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (Refer to Attachment)				
5. Administration of Medications (Refer to attachment)				
A. Identified resident				
B. Gathered appropriate equipment and keeps equipment clean				
C. MAR utilized when medications are administered and also when medications are prepared or poured (if prepouring is allowed)				
D. Read the label 3 times; Label is checked against order on MAR				
E. Used sanitary technique when pouring and preparing medications into appropriate container				
F. Offered sufficient fluids with medications				
G. Observed resident taking medications and assures all medications have been swallowed.				
6. Utilized Special Administration/Monitoring Techniques as indicated(vital signs, crush meds. check blood sugar, mix with food or liquid) (Refer to Attachment)				
7. Administered medications at appropriate time (Refer to attachment)				
8. Described methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status (Refer to Attachment)				
9. Utilized appropriate hand-washing technique and infection control principles during medication pass (Refer to Attachment)				
10. Documentation of Medication Administration (Refer to Attachment)				
A. Initialed the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.				
B. Documented medications that are refused, held or not administered appropriately				
C. Administered and documented PRN medications appropriately				
D. Recorded information on other facility forms as required				
E. Wrote a note in the resident's record when indicated				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME: _____

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
11. Completion of Medication Pass (Refer to Attachment)				
A. Stored medications properly				
B. Disposed of contaminated or refused medications				
C. Rechecked MARs to make sure all medications had been given and documented				
12. Medication Storage (Refer to Attachment)				
A. Maintained security of medications during medication administration				
B. Stored controlled substances appropriately and counted and signed controlled substances per facility policy				
C. Assured medication room/cart/cabinet is locked when not in use				
13. Administered medications using appropriate technique for dosage form/route & administered accurate amount: (Refer to Attachment)				
A. Oral tablets and capsules				
B. Oral liquids				
C. Sublingual medications				
D. Oral Inhalers				
E. Eye drops and ointments				
F. Ear drops				
G. Nose drops				
H. Nasal Sprays/Inhalers				
I. Transdermal medications/Patches				
J. Topical (creams and ointments; not dressing changes)				
K. *Clean dressings				
L. *Nebulizers				
M. *Suppositories 1. Rectal 2. Vaginal				
N. *Enemas				
O. *Injections 1. Insulin** 2. Other subcutaneous medications				
P. *Gastrostomy Tube				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME: _____

Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>Section 1: Basic Medication Administration Information and Medical Terminology</p> <p>A. Match common medical abbreviations with their meaning</p> <p>B. List/Describe common dosage forms of medications and routes of administration</p> <p>C. List the 6 rights of medication administration</p> <p>D. Describe what constitutes a medication error and actions to take when a medication error is made or detected</p> <p>E. Describes resident's rights regarding medications, i.e., refusal, privacy, respect</p>	<p>Section 1: The employee must be knowledgeable of at least:</p> <p>A. The common abbreviations on ATTACHMENT A. The employee is to be familiar with the common medical abbreviations and be able to find a list when needed.</p> <p>B. The common dosage forms and routes of administration on ATTACHMENT A & B. The employee is to be familiar with the common dosage forms. Medications are available as different dosage forms, e.g., tablets, capsules, liquids, suppositories, topicals which include lotions, creams, ointments and patches, inhalants and injections. An order is to indicate the route of administration. Some medications may come in several dosage forms. An example is Phenergan. It is available in tablet, liquid, suppository and injectable.</p> <p>C. Six Rights of Medication Administration: 1.Right Resident 2.Right Medication 3.Right Dose 4.Right Route 5.Right Time 6.Right Documentation</p> <p>D. A medication error occurs when a medication is not administered as prescribed. Examples of medication errors include: omissions; administration of a medication not prescribed by the prescribing practitioner; wrong dosage; wrong time, wrong route; crushing a medication that shouldn't be crushed; and documentation errors. The employee must be able to explain the facility's medication error policy and procedure or at least be knowledgeable of where to find it. The procedure is to include who to notify, i.e., supervisor and health professional and forms to complete. The employee is to be able to recognize medication errors. The employee needs to understand that recognizing medication errors and acting quickly to correct them help prevent more serious problems.</p> <p>E. Medication administration can effect a resident's rights which include, but not limited to, the following: 1. <u>Respect</u> – How the resident is addressed; The resident should not be interrupted while eating for the administration of medications such as oral inhalers and eye drops. The resident should not be awakened to administer a medication that could be scheduled or administered at other times; Explain to the resident the procedure that the employee is about to perform; Answer questions the resident may have about the medication. 2. <u>Refusal</u> – The resident has a right to refuse medications. A resident should never be forced to take a medication. The facility should have a policy and procedure to be followed when residents refuse medications. The policy and procedure is to ensure the physician is notified timely (based on the resident's condition, physically and mentally and the medication.) 3. <u>Privacy</u> – Knock on closed doors before entering; Do not administer medications when the resident is receiving personal care or in the bathroom; Administration of injections outside the resident's room is not acceptable if the resident receiving the injection or other residents present are offended by this; Administration of medications requiring privacy, e.g., vaginal and rectal administrations, dressing changes and treatments requiring removal of clothing. 4. <u>Chemical Restraint</u> Medications, especially psychotropics, are not to be administered for staff convenience.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>F. Define medication “allergy” and describe responsibility in relation to identified allergies and suspected allergic reactions</p> <p>G. Demonstrate the use of medication resources or references</p> <p>Section 2: Medication Orders</p> <p>A. List/Recognize the components of a complete medication order</p>	<p>F. Medication Allergy: a reaction occurring as the result of an unusual sensitivity to a medication or other substance. The reaction may be mild or life-threatening situation. These may include rashes, swelling, itching, significant discomfort or an undesirable change in mental status, which should be reported to the physician. A severe rash or life-threatening breathing difficulties require immediate emergency care. The employee should understand that information on allergies should be reported to the pharmacy and physician and this information is recorded in the resident’s record. Upon admission, it is important to document any known allergies. If there are no known allergies, this should be indicated also.</p> <p>G. The employee should be familiar with medication resources or references, including the facility’s policy and procedure manual, and be able to find information. Resources written for non-health professionals, including information sheets from the pharmacy, are recommended instead of references written for health professionals, such as the <u>PDR</u>.</p> <p>Section 2</p> <p>A. Components of a complete order:</p> <ol style="list-style-type: none"> 1. Medication name; 2. Strength of medication (if one is required); 3. Dosage of medication to be administered; 4. Route of administration; 5. Specific directions for use, including frequency of administration; and, 6. PRN or “as needed” orders must also clearly state the reason for administration <p>Orders for psychotropic medications prescribed for “PRN” administration must include symptoms that require the administration of the medication, exact dosage, exact time frame between dosages and maximum dosage to be administered in 24 hour period. Example: Ativan 0.5 mg. by mouth every 4 hours prn for pacing or agitation. Physician is to be contacted if more than 4 doses are needed in 24-hour period.</p> <p>For items B. through E. of this section: If the employee has any responsibility for transcription of orders and processing admissions, the employee is to describe and demonstrate the procedures involved in these areas. If the employee does not have any responsibility for transcription or processing orders, the employee still needs to have general knowledge of the procedures and be able to screen orders to determine correctness.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. Transcribe orders onto the MAR</p> <ol style="list-style-type: none"> 1. Use proper abbreviations 2. Calculate stop dates correctly 3. Transcribe PRN orders appropriately 4. Copy orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinue orders properly <p>C. Describe responsibility in relation to telephone orders</p> <p>D. Describe responsibility in relation to admission and readmission orders and FL2 forms</p>	<p>B. Transcription of orders onto the medication administration record is to include:</p> <ol style="list-style-type: none"> 1. Orders are to be transcribed onto the medication administration record when obtained or written. The employee is to initial or sign and date orders written on the medication administration record. (Waiting until the medication arrives from the pharmacy before transcription of an order onto the medication administration record is not correct. The directions on the medication label from the pharmacy must be checked against the order on the medication administration record. If there is a discrepancy between the information on the medication administration record and the medication label, the order in the resident's record is to be checked. When there are discrepancies between the medication label and the order, the employee is to follow the facility's policy and procedure, which would address who to contact.) 2. Transcribe using proper abbreviations or written out completely. The order is to be complete. 3. When calculating stop dates for medication orders such as antibiotics that have been prescribed for a specific time period, the number of dosages to be administered should be counted instead of the number of days. 4. PRN orders are not scheduled for administration at specific times. PRN medications are given when the resident "needs" the medication for a certain circumstance. 5. Review medication administration records monthly at the beginning of the cycle to assure accuracy and the update the medication administration records as needed. 6. A discontinue order has to be obtained for an order to be discontinued, unless the prescribing practitioner has specified the number of days or dosages to be administered or indicates that a dosage is to be changed. For example, a prescription with "No Refills" does not automatically mean the order is to be discontinued. <p>C. Telephone or verbal orders may be accepted only by a licensed nurse, registered pharmacist or qualified staff responsible for medication administration. The order is to be dated and signed by the person receiving the order and signed by the prescribing practitioner within 15 days of when the order is received. It is important that the employee understands that a copy of an order, including a telephone order, is always kept in the resident's record.</p> <p>D. A FL2 form is required for new admissions. It is important that all the information on the FL-2 is reviewed for accuracy. If any clarification is needed, the prescribing practitioner is to be contacted. If the FL-2 has not been signed within 24 hours of admission, the orders are to be verified by the facility with the prescribing practitioner. Verification of orders may be by fax or telephone. There has to be documentation of this verification in the resident's record, e.g., a note in the progress notes or the orders may be rewritten as telephone orders and signed by the prescribing practitioner. The orders could also be faxed to the prescribing practitioner for review, signature and date.</p> <p>Readmission from the hospital requires a transfer form, discharge summary <u>or</u> FL-2 signed by the prescribing practitioner. Often, the facility may receive a discharge summary or transfer form and a FL-2. The employee must be able to describe the procedures for readmission, especially when two or more forms with orders are received. Orders are to be verified by facility staff with the prescribing practitioner if the orders have not been signed within 24 hours of admissions, if clarification is needed or if the prescribing practitioner has not signed the orders. If a</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>E. Describe or demonstrate the process for ordering medications and receiving medications from pharmacy</p> <p>F. Identify required information on the medication label</p> <p>Section 3 : Using appropriate technique to obtain and record the following:</p> <p>A. * Blood Pressure</p>	<p>prescribing practitioner does not sign orders, the orders are to be processed per facility policy and signed by the prescribing practitioner. This may be by telephone or facsimile.</p> <p>Medication orders are to be reviewed and signed by the physician at least every 6 months. When the orders are renewed and there are changes without any reason, the physician or prescribing practitioner should be contacted for clarification. A medication could have been accidentally left off or the wrong dosage could have been written.</p> <p>Clarification is obtained whenever orders are unclear, incomplete or conflicting. New orders will need to be written as necessary for these clarifications.</p> <p>“Continue previous medications” or “Same Medications” are not complete medication orders and are not to be accepted for medication orders.</p> <p>An order has to be obtained for any medication administered, i.e., over-the-counter or prescription. The employee is to understand the difference between a prescription and an order. The facility needs an order to administer a medication. The prescription may be used for the signed order.</p> <p>E. The employee should be knowledgeable of the facility’s procedures on ordering medications, including refills, procedures for emergency pharmaceutical services and on receiving medications when delivered from the pharmacy. The facility is to be able to account for medications administered by staff; therefore, the facility is to have procedures to ensure that dispensing information, i.e., date, name, strength and quantity of medication, can be readily available. For situations such as admissions when the resident or responsible party brings medications into the facility, the name, strength and quantity of medication brought in should be documented.</p> <p>F. The employee has to be able to identify the following information on the label: medication name and strength; quantity dispensed and dispensing date; directions for use; the pharmacy that dispensed the medication and the prescription number; and expiration date. The employee should understand the difference between generic and brand names and know that an equivalency statement should be on the medication label when the brand dispensed is different than the brand prescribed. The employee should also know labeling requirements for over-the-counter (OTC) medications, according to the regulation 10A NCAC 13F/13G .1004.</p> <p>Section 3</p> <p>A. Blood Pressure (B/P)– The employee is to know how to check a blood pressure by using the facility’s blood pressure device. If electronic machines are used, the employee should understand that the device needs to be checked for accuracy according to the manufacturer’s recommendations. The instructor needs to indicate on the checklist how the employee obtained the resident’s blood pressure, i.e., electronically or manually with a stethoscope and blood pressure cuff. The employee should know that blood pressure cuffs that are too small or large for the resident’s arm might result in an inaccurate reading. Ranges for high and low blood pressures that indicate the resident’s blood pressure should be reported are to be established by the facility’s policy or physician’s order.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. * Temperature</p> <p>C. * Pulse</p> <p>D. * Respirations</p> <p>E. Fingersticks/Glucose Monitoring (Only required to be validated if the employee will be performing this task.)</p> <p>Section 4: If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (only has to be completed if applicable to facility)</p> <p>Section 5: Administration of Medications</p> <p>A. Identify resident</p>	<p>B. Temperature (T or TEMP.)– The employee should know how to obtain the resident’s temperature using the facility’s thermometer: i.e., electronic, glass or tympanic. The employee should know the normal oral temperature and that temperature is measured using either the Fahrenheit or Celsius scale. Normal oral temperature is 36.5 – 37.5 degrees Celsius or 96.7 – 99.6 degrees Fahrenheit. The employee should know that activity, food, beverages and smoking all affect body temperature.</p> <p>C. Pulse – Number of heartbeats counted in one full minute. The employee should know how to take a radial (heart rate measured at the thumb side of the inner wrist) and apical pulse (heart rate measured directly over the heart using a stethoscope). A pulse may be obtained by using an electronic device. Normal range is 60 to 100 beats/minute.</p> <p>D. Respirations (R) – Number of breaths a person takes per minute. The normal range is 10 to 24 breaths per minute. One full breath is counted after the resident has inhaled and exhaled. The most accurate rate is taken when the resident is not aware that his/her respirations are being monitored.</p> <p>E. The employee is to know how to operate devices used for the collection and testing of fingerstick blood samples, such as glucose monitoring devices. Staff is to know about calibrating and cleaning the machine per manufacturer’s instructions. The range of a monitoring device should be posted with the MARs or available for staff for reference. Ranges for devices, such as glucose monitoring machines, may vary. The facility should have procedures developed when a reading is obtained, especially if the reading is low or high. The employee is to be knowledgeable of the procedures and know where to locate the information if needed. The employee is to be knowledgeable of infection control measures, such as wearing gloves, disposal of lancets in sharps container and the cleaning of machines per manufacturer’s instructions, for procedures with which bleeding occurs or the potential for bleeding exists.</p> <p>Section 4</p> <p>The containers must be prepared and labeled according to regulation 10A NCAC 13F/13G .1004. If the medications are not dispensed in sealed packages, the container has to be capped or sealed and each medication prepared is to be identified on the container. The MAR is to be used when prepouring or preparing medications. If the person who prepares the medication is not the same person to administer the medication, the person preparing the medication must document each medication prepared. (This is in addition to documentation by the person who actually administers the medications. The administration of medications is not to be documented until after the resident is observed to take the medications.)</p> <p>Section 5</p> <p>A. The employee is to know the procedures for identifying residents. The most common method used is photographs of residents in the medication administration records. The photos should be kept updated and the photograph is to have the name of the resident on it. Relying on other staff to identify residents is not appropriate.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. Gathered appropriate equipment and keeps equipment clean</p> <p>C. Medication administration records utilized when medications are prepared and administered. They are also used when medications are prepoured, if prepouring is allowed.</p> <p>D. Read the label 3 times; Check label against order on the medication administration record.</p> <p>E. Use sanitary technique when pouring or preparing medications into the appropriate container</p> <p>F. Offer sufficient fluids with medications</p>	<p>B. This will depend on the medications to be administered. Supplies/equipment to have for medication administration need to include at least the following:</p> <ol style="list-style-type: none"> 1. Medication administration records 2. Medication cups for oral medications, i.e., liquids and tablets 3. Sufficient fluids available to administer medications 4. Food substance, i.e., applesauce or pudding, if needed. 5. If soap and water is not available for washing hands, an appropriate antiseptic is to be available for use. <p>Supplies and equipment used in the process of administering medications is to be kept clean and orderly, i.e., medication carts, trays and pill crusher.</p> <p>C. Employee is to use the medication administration record when administering medications.</p> <p>D. Reading the label - The employee should compare the label to the MAR 3 times:</p> <ol style="list-style-type: none"> 1. when selecting the medication from the storage area 2. prior to pouring the medication 3. after pouring and prior to returning the medication to the storage area. <p>The information on the MAR and the medication label should match, unless there has been a change in the directions. The employee is to be familiar with the facility's policy on direction changes. A medication label can only be changed or altered by the dispensing practitioner.</p> <p>E. Medications are not to be touched or handled by the employee's hands. Medications are to be poured from the medication container into an appropriate medication container or cup and given to the resident. It is not acceptable for the employee to use his/her hands to administer the medications or for the resident to have to use his/her hands to receive the medications. (This is referring to the facility not having adequate or appropriate supplies or the employee not using the supplies to administer medications. This is not referring to residents pouring the medication, e.g., tablet, or wanting the medication poured into their hands.)</p> <p>F. The resident should be offered sufficient fluids following the administration of medications even if the medication is administered in a food substance.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>Section 9: Utilize appropriate hand-washing technique and infection control principles during medication pass</p>	<p>Section 9</p> <p>Universal Precautions are to be implemented. This includes employees wearing gloves when there may be exposure to bodily fluids. The employee is to be knowledgeable of when to wear gloves and when to change gloves. Handwashing should be with soap and water. When soap and water is not readily available, an antiseptic gel or product must be used in place of soap and water. Handwashing is required when there has been contact with the resident's body or bodily fluids during the administration of medications. Gloves should be worn and handwashing must also be done when transdermal products, i.e., Nitroglycerin or Durgesic patches, are applied or removed.</p>
<p>Section 10 – Documentation of Medication Administration</p> <p>A. Initial the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.</p> <p>B. Document medications that are refused, held or not administered, appropriately</p> <p>C. Administer and document PRN medications appropriately</p>	<p>Section 10</p> <p>A. The employee is to sign the MAR only after observing the resident take the medications. Precharting is not permitted and this includes signing the MAR anytime prior to the medications being administered. The MAR is to be signed immediately after the medications are administered and prior to the administration of the next resident's medications. The employee is also to document an equivalent signature to correspond with the initials used on the MAR.</p> <p>B. The facility is to have procedures to ensure that there is a consistent method of documenting why a medication was not administered. The employee is to be knowledgeable of the facility's policy and procedures. If the facility uses abbreviations such as "R" or "H", there is to be documentation on the medication administration records of the abbreviations and what the abbreviations mean. The facility may have staff circle their initials and document the reason a medication was not administered on the back of the MAR.</p> <p>The employee is also to be knowledgeable of the facility's policy when a resident refuses medications, i.e., notifying the supervisor or physician.</p> <p>If the medications are not administered because the resident is out of the facility, i.e., leave of absence and workshops, there should also be documentation of the medications sent with the resident. (A medication release form is often used for leave of absence.)</p> <p>C. Documentation of PRN medications is to include the amount administered, the time of administration and the reason for administration. The reason a PRN medication is to be administered is to be indicated in the order. The effectiveness of the medication is to also be documented when determined. A different employee, depending on the time of administration and shift schedules may record the effectiveness of the medication. If a resident is requesting or requiring administration of a prn medication on a frequent or routine basis, the employee should report this to the supervisor or the physician. PRN medications are to be administered when a resident needs the medication but may not be administered more frequently than the physician has ordered. The need for medication may be based upon the resident's request for the medication or observation by staff, i.e., resident exhibiting pain but does not request medications or may not be able to request the medication.</p>

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<p>D. Record information on other facility forms as required</p> <p>E. Write a note in the resident's record when indicated</p> <p>Section 11: Completion of Medication Pass</p> <p>A. Store medications properly</p> <p>B. Dispose of contaminated or refused medications per policy</p> <p>C. Recheck medication administration records to make sure all medications are administered and documented</p> <p>Section 12: Medication Storage</p> <p>A. Maintain security of medications during medication administration</p>	<p>D. The forms to be completed would depend on the facility's policy and procedures. The employee is to be knowledgeable of forms to complete, i.e., administration of controlled substances and documentation of medications provided for leave of absence.</p> <p>E. Any contact with the prescribing practitioner is documented in the resident's record. The employee needs to be knowledgeable of how to write a note in the resident's record appropriately, i.e., date and employee's signature. The employee also must be knowledgeable of the facility's procedures for documenting information that needs to be communicated to other staff or health professionals. This may be in the resident's record or on some other document used to communicate with staff or health professionals.</p> <p>Section 11</p> <p>A. External and internal medications are to be stored in separate designated areas. The employee should store refrigerated medications in the medication refrigerator or locked container. Medications requiring refrigeration are to be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).</p> <p>A resident's oral solid medications should be stored together and separated from other residents' medications. It may not be possible for other medications, i.e., liquids and topical medications, to be separated by dividers for each resident. Medication storage areas need to be orderly so medications may be found easily.</p> <p>B. Dosages of medications that have been opened and prepared for administration and not administered for any reason should be disposed of promptly. The disposal of these medications should be in accordance with the facility's policy and procedures. Loose medications are not to be kept in the facility or returned to the pharmacy.</p> <p>C. When the medication pass is complete, the employee is to recheck the medication administration records to make sure all medications have been administered and documented appropriately. At the end of the medication pass if a medication is not signed off upon recheck of the medication administration record, and the employee is certain the medication was administered, it is acceptable for the employee to document the administration. This is acceptable when there are only a few, i.e., one or two, omissions. It is not acceptable for the employee to have omitted documentation of the administration of medications for multiple residents.</p> <p>Section 12</p> <p>A. Medications are to be stored in a locked area, unless the medications are under the direct supervision of staff. Direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary.</p>
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>B. Store controlled substances appropriately and count and sign controlled substances per facility policy</p> <p>C. Assure medication room/cart/cabinet is locked when not in use</p> <p>Section 13: Administer medication utilizing appropriate technique for dosage form/route and administer accurate amount</p> <p>A. Oral tablets and capsules B. Oral liquids</p>	<p>B. The storage of controlled substances is to be in accordance with the facility's policy and procedures. Controlled substances may be stored in one location in the medication cart or medication room. When Schedule II medications are stored in one location together or with other controlled substances, the controlled substances are to be under double lock. When controlled substances, including Schedule II, are stored with the resident's other medications, only a single lock is required. There has to be a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. The employee is to be knowledgeable of any forms to be completed.</p> <p>C. Medication room/cart/cabinet is locked when not in use. Unless the medication storage area is under the direct supervision of staff, the medication area including carts is to be locked. When the medication cart is not being used, it should be stored in a locked area or stored in an area where it is under the supervision of staff.</p> <p>Section 13</p> <p>The employee is to actually perform or at least be able to demonstrate to the instructor the proper technique for administering the different dosage forms and routes of administration for A through J prior to the employee being assigned to administer medications in the adult care home.</p> <p>Routes of administration for K through P only have to be validated if the employee will be responsible for administering these medications or medications by these routes.</p> <p>The information below does not provide step by step procedures for administering medications. It provides pertinent information on techniques and infection control that the employee is to know. Refer to the State Approved Medication Administration Courses for Adult Care Homes for step by step procedures.</p> <p>A. & B. Oral Medications</p> <ul style="list-style-type: none"> • Appropriate positioning of resident, elevation of head. • The amount of medication to be administered, such as liquids, is never to be approximated. The amount ordered is to be the amount administered; therefore, a calibrated syringe is often necessary for measuring liquids in amounts less than 5 ml. and unequal amounts. • Liquid medications must be measured in a calibrated medication cup/device. • Measuring devices used for administering medications are to be calibrated and designed for measuring medications. Eating utensils or other household devices are not to be used for administering medications. • When measuring liquids, the medication cup should be placed on a flat surface, and measured at eye level to ensure accuracy. • For liquids, hold the medication container so that the medication flows from the side opposite the label so it doesn't run down the container and stain or obscure the label. • Powdered medications such as bulk laxatives need to be given with the amount of fluids indicated. • More than one capsule or tablet may be in the same medication cup, but liquid medications are not to be mixed together.
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>C. Sublingual medications</p> <p>D. Oral Inhalers</p> <p>E. Eye drops and ointments</p> <p>F. Ear drops</p> <p>G. Nose drops H. Nasal Sprays/Inhalers</p>	<ul style="list-style-type: none"> • Special measuring devices for certain medications should only be used for that medication. (These measuring devices have increments marked off in “mgs.” instead of “mls” and usually have the name of the medication on the measuring device.) • Liquids may have administration requirements such as Shake Well and Requires Dilution prior to administration. Examples of these liquids are Dilantin Suspension, which must be shaken thoroughly because the medication settles after administration and gives inconsistent dosing; Liquid Potassium and bulk laxatives have to be mixed with sufficient fluids to decrease side effects. • Refer to ATTACHMENT C for additional information. <p>C. Sublingual</p> <ul style="list-style-type: none"> • The medication is to be placed under the resident’s tongue. The resident should be instructed not to chew or swallow the medication. Do not follow with liquid, which might cause the tablet to be swallowed. <p>D. Oral Inhalers</p> <ul style="list-style-type: none"> • For information on technique for meter dose inhaler refer to ATTACHMENT D. • Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. • The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR. • The use of spacer or other devices to aid with administration should be discussed with the employee. • Wait at least one minute between puffs for multiple inhalations <p>E. Eye drops and ointments</p> <ul style="list-style-type: none"> • Hands are to be washed prior to and after administration of eye drops and ointments. Gloves are to be worn as indicated. Gloves are to always be worn when there is redness, drainage or possibility of infection. • When two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. • Dropper or medication container should not touch the resident’s eyes. <p>F. Ear Drops</p> <ul style="list-style-type: none"> • Wash hands before and after administration of medication. Gloves are to be worn as indicated. • By gently pulling on the ear, straighten the ear canal • The employee should request the resident to remain in same position for 5 minutes to allow medication to penetrate. It may be necessary to gently plug the ear with cotton to prevent excessive leakage. <p>G. & H. Nose Drops & Nasal Sprays/Inhalers</p> <ul style="list-style-type: none"> • Wash hands before and after. Gloves are to be worn as indicated. • For drops: Resident should lie down on his/her back with head tilted back and the employee should request the resident to remain in the position for about 2 minutes to allow sufficient contact of medication with nasal tissue. • For Sprays: Hold head erect and spray quickly and forcefully while resident “sniffs” quickly. It may be necessary
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Guidelines for Completing the Medication Administration Clinical Skills Checklist

<p>I. Transdermal medications/Patches</p> <p>J. Topical (creams and ointments; not dressing changes)</p> <p>K. *Clean dressings</p> <p>L. *Nebulizers</p> <p>M. *Suppositories 1. Rectal 2. Vaginal</p> <p>N. *Enemas</p> <p>O. *Injections 1. Insulin** 2. Other subcutaneous medications</p>	<p>to have the resident tilt head back to aid penetration of the medication into the nasal cavity.</p> <ul style="list-style-type: none"> • The dropper or spray should be at least wiped with a tissue before replacing the cap. <p>I. Transdermal Products/Patches</p> <ul style="list-style-type: none"> • Application sites for transderm patches should be rotated to prevent irritation. The application sites should be documented on the MAR. • If the patch is ordered to be worn for less than 24 hours, documentation on the medication administration record is to reflect that the patch was removed and the time it was removed. • Gloves should be worn and hands washed after the patch is applied or removed. • When a patch is removed, the area should be cleaned to remove residual medication on the skin. <p>J. Topical</p> <ul style="list-style-type: none"> • Wearing gloves and use a tongue bade, gauze or cotton tipped applicator to apply the medication. • A new applicator should be used each time medication is removed from container to prevent contamination. • Privacy should be provided, as necessary. This would depend on the area to be treated. • The lid or cap of the container should be placed to prevent contamination of the inside surface. • Gloves and supplies used should not be discarded in areas accessible to residents. <p>(Validation for items K. through P is only necessary if the employee will be performing the task. These are tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504; .0505 and .0903.)</p> <p>K. *Clean Dressing</p> <ul style="list-style-type: none"> • The employee is to be knowledgeable of techniques with dressing change to ensure there is no cross-contamination • Information under item J is also applicable to dressing changes. <p>L. *Nebulizers</p> <ul style="list-style-type: none"> • Nebulizer equipment, tubing and mask, is to be cleaned and changed in accordance with the facility's policy. <p>M.&N. Suppositories & Enemas</p> <ul style="list-style-type: none"> • Wash hands before and after. Gloves are to be worn and properly disposed of. • Remove foil or wrapper from suppository. A small amount of lubricant applied to the suppository will aid with administration of rectal preparations. • Privacy is to be provided. • Reusable applicators are to be cleaned with soap and water and properly stored. <p>O. Injections</p> <ul style="list-style-type: none"> • Syringes are not to be recapped and must be disposed of in appropriate containers, i.e., Sharps. • **For insulin, the employee is to have also received training according to regulation 10A NCAC 13F/13G .0505.
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**Guidelines for Completing the
Medication Administration Clinical Skills Checklist**

EXERCISE

Medication Aide Qualifications

The following checklist was completed during routine monitoring of medication aide qualification at Fruitful Living Rest Home of Raleigh. Based upon facility information the following were identified as medication aides. MAR review revealed that each had administered medications during the current month. The medication aide qualifications were completed based upon information gathered for each aide. Which medication aides, if any, do not meet the required qualifications? Which medication aides, if any, would be required to complete the required medication training? Why?

MEDICATION AIDE QUALIFICATIONS CHECKLIST

NCDHHS, Division of Health Service Regulation, Raleigh, NC

Facility Name/Location **Fruitful Living Rest Home of Raleigh** Survey Date(s) **11/18/13**

<i>Name of Staff Person</i>	<i>Title of Staff Person</i>	<i>Date of Hire</i>	<i>Clinical Skills Checklist?</i>	<i>If Yes, Date Completed</i>	<i>Med Test Certificate?</i>	<i>If Yes, Date Passed</i>	<i>Medication Training Required?</i>
Charles Cherry	Med Aide	12/05/12	Yes	12/08/12	Yes	03/01/13	
Patty Pear	NA and Med Aide	10/17/11	No		No		
Pricilla Peach	Med Aide	06/02/13	Yes	06/05/13 09/03/13	No		
Paul Pineapple	Med Aide	09/01/13	No		Yes	01/29/04	
Anne Apple	Med Aide	10/28/13	Yes	11/05/13	No		

Notes: Revised 11/13

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME Clayton		FIRST Garrett		MIDDLE	2. BIRTHDATE (M/D/Y) 10-17-30	3. SEX M	4. ADMISSION DATE (CURRENT LOCATION) 9/1/04
5. COUNTY AND MEDICAID NUMBER Johnston 021-13-1415			6. FACILITY Adult Care Assisted Living			7. PROVIDER NUMBER	
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bruton Adams Building City, N.C.				9. RELATIVE NAME AND ADDRESS Ben Clayton (brother)			
10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input checked="" type="checkbox"/> HOSPITAL		11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> OTHER		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER	
				13. DATE APPROVED/DENIED			

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. seizure disorder	5. CHF
2. hypertension	6.
3. insulin-dependent diabetes (IDDM)	7.
4. Asthma	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	<input checked="" type="checkbox"/> AMBULATORY	<input checked="" type="checkbox"/> CONTINENT	<input checked="" type="checkbox"/> CONTINENT
INTERMITTENTLY	SEMI-AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSTOMY
WANDERER	FUNCTIONAL LIMITATIONS	EXTERNAL CATHETER	RESPIRATION
VERBALLY ABUSIVE	SIGHT	COMMUNICATION OF NEEDS	NORMAL
INJURIOUS TO SELF	HEARING	<input checked="" type="checkbox"/> VERBALLY	TRACHEOSTOMY
INJURIOUS TO OTHERS	SPEECH	NON-VERBALLY	OTHER:
INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	O2 PRN CONT.
OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	PASSIVE	<input checked="" type="checkbox"/> NORMAL	<input checked="" type="checkbox"/> DIET NCS
<input checked="" type="checkbox"/> BATHING	<input checked="" type="checkbox"/> ACTIVE	OTHER:	SUPPLEMENTAL
FEEDING	GROUP PARTICIPATION	DECUBITI – DESCRIBE:	SPOON
<input checked="" type="checkbox"/> DRESSING	RE-SOCIALIZATION		PARENTERAL
TOTAL CARE	FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		GASTROSTOMY
30 DAYS	CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
<input checked="" type="checkbox"/> 60 DAYS	GRAND MAL	DRESSINGS:	FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT
	FREQUENCY		HEIGHT
17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE		BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING	<i>FSBS ac breakfast & supper</i>	RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Dilantin 125mg/5ml - 4ml po q.o.d.	7. Humulin-R insulin - sliding scale
2. Lasix 40mg po twice daily	8. BS = 200-250 - 3 units
3. Tylenol 325mg 1-2 tabs po q6hr prn pain	9. BS = 251-300 - 4 units
4. or temp greater than 100°F	10. BS = 301-350 - 5 units
5. Humulin 70/30 - 10 units sq. ac breakfast	11. call MD if > 350
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

PPD 8/28/03 Omm

PPD 2nd 9/15/03 Omm

** allergies - codeine*

21. PHYSICIAN'S SIGNATURE



22. DATE

9/1/04

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
RESIDENT'S HEALTH SERVICE RECORD

HOME FOR THE AGED FAMILY CARE HOME DDA HOME

NAME OF FACILITY: Adult Care Assisted Living

NAME OF RESIDENT: Garrett Clayton

RESIDENT'S PHYSICIAN: Dr. Bruton TELEPHONE: 855-3765

DOCUMENT PHYSICIAN AND ALL OTHER LICENSED HEALTH PROFESSIONAL CONTACTS

DATE

FINDINGS /ORDERS/ RECOMMENDATIONS

10/08/06

Resident complaint of sore throat and congestion.

Amoxicillin 500mg po TID for 10 days.

To be seen in 4 days if still complaining.



NOTED _____ DATE _____ TIME _____ INITIAL _____ FAXED DATE _____ TIME _____ INITIAL _____

PHYSICIANS ORDERS	Last Name Clayton , Garrett		First Name	Med. Rec.	Attending Physician Dr. Bruton	Room No. 000	Facility No.
	Date Ordered	Date Discontinued	ORDERS				
	<i>10/13/04</i>		Decrease Lasix to 40mg once daily				
Signature of Nurse Receiving Order	<i>BBG, MT</i>		Date/Time <i>10/13/04 8AM</i>	Signature of Physician <i>Bruton</i>	Date <i>10/20/04</i>		

LTC DRUGS, INC. CITY, NC TELEPHONE 919-911-1212	
Name: Garrett Clayton	Age:
Address: Adult Care Assisted Living	Date: 10/11/04
R Ambien 5mg Sig: 1 tab po qhs #30	
Refill <u> 0 </u>	
MD	MD <i>Bruton</i>
Product Selection Permitted	Dispense as Written
Physician Address: Adams Bldg City, NC Telephone: 919-555-1212	
Physician DEA and UPIN number are required to process insurance and Medicaid or Medicare forms	
DEA # :	UPIN # :

Medication Administration Monitoring Form

Resident's Name: Garrett Clayton Date of Birth: 10/17/30
 Diagnosis: Seizure Disorder, HTN, IDDM, Asthma, CHF Date of Admission: 09/01/04
 Allergies: Codeine Facility: Adult Care Assisted Living

FL-2 / Discharge Summary / Transfer Form DATE: <u>09/01/04</u>	Subsequent Orders	Medication Administration Record	Medication on Hand Labeled Correctly
Dilantin 125mg/5ml - 4ml po every other day		OKAY	OKAY
Lasix 40mg po twice daily	Telephone order 10/13/04 - Lasix changed to 40mg once daily	OKAY	Bottle has "Direction Change" sticker (filled 10/01/04)
Tylenol 325mg 1-2 tabs q 6 hrs prn pain or T > 100°F		OKAY - charting time, amount, reason, and result	OKAY
Humulin 70/30 10 units sq ac breakfast		OKAY	OKAY
Humulin R (sliding scale) BS - 200-250 = 3 units BS - 251-300 = 4 units BS - 301-350 = 5 units Call MD if > 350		OKAY - 4 episodes of requiring insulin - given appropriately	OKAY
Fingersticks bid ac breakfast and supper		OKAY	_____
	10/08/04 - Amoxicillin 500mg tid for 10 days	OKAY	No medication available - finished
	10/11/04 - Ambien 5mg 1 tab at bedtime	OKAY	OKAY



North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt
Division Director

April 9, 2015

MEMORANDUM

TO: N.C. Adult Care Home & Family Care Home Providers
Directors, N.C. County Departments of Social Services
Supervisors, Adult Services, N.C. County Departments of Social Services
Adult Home Specialists, Adult Services, N.C. County Departments of Social Services

FROM: Megan Lamphere, MSW
Section Chief, DHSR Adult Care Licensure Section

RE: Amended Licensure Rules 10A NCAC 13F & 13G .1003 and .1010
(Regarding medications for a resident's leave of absence)

Effective April 1, 2015, the requirements for adult care and family care home facilities related to the provision of a resident's medications for a leave of absence (LOA) were amended. Specifically, the following rules have been amended:

10A NCAC 13F .1003 Medication Labels
10A NCAC 13F .1010 Pharmaceutical Services

10A NCAC 13G .1003 Medication Labels
10A NCAC 13G .1010 Pharmaceutical Services

The N.C. Medical Care Commission initiated these rule changes on September 12, 2014 and adhered to the requirements of the rule-making process set forth in G.S. 150B. The Commission welcomed and incorporated feedback on the rule changes from a variety of stakeholders, including facility representatives, pharmacists, and other interested parties.

The final rule amendments, as well as the rule-making process, may be found on the DHSR Rule Actions webpage at <http://www.ncdhhs.gov/dhsr/rules/acls2014> . The rules without the changes noted in the text of the rule are attached to this memo and will eventually be available on-line in the N.C. Administrative Code at <http://reports.oah.state.nc.us/ncac> .

In addition, the Adult Care Licensure Section has updated an optional form that has been available for providers to use when releasing a resident's medication for a LOA. Again, this form is optional. The form may be completed electronically, then printed out for signature by the staff and resident or person accompanying the resident on the LOA. We hope that facilities will find this form useful. The form can be found on the ACLS website at <http://www.ncdhhs.gov/dhsr/acls/pdf/medreleaseform.pdf> .

Adult Care Licensure Section

www.ncdhhs.gov • www.ncdhhs.gov/dhsr
Tel 919-855-3765 • Fax 919-733-9379

Location: Broughton Building, 805 Biggs Drive • Raleigh, NC 27603
Mailing Address: 2708 Mail Service Center • Raleigh, NC 27699-2708
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10A NCAC 13F .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

- (1) the name of the resident for whom the medication is prescribed;
- (2) the most recent date of issuance;
- (3) the name of the prescriber;
- (4) the name and concentration of the medication, quantity dispensed, and prescription serial number;
- (5) unabbreviated directions for use stated;
- (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
- (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
- (8) auxiliary information as required of the medication;
- (9) the name, address, and telephone number of the dispensing pharmacy; and
- (10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;

Eff. July 1, 2005;

Amended Eff. April 1, 2015.

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10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

- (a) An adult care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.
- (b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.
- (c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.
- (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:
- (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;
 - (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:
 - (A) the name and strength of the medication;
 - (B) the directions for administration as prescribed by the resident's physician;
 - (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
 - (3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and
 - (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.



The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

(f) A facility with 12 or more beds shall have a current, written agreement with a pharmacy provider for dispensing services. The written agreement shall include a statement of the responsibility of each party.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015.*



10A NCAC 13G .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

- (1) the name of the resident for whom the medication is prescribed;
- (2) the most recent date of issuance;
- (3) the name of the prescriber;
- (4) the name and concentration of the medication, quantity dispensed, and prescription serial number;
- (5) unabbreviated directions for use stated;
- (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
- (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
- (8) auxiliary information as required of the medication;
- (9) the name, address, and telephone number of the dispensing pharmacy; and
- (10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;

Temporary Adoption Eff. December 1, 1999;

Eff. July 1, 2000;

Amended Eff. April 1, 2015.

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10A NCAC 13G .1010 PHARMACEUTICAL SERVICES

(a) A family care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:

- (5) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;
- (6) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:
 - (D) the name and strength of the medication;
 - (E) the directions for administration as prescribed by the resident's physician;
 - (F) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
- (7) The resident's medications shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and
- (8) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.



The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015.*



ABBREVIATIONS

DOSES

gm = gram
mg = milligram
mcg = microgram
cc = cubic centimeter
ml = milliliter
tsp = teaspoonful
tbsp = tablespoonful
gtt = drop
ss = 1/2
oz = ounce
mEq = milliequivalent

ROUTES OF ADMINISTRATION

po = by mouth
pr = per rectum
OD = right eye
OS = left eye
OU = both eyes
AD = right ear
AS = left ear
AU = both ears
SL = sublingual (under the tongue)
SQ = subcutaneous (under the skin)
per GT = through gastrostomy tube

TIMES

QD = every day
BID = twice a day
TID = three times a day
QID = four times a day
q_h = every __ hours
qhs = at bedtime
ac = before meals
pc = after meals
PRN = as needed
QOD = every other day
ac/hs = before meals and at bedtime
pc/hs = after meals and at bedtime
stat = immediately

OTHER

MAR = medication administration record
OTC = over the counter
SIG = label or directions

Reviewer's Initials: _____

Resident's Name _____

Medication Monitoring Form

Standing Orders: _____

LOC _____	FL-2 / DC Summary DATE _____	Subsequent Orders	Medication Administration Record	Medication Labeled Correctly?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				

Chapter 4

Staff Training and Competency

Staff Training & Competency

Adult Care Licensure Section
Division of Health Service Regulation

WHY Monitor?

Lack of staff or lack of qualified staff negatively impacts resident care.

How Does Monitoring Help?

- Causes the facility to focus on staffing and staff qualifications.
- Determines and ensures adequate number of staff.
- Ensures follow-up on new staff qualifications.
- Tracks and updates staff qualifications.

What Is To Be Determined?

Staffing

Does the facility have the required number of staff on duty to meet resident needs?

Staff Qualification

Are the staff trained to provide the care they are giving?

Do staff meet personnel requirements?

When Do I Monitor Staffing?

- Annual Comprehensive Review
- Complaint
- Resident Care Not Being Provided
- Lack of Staff and Frequent Staff Turnover

Plan & Prepare

- Review DSS Facility File
- Review Annual Monitoring Plan
- Look for Related Complaints/Problems
- Review Perpetual Staff Log
- Plan a Targeted Sample of Staff Record Reviews
- Complaints Related to Staffing
- Review Incident & Accident Reports

Targeted Sample for Qualifications

Variety of Staff

Administrator, Supervisor in Charge (SIC), Medication Aide, Activity Director, Food Service, Housekeeping

New Hires

Including Aides hired within last 6 months and long-term employees

Entrance Conference

Administrator or SIC

Purpose of Visit:

- Monitoring number of staff
- Monitoring staff qualifications
- Work plan

Request:

- Current census
- Access to staff personnel and/or training records
- Access to private workspace

Collect & Record Data

Observations

- Facility Tour First

Interview

- Facility Staff/Residents

Record Review Last

- Facility Personnel Records, Resident Record, Scheduling/Time Records

Observation Tips

- Administrator Certificate Posted?
- Who are Staff on Duty?
- What are Staff Doing?
New staff? Working alone?
- Record Names and Times

Interview Tips

- Private & Confidential
- During Tour & After Record Review
- Have Staff Describe Own Job Duties

Questions to Ask

Staff

- How were you oriented to the facility?
- What was taught during orientation?
- What is the chain of command?
- Tell me about Resident Rights?
- Tell me about your training on oxygen, restraints and pressure ulcers?

Residents

- How do you get your needs met?
- How about on 3rd shift?
- How do you get along with staff?
- How do the staff treat you?
- Do you have any concerns about staff that I haven't asked about?

Record Review Tips

- Request Personnel and Training Record
- If You Can't Find it Ask
- Keep Organized Notes
- Remember the Bold Faced Items on the Staff Qualification Log
- Match Job Description to Job

Evaluate Data

- Review Initial Plan
- Ensure Findings are Complete, Accurate, and Rule-Based
- Determine Actions

Evaluate Data

- Organize Findings/Compare Findings to Rules
- Determine Scope (*extent of system failure*)
- Determine Severity (*impact on residents*)
- Document Findings
 - Monitoring Report Concern
 - Corrective Action Report
 - Type A1, A2 or B Violation or Standard Deficiency

Perpetual Staff Log

For _____
Facility Name

Complete for all staff once and update every routine monitoring visit for new staff or expiring items. Note: Mark N/A if does not apply. Delete employees who terminate. **Bolded** areas must be rechecked and updated, so write those in pencil. File inside specific agency facility file.

Staff Names ⇒ Items and references ↓					
Type Position					
Hire Date					
Date Health Care Personnel Registry Ck (code #) G.S. 131E-256 10A NCAC 13G .0406 & .1206 10A NCAC 13F .0407 & .1205					
Date Criminal Hx Ck G.S. 131D-40 10A NCAC 13G .0406 10A NCAC 13F .0407					
Date TB 2-step started/completed 10A NCAC 13G .0405 10A NCAC 13F .0406					
Date Drug Testing prior to employment G.S. 131D-45					
CPR (q24 mos.) last date taken 10A NCAC 13G .0507 10A NCAC 13F .0507 (Need one on duty /shift)					
Personal Care Staff Trng & Comp.(W/I 6mos hire) or qualified exemption 10A NCAC 13G .0501 10A NCAC 13F .0501					
Competency Validation for LHPS Personal Care task prior to doing task 10A NCAC 13G .0504 10A NCAC 13F .0504					
Adm. of 7 or more bed facility currently Certified 10A NCAC 13F .0401					
FCH Adm. Approval letter/cert from DHSR for facility 10A NCAC 13G .0401					
FCH Adm. 15 hr CE annually 10A NCAC 13G .0401					

Notes:

Perpetual Staff Log

For _____
Facility Name

Staff Names ⇒ Items and references ↓					
Medication Staff					
Med Staff & Med Staff Supervisors Date Med Admin Clinical Skills Checklist completed 10A NCAC 13G .0403/.0503 10A NCAC 13F .0403/.0503					
Med Staff & Med Staff Supervisors (employment prior to 10/01/13 OR exempt from required medication training) Date Passed Med Test (W/I 90 days of Validation date) 10A NCAC 13G .0403/.0503 10A NCAC 13F .0403/ .0503					
Med Staff & Med Staff Supervisors hired after 10/01/13 & NOT exempt from required medication training Date 5/10/15 Hour Training Completed GS 131D-4.5B (b)					
Med Staff & Med Staff Supervisors hired after 10/01/13 & NOT exempt from required medication training Date Passed Med Test (W/I 60 days of Validation date) GS 131D-4.5B (b)					
Med Staff & Med Staff Supervisors 6 hours Med CE/yr 10A NCAC 13G .0403 10A NCAC 13F .0403					
Med Staff and Med Staff Supervisors Date Annual Infection Control Training GS 131D-4.5B (a)					
Special Care Unit Staff					
SCU training New employees 20 hr. W/I six months 10A NCAC 13F.1309					

Notes:

Chapter 5

Licensed Health Professional Support

Licensed Health Professional Support

Adult Care Licensure Section
Division of Health Service Regulation

OBJECTIVES

- ▶ To learn about the rules relating to licensed health professional support (LHPS).
- ▶ To assess the quality of LHPS services provided to residents through observation, interview, and record review.
- ▶ To improve the quality of LHPS services through effective interventions.

HISTORY

- ▶ Senate Bill 864 (1996 Session of the General Assembly)
- ▶ To allow unlicensed personnel to perform specific heavy care tasks with Registered Nurse (RN) oversight.

Fundamental Licensed Health Professional Support Rules

▶ 10A NCAC 13F .0903

On-site review and evaluation of the residents' health status, care plan, and care provided related to a particular task.

▶ 10A NCAC 13F .0504

Training and skill validation of staff to ensure they are competent to perform the tasks.

TASKS THAT REQUIRE LHPS REVIEW

- Splints, braces, bandages, dressing changes
- Feeding techniques
- Bowel/bladder programs
- Enemas, suppositories, fecal impactions
- Urinary catheter, fluids, intake/output data
- Oxygen
- Continuous positive airway pressure (CPAP)
- Bi level positive airway pressure (BiPAP)
- Medication administration via injection
- Medication administration via gastrostomy
- Nurse Aide II tasks
- Physical and Occupational Therapy
- Chest physiotherapy/postural drainage
- Pressure ulcers
- Finger stick blood samples
- Colostomy or ileostomy
- Inhalation medication by machine
- Restraints
- Oral suctioning
- Tracheostomy
- Tube feedings
- Heat therapy
- Prosthetic devices
- Ambulation with assistive devices
- Transfers
- Range of motion exercises

G.S. 131D– 2.2 (a)

Adult care homes shall not care for individuals with:

- ▶ Ventilator
- ▶ Continuous nursing care
- ▶ Medical Doctor (MD) certification that placement is no longer appropriate for resident
- ▶ Facility cannot meet the resident's needs
- ▶ Other medical and functional care needs as determined by the Medical Care Commission

RULE UPDATE

10A NCAC 13F .0504 (c)

- ▶ Physician may certify staff on a **TEMPORARY** basis.
- ▶ Prevents unnecessary relocation of an admitted resident.

Who CAN PERFORM LPHS REVIEWS?

10A NCAC 13F .0903(c)

- ▶ Registered Nurse (RN)
- ▶ Occupational and/or Physical Therapist

When ARE REVIEWS TO BE COMPLETED?

The review and evaluation are to be conducted:

- ▶ First 30 days of admission
- ▶ Within 30 days from date resident develops need for task
- ▶ At least QUARTERLY thereafter

Where ARE REVIEWS TO BE COMPLETED?

- ▶ Onsite
- ▶ Reviews are maintained in the facility

What DOES THE REVIEW INCLUDE?

- ▶ Physical assessment of resident
- ▶ Evaluation of care provided
- ▶ Recommended changes
- ▶ Documentation

LHPS Recommendations

- ▶ Documentation of facility response
- ▶ Notification to physician or appropriate health professional

Who CAN VALIDATE LHPS SKILLS?

10A NCAC 13F .0504

- ▶ **RN:**
 - All Tasks
- ▶ **Pharmacist:**
 - Fingertick Blood Test
- ▶ **PT / OT:**
 - Heat Therapy
 - Ambulation with Assistive Devices
 - Range of Motion
 - Transfers and Other Prescribed PT and OT
- ▶ **Respiratory Therapist:**
 - Chest Physiotherapy
 - Medication by Inhalation
 - Oxygen
 - Oral Suctioning
 - Tracheotomy Care

Competency Validation

- ▶ Unlicensed staff must be trained and validated in the specific tasks outlined in paragraphs (a) and (b) of the rule.
- ▶ Training on diabetes provided prior to staff administering insulin.
- ▶ Ongoing competency.

When ARE COMPETENCY VALIDATIONS PERFORMED?

10A NCAC 13F .0504 (a)

- ▶ **PRIOR** to the performance of the task
- ▶ Documented and available

Orienting the LHPS

- ▶ Provide rule book
- ▶ Discuss LHPS rules
- ▶ Information for Adult Home Specialist
- ▶ Information for Division of Health Service Regulation

Review Resident and Staff Needs

- ▶ Identify residents (tracking system)
- ▶ Identify staff that need training and competency validation

Monitoring Tips

- ▶ Are competency validations done prior to staff performing the task?
- ▶ Are return demonstrations done?
- ▶ Are staff knowledgeable in performing tasks?
- ▶ Are staff performing tasks with proficiency?

Monitoring Tips

Did the RN's documentation include the following?

- ▶ Indication of staff competency
- ▶ Physical assessment related to diagnosis and current condition
- ▶ Response to care being provided
- ▶ Recommendations for changes in care if necessary

Monitoring Tips for LHPS

- ▶ **Observations**
What have you seen?
- ▶ **Interview**
What have you heard?
- ▶ **Record Review**
What have you read?
- ▶ **Analysis**
Is there a problem?
What is causing the problem?
What is the impact on residents?

Conclusion

- ▶ Assure safety and accountability
- ▶ Use your available resources
- ▶ Ask questions

OPTIONAL

LICENSED HEALTH PROFESSIONAL SUPPORT 10A NCAC 13 F/G .0903

LHPS reviews for the following tasks may include, but are not limited to the following:

1. Applying and removing ace bandages, ted hose, binders, and braces and splints
 - a. Assessment
 - i. Site of application of ace bandages, binders, braces and splints (note any swelling)
 - ii. Ted Hose smooth and not wrinkled, time applied, time removed?
 - iii. Condition of skin under splints, TEDS, braces, and binders(note irritation/blisters/reddened/painful areas)
 - iv. If splint, note circulation in extremities
 - v. Appliance clean/condition
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
2. Feeding Techniques for residents with swallowing problems
 - a. Assessment
 - i. Type of technique identified (e.g. chin tuck, double swallow, etc.)
 - ii. Lung sounds
 - iii. Appetite
 - iv. Staff assisting with feeding?
 - v. Diet served as ordered (e.g. puree, thickened liquids) medication served with thickened liquids?
 - vi. Alternate foods and fluids frequently?
 - vii. Feeding with tip of spoon?
 - viii. Spoon only half filled?
 - ix. Straw use or non-use?
 - x. Weight
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
3. Bowel or Bladder training programs to regain continence
 - a. Assessment
 - i. How often and amount fluids offered
 - ii. How often toileted
 - iii. How often incontinent
 - iv. If bowel program,
 1. Response to suppositories, enemas, etc.
 2. How often incontinent?
 3. Dietary recommendations (e.g. encourage fluids)
 - v. Condition of skin under briefs?

OPTIONAL

- b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c
4. Enemas, suppositories, break-up and removal of fecal impactions and vaginal douches
- a. Assessment
 - i. Why enemas, suppositories given?
 - ii. Results of enemas, suppositories, and frequency given
 - iii. How often fecal impactions removed?
 - iv. Resident tolerance of procedure
 - v. Vaginal douches—why given, effectiveness, and resident tolerance
 - vi. Observations of vaginal discharge, perineal skin or anal condition
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c
5. Positioning and emptying of urinary catheter bag and cleaning around the urinary catheter
- a. Assessment
 - i. When catheter last changed?
 - ii. Description of urine in bag and tubing (color, amount, exudates?)
 - iii. Leakage around catheter?
 - iv. Frequency of staff cleaning
 - v. Positioning of drainage bag
 - vi. Any treatments for UTI's?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
6. Chest physiotherapy or postural drainage
- a. Assessment
 - i. Lung sounds
 - ii. Description of secretions and amount
 - iii. Coughing/Shortness of breath?
 - iv. Frequency of procedure
 - v. Resident assessment of effectiveness of procedure
 - vi. Hospitalizations or infections?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

OPTIONAL

7. Clean dressing changes, excluding packing wound and application of prescribed enzymatic debriding agents
 - a. Assessment
 - i. Site and type of dressing
 - ii. Frequency of change
 - iii. Description of wound
 - iv. Positioning of resident required?
 - v. Pressure reducing devices used?
 - vi. Home Health involved?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

8. Collecting and testing of finger stick blood samples.
 - a. Assessment
 - i. Blood sugar ranges
 - ii. Skin assessment (open or irritated areas/ circulation in feet)
 - iii. Nail assessment (particularly toenails)
 - iv. Dietary compliance
 - v. Resident understanding of disease
 - vi. Dental problems?
 - vii. Visual problems?
 - viii. Frequency of sliding scale administration if indicated
 - ix. Complaints of peripheral neuropathy?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)
 - a. Assessment
 - i. Description of stoma
 - ii. Description of skin around stoma
 - iii. Description of fecal material in bag
 - iv. Frequency of appliance change
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater
 - a. Assessment

OPTIONAL

- i. Site of ulcer
- ii. When first discovered?
- iii. Description of ulcer
- iv. Home health involvement?
- v. Dressings and/or frequency of change
- vi. Pressure reducing devices?
- vii. Positioning and turning requirement?
- viii. Resident response to treatments
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c.

11. Inhalation by machine

- a. Assessment
 - i. Assessment of Lungs
 - ii. Frequency of Nebulizer treatments
 - iii. Resident response to the treatments
 - iv. Equipment clean and in good working order?
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c.

12. Forcing and restricting fluids

- a. Assessment
 - i. Required amount of fluids to be forced or restricted
 - ii. Resident compliance with order?
 - iii. Recorded amounts forced or restricted?
 - iv. Weights if indicated
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
- d. Documentation of a, b, and c

13. Maintaining accurate intake and output records

- a. Assessment
 - i. Reason for measuring intake and output (e.g. dialysis, CHF)
 - ii. Review of intake and output record
 - iii. Diet compliance if indicated(e.g. NAS)
 - iv. Resident understanding and compliance with measuring intake and output?
 - v. Weights if indicated
- b. Evaluate the resident's progress to the care provided
- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

OPTIONAL

- d. Documentation of a, b, and c.
14. Medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established)
- a. Assessment
 - i. Assessment of skin around tube placement
 - ii. Abdominal assessment to include bowel sounds
 - iii. Resident tolerance of procedure
 - iv. Frequency of medication administration (if applicable)
 - v. Amount of water used to flush tubing
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
15. Medication administration through injection (Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin)
- a. Assessment
 - i. Assessment of injection sites
 - ii. Frequency of injections
 - iii. Response to injection (e.g. Haldol injection---resident behaviors)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c.
16. Oxygen administration and monitoring
- a. Assessment
 - i. Type of oxygen delivery (e.g. tank, concentrator, portable tank, or combinations)
 - ii. Rate of oxygen flow (as ordered)
 - iii. Frequency of administration (self-administration/staff?)
 - iv. Lung assessment
 - v. Resident's response (i.e. able to ambulate to and from DR without SOB)
 - vi. Resident compliant with treatment?
 - vii. Condition/maintenance of equipment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

OPTIONAL

17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints
 - a. Assessment
 - i. Date of restraint order
 - ii. Type of restraint used (least restrictive)
 - iii. Frequency of use
 - iv. Applied correctly?
 - v. How often checked and released
 - vi. Reason for restraint
 - vii. Skin assessment
 - viii. Resident response to restraint
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

18. Oral suctioning
 - a. Assessment
 - i. Reason for suctioning
 - ii. Frequency of suctioning
 - iii. Lung assessment
 - iv. Assessment of mouth
 - v. Resident response to suctioning
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

19. Care of well-established tracheostomy, not to include endotracheal suctioning
 - a. Assessment
 - i. Assessment of stoma and skin surrounding stoma
 - ii. Description and frequency of care involved
 - iii. Assessment of secretions
 - iv. Lung assessment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.

20. Administering and monitoring of tube feedings through a well-established gastrostomy tube
 - a. Assessment
 - i. Assessment of site and skin around site
 - ii. Abdominal assessment

OPTIONAL

- iii. Residuals noted?
 - iv. Lung assessment
 - v. Description of type of tube feeding (e.g. Bolus or continuous and type of formula used)
 - vi. Mouth care provided and assessment of oral mucosa
 - vii. Resident response to procedure
 - viii. Weights
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)
- a. Assessment
 - i. Type of device used (CPAP or BIPAP)
 - ii. Self administer or staff assisted?
 - iii. Resident compliance with order?
 - iv. Resident response to treatment
 - v. Equipment clean and in good working order?
 - b. Evaluate the resident's progress to the care provide
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
22. Application of prescribed heat therapy
- a. Assessment
 - i. Type and frequency of application
 - ii. Site of application
 - iii. Assessment of skin after prescribed heat therapy
 - iv. Resident response to treatment
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
23. Application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity
- a. Assessment
 - i. Type of prosthetic
 - ii. Resident compliant with use of prosthetic?
 - iii. Assessment of stump
 - iv. Length of time worn
 - v. Any problems with prosthesis?
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

OPTIONAL

- d. Documentation of a, b, and c.
24. Ambulation using assistive devices that requires physical assistance
- a. Assessment
 - i. Type of assistive device required (slide board, walker, waist belt)
 - ii. Type of help required in use of assistive device (e.g. 1 person stand by assist)
 - iii. Frequency of staff assistance required
 - iv. Resident response to ambulation (e.g. resident able to ambulate approximately 500 feet with 1 person stand by assist)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
25. Range of motion exercises
- a. Assessment
 - i. Frequency of ROM exercises
 - ii. Active, Assistive or Passive ROM
 - iii. What extremities involved?
 - iv. Evaluation of movement of affected area
 - v. Assessment of any contracture
 - vi. Response to ROM exercises
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b and c.
26. Any prescribed physical or occupation therapy
- a. Assessment
 - i. Type of therapy prescribed
 - ii. Frequency of therapy
 - iii. Therapy provided by PT or OT?
 - iv. Resident response to therapy (e.g. able to ambulate to DR with stand by assist only)
 - b. Evaluate the resident's progress to the care provided
 - c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
27. Transferring semi-ambulatory or non-ambulatory residents
- a. Assessment
 - i. Type of transfer (e.g. Hoyer lift, bed to chair, etc.)
 - ii. Number of people required for transfer
 - iii. Resident tolerance, response to transfers
 - b. Evaluate the resident's progress to the care provided

OPTIONAL

- c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
 - d. Documentation of a, b, and c.
28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.
- a. www.ncbon.com/

Optional Form
LICENSED HEALTH PROFESSIONAL SUPPORT
INITIAL EVALUATION & QUARTERLY REVIEW OF RESIDENTS

RESIDENT: _____ **DATE OF BIRTH:** _____ **ROOM:** _____

DATE OF EVALUATION: _____ **DATE OF LAST EVALUATION:** _____

PRIMARY DIAGNOIS: _____ **OTHER Dx.:** _____

HEIGHT: ____ **WEIGHT:** ____ **PULSE RATE:** ____ **TEMP.:** ____ **RESPIRATION:** ____ **BP:** ____

Personal care tasks currently present: (check all that apply)

<input type="checkbox"/> Applying and removing ace bandages, ted hose, binders, and braces and splints	<input type="checkbox"/> Feeding techniques for residents with swallowing problems	<input type="checkbox"/> Bowel or bladder training programs to regain continence	<input type="checkbox"/> Enemas, suppositories and vaginal douches
<input type="checkbox"/> Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter	<input type="checkbox"/> Chest physiotherapy or postural drainage	<input type="checkbox"/> Clean dressing changes excluding packing wounds & application of prescribed enzymatic debriding agents	<input type="checkbox"/> Collecting and testing of fingerstick blood samples
<input type="checkbox"/> Care of well-established colostomy or ileostomy	<input type="checkbox"/> Care for pressure ulcers up to and including a Stage II pressure ulcer	<input type="checkbox"/> Inhalation medication by machine	<input type="checkbox"/> Forcing and restricting fluids
<input type="checkbox"/> Maintaining accurate intake and output data	<input type="checkbox"/> Medication administration through a well established gastrostomy feeding tube	<input type="checkbox"/> Medication administration through injections	<input type="checkbox"/> Oxygen administration and monitoring
<input type="checkbox"/> Care of residents who are physically restrained and the use of care practices as alternatives to restraints	<input type="checkbox"/> Care of well-established tracheostomy	<input type="checkbox"/> Administering and monitoring of tube feedings through a well-established gastrostomy tube	<input type="checkbox"/> Monitoring of continuous positive air pressure devices (CPAP and BIPAP)
<input type="checkbox"/> Application and removal of prosthetic devices	<input type="checkbox"/> Ambulation using assistive devices that requires physical assistance	<input type="checkbox"/> Range of motion exercises	<input type="checkbox"/> Any other prescribed physical or occupational therapy
<input type="checkbox"/> Transferring semi-ambulatory or non-ambulatory residents	<input type="checkbox"/> Application of prescribed heat therapy	<input type="checkbox"/> Tasks performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under the act in 21 NCAC 36	<input type="checkbox"/> Oral Suctioning

Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care:

Changes and follow up recommended to meet the Resident's Needs:

LHPS Personal Care Task Provided

Staff Competency Validated

yes _____ no _____
 yes _____ no _____
 yes _____ no _____
 yes _____ no _____

Signature/Title _____

Date: _____

Note: The facility shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring, but not limited to, one or more of the above tasks.

EXAMPLE: paranoid schizophrenia NIDDM

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name _____ Date of Evaluation 4/05/12
Mr. Very Pleasant Resident _____ Date of Last Evaluation 12/14/11

Review of Health Status and Care Provided--Physical Assessment as related to
Diagnoses/Current condition

Receives Risperdol Consta 37.5mg. injections every 2 weeks. Dosage was increased from 25mg. last month. Shots given by ACT team nurse. Resident compliant with injection appointments and lab work. even though he states he does not believe he needs these injections. Resident is alert and oriented X3. Resident still has delusions about his deceased mother visiting him. Reports the frequency of the voices is decreasing. Resident is easily re-directed when he becomes agitated. No outbursts observed by staff this quarter.
Resident has gained 3 lbs this quarter (Jan, Feb, Mar 2012) Weight today 223 lbs. Resident and staff report non-compliant with NCS diet.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue to encourage compliance with NCS diet, healthy snacking. Monitor for additional weight gain. Report changes in behavior and additional weight gain to MD.

LHPS Personal Care Task Provided	Staff Competency Validated	
Injection	YES X	NO

Signature/title Mrs. Good Nurse RN

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

EXAMPLE: Resident with diagnosis of diabetes and lung disease

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name _____ Date of Evaluation 4/05/12
Mr. Pleasant Resident _____ Date of Last Evaluation 12/14/11

Review of Health Status and Care Provided--Physical Assessment as related to
Diagnoses/Current condition

Finger sticks ordered BID and recorded on the March 2006 MAR at -
7:30am and 4:30pm. FSBS range from 98-150. No skin problems noted,
good circulation in feet, nails clean and trimmed. Insulin injection daily
controls blood sugar. Staff and Resident reveal compliance with NCS
diet. No visual or dental complaints.

No complaints of shortness of breath, lungs clear, no wheezes noted.
Nail beds pink, gets Nebulizer treatment at 8:00am and 8:00pm
Resident is not using prn inhalers.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue FSBS checks as ordered

LHPS Personal Care Task Provided	Staff Competency Validated	
FSBS	YES X	NO
Injection	YES X	NO
Nebulizer	YES X	NO

Signature/title Mrs. Good Nurse RN

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

Optional Form
**LICENSED HEALTH PROFESSIONAL SUPPORT
 INITIAL EVALUATION & QUARTERLY REVIEW OF RESIDENTS**

RESIDENT: _____ **DATE OF BIRTH:** _____ **ROOM:** _____

DATE OF EVALUATION: _____ **DATE OF LAST EVALUATION:** _____

PRIMARY DIAGNOIS: _____ **OTHER Dx.:** _____

HEIGHT: ____ **WEIGHT:** ____ **PULSE RATE:** ____ **TEMP.:** ____ **RESPRIATION:** ____ **BP:** ____

Personal care tasks currently present: (check all that apply)

<input type="checkbox"/> Applying and removing ace bandages, ted hose, binders, and braces and splints	<input type="checkbox"/> Feeding techniques for residents with swallowing problems	<input type="checkbox"/> Bowel or bladder training programs to regain continence	<input type="checkbox"/> Enemas, suppositories and vaginal douches
<input type="checkbox"/> Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter	<input type="checkbox"/> Chest physiotherapy or postural drainage	<input type="checkbox"/> Clean dressing changes excluding packing wounds & application of prescribed enzymatic debriding agents	<input type="checkbox"/> Collecting and testing of fingerstick blood samples
<input type="checkbox"/> Care of well-established colostomy or ileostomy	<input type="checkbox"/> Care for pressure ulcers up to and including a Stage II pressure ulcer	<input type="checkbox"/> Inhalation medication by machine	<input type="checkbox"/> Forcing and restricting fluids
<input type="checkbox"/> Maintaining accurate intake and output data	<input type="checkbox"/> Medication administration through a well established gastrostomy feeding tube	<input type="checkbox"/> Medication administration through injections	<input type="checkbox"/> Oxygen administration and monitoring
<input type="checkbox"/> Care of residents who are physically restrained and the use of care practices as alternatives to restraints	<input type="checkbox"/> Care of well-established tracheostomy	<input type="checkbox"/> Administering and monitoring of tube feedings through a well-established gastrostomy tube	<input type="checkbox"/> Monitoring of continuous positive air pressure devices (CPAP and BIPAP)
<input type="checkbox"/> Application and removal of prosthetic devices	<input type="checkbox"/> Ambulation using assistive devices that requires physical assistance	<input type="checkbox"/> Range of motion exercises	<input type="checkbox"/> Any other prescribed physical or occupational therapy
<input type="checkbox"/> Transferring semi-ambulatory or non-ambulatory residents	<input type="checkbox"/> Application of prescribed heat therapy	<input type="checkbox"/> Tasks performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under the act in 21 NCAC 36	<input type="checkbox"/> Oral Suctioning

Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care:

Changes and follow up recommended to meet the Resident's Needs:

LHPS Personal Care Task Provided

Staff Competency Validated

yes ____ **no** ____

yes ____ **no** ____

yes ____ **no** ____

yes ____ **no** ____

Signature/Title _____

Date: _____

Note: The facility shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring, but not limited to, one or more of the above tasks.

**Skills/Competency Evaluation
(Licensed Health Professional Support)**

Optional Form

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
1. Applying and removing ace bandages, Ted hose, binders, and braces, and splints					
2. Feeding techniques for residents with swallowing problems					
3. Bowel or bladder training programs to regain continence					
4. Enemas, suppositories, breaking up of fecal impactions and vaginal douches					
5. Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter					
6. Chest physiotherapy or postural drainage					
7. Clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents					
8. Collecting and testing of fingerstick blood samples					
9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)					
10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater					
11. Inhalation medication by machine					
12. Forcing and restricting fluids					
13. Maintaining accurate intake and output date					
14. Medication administration through a well established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established.)					
15. Medication administration through injection (sub q only)					
16. Oxygen administration and monitoring					
17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints					
18. Oral suctioning					
19. Care of well established tracheostomy, not to include indo-tracheal suctioning					

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
20. Administering and monitoring of tube feedings through a well established gastrostomy tube (see description in Subparagraph (14))					
21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)					
22. Application of prescribed heat therapy					
23. Application and removal of prosthetic devices except as used in early postoperative treatment for shaping of the extremity					
24. Ambulation using assistive devices that requires physical assistance					
25. Range of motion exercises					
26. Any other prescribed physical or occupational therapy					
27. Transferring semi-ambulatory or non-ambulatory residents					
28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36					

Additional Tasks List Below					

Instructor's Initials _____ **Name & Title** _____ **Instructor's Initials** _____ **Name & Title** _____

EMPLOYEE SIGNATURE _____ **DATE:** _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____

OPTIONAL

Tracking Tool

(Administrator/designee's use)

10A NCAC 13F/G .0903 Licensed Health Professional Support

- (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following
- (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the onsite review and evaluation of the residents' health status, care plan and care provided as required in Paragraph(a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter

FACILITY: _____

RESIDENT: _____

Administrator/Designated Staff

Signature (completing check sheet) _____ **Date:** _____

Date referred to RN: _____ **Date referred to OT or PT:** _____

Name of RN: _____ **Name of PT/OT:** _____

CHECK ALL TASKS REQUIRED

- applying and removing ace bandages, ted hose, binders, braces and splints
- feeding techniques for residents with swallowing difficulties
- bowel or bladder training programs to regain continence
- enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches
- positioning & emptying of the urinary catheter bag and cleaning around the urinary catheter
- chest physiotherapy or postural drainage
- clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents
- collecting and testing of fingerstick blood samples
- care of well-established colostomy or ileostomy
- care for pressure ulcers up to and including Stage II pressure ulcer
- inhalation medication by machine
- forcing and restricting fluids
- maintaining accurate intake and output data
- medication administration through gastrostomy feeding tube
- medication administration through injections (subcutaneous, excluding anticoagulants)
- oxygen administration and monitoring
- restraints
- oral suctioning
- tracheostomy care (not to include endotracheal suctioning)
- tube feedings through established gastrostomy tube
- CPAP or BiPap
- heat therapy
- application or removal of prosthetic devices
- ambulation using assistive devices that require physical assistance
- transferring semi-ambulatory or non-ambulatory residents

TEMPORARY LICENSED HEALTH PROFESSIONAL SUPPORT TASK
PHYSICIAN'S CERTIFICATION

Resident's Name _____

Facility _____

I certify that the **NON-LICENSED** facility staff may be competency validated by an appropriate licensed health professional, according to Rule 10A NCAC 13F .0504 or 13G .0504, to perform (*please specify task below*)

on a **temporary** basis for: _____ one day

_____ up to seven days

_____ up to thirty days

MD Signature _____ Date _____

OPTIONAL

This check list has been developed as a tool to evaluate and monitor areas pertaining to Licensed Health Professional Support in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based. Items on the checklist that are recommendations may prevent problems from developing but do not have a licensure regulation referenced.

10A NCAC 13F/G .0903 Licensed Health Professional Support

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
<p>1. The facility has an appropriate LHPS that participates in the on-site review and evaluation of resident's health status, care plan and care provided requiring one or more of the 28 personal care task(s) outlined in rule 10 A NCAC 13 F/G .0903 (a)(b)</p>			
<p>2. The evaluation is on site and hands on 10A NCAC 13F/G .0903 (c)</p>			
<p>3. The evaluation is completed within the first 30 days of admission or within 30 days of developing the task 10A NCAC 13F/G .0903(c)</p>			
<p>4. The evaluation is performed at least quarterly thereafter 10A NCAC 13 F/G .0903 (c)</p>			
<p>5. The evaluation contains the following: 10A NCAC 13F/G .0903 (c)(1)(2)(3)(4)</p> <ul style="list-style-type: none"> • Performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of the Rule 			

OPTIONAL

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
<ul style="list-style-type: none"> • Evaluating the resident’s progress to care being provided • Recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and • Documenting the activities in Subparagraphs (1) through (3) outlined above. 			
6. Action is taken in response to the LHPS review 10A NCAC 13F/G .0903 (d)			
7. Documentation of the facility response to the recommendation is available for review 10A NCAC 13F/G .0903 (d)			
8. The physician or appropriate health profession is informed of the recommendations when necessary 10A NCAC 13F/G .0903 (d)			
9. There is a system in place to identify residents’ requiring the LHPS review			
10. There is a system in place to notify the LHPS nurse of the new task or a new admission with a task			
11. There is a system in place to assure the reviews are completed timely.			
12. There is a system in place to assure the reviews contained the required information			

OPTIONAL

	<i><u>Yes</u></i>	<i><u>No</u></i>	<i><u>COMMENTS</u></i>
13. There is a system in place to ensure the LHPS nurse has a copy of the rules and understand the requirements.			
14. System to verify license of RN performing LHPS			

Chapter 6

Healthcare

Monitoring Healthcare

Adult Care Licensure Section
Division of Health Service Regulation

Objectives

- I. Demonstrate knowledge of the rules pertaining to health care.
- II. Demonstrate the ability to monitor for compliance.

Planning & Preparing to Monitor

- Review rule areas
- Review previous monitoring and incident reports
- Monitoring materials

Fundamental Health Care Rules

- ❑ 10A NCAC 13F .0902(a)
- ❑ 10A NCAC 13F .0902(b)
- ❑ 10A NCAC 13F .0902(c)(1)(2)
- ❑ 10A NCAC 13F .0902(c)(3)(4)
- ❑ 10A NCAC 13F .0902(d)(1)(2)

How to Monitor Health Care

- ❑ Observations *FL-2*
MAR
- ❑ Interviews *DMA 3050-R*
- ❑ Record Review *Progress Notes*
Hospital Records
Home Health Notes
PT & OT Notes

10A NCAC 13F .0902(a)

An adult care home shall provide care and services in accordance with the resident's care plan.

10A NCAC 13F .0902(b)

The facility shall assure referral and follow up to meet the routine and acute health care needs of residents.

Routine Health Care Needs

- Lab work
- Doctor appointments
- Referrals to Mental Health, PT, OT or Podiatry

10A NCAC 13F .0902(c)(1)(2)

1. The facility shall assure documentation of the following in the resident's record:
 - Contacts with the resident's physician
 - Physician service
 - Other LHP including mental health
- &**
2. All visits of the resident to or from the resident's physician, physician service or other LHP, including mental health, of which the facility is aware.

10A NCAC 13F .0902(c)(3)(4)

- 3. Documentation of written procedures, treatments or orders from a physician or other LHP.
- 4. Implementation of procedures, treatments or orders.

10A NCAC 13F .0902(d)(1)(2)

- 1. The resident or responsible person shall be allowed to choose a physician or physician service to attend the resident.
- 2. Ensuring that another physician is secured within 45 days when they are no longer able to remain under the care of their medical doctor.

Next Steps

- Conduct entrance conference with Administrator or Supervisor in Charge
- Explain purpose of visit
- Request primary contact person
- Request specific information (resident roster, staffing schedule)
- Quiet place to work
- Approximate length of visit

Then...

- ❑ Tour facility and choose most appropriate residents for sample
- ❑ Observe residents and staff
- ❑ Record review:
 - FL-2s, MARs, DMA 3050-R, Progress Notes, Hospital Records, Home Health
 - Notes, LHPS Reviews

Putting it All Together

- | | |
|---|--|
| ❑ Record Review
What have you read? | ❑ Observation
What have you seen? |
| ❑ Interview
What have you heard? | ❑ Analysis
Is there a problem?
What is causing the problem?
What impact does it have on the residents? |

Don't Forget!

- ❑ Have you used all appropriate methods of investigation?
- ❑ Do you have all the necessary information?
- ❑ Is your sample sufficient and well chosen?
- ❑ Did you find rule deficiencies?
- ❑ What is the scope and severity of your findings?
- ❑ What impact does it have on the residents?

The End

- Exit
- Appropriate Reports
- Follow-Up

Resources

- ▶ Form 4625 Labs
- ▶ Form 4626 Medical Appointments
- ▶ Form 4636 Health Care Check List

Team 1
Health Care 10A NCAC 13F/G .0902 (b)
Facility Census 53

You are in the facility on May 7, 2015 monitoring health care.

Resident #23 is in your sample.

Let's say you reviewed 5 records and 3 records had problems with health care. (2 were finger stick blood sugar, 1 lab not done)

Resident #23 had physician orders to check blood sugar twice a day and to call the physician if the value was less than 60 or greater than 450.

Review of the resident's Medication Administration Records (MARs) for February and March 2015 revealed on 15 different days, the resident's blood sugar was not recorded. Three days in March on the 6th, 12th, and the 15th at 7:30am revealed blood sugars greater than 450. There was no documentation the physician had been notified.

- A. Explain your investigation process. Start with the tour; pick a sample; who will that include? Record Reviews (what), Interviews (who)? Other contacts?

- B. Is there deficient practice? How did you determine this?

- C. Determine what the level of deficiency will be. How did you determine this?

- D. Write your deficient practice statement below.

OPTIONAL FORM

MEDICAL APPOINTMENTS

NAME OF RESIDENT	NAME OF PHYSICIAN, LAB, HOSPITAL, ETC.	DATE AND TIME OF APPOINTMENT	PAPER WORK SENT WITH RESIDENT	INITIALS OF STAFF
		Date: Time:		

OPTIONAL

This Check list has been developed as a tool to evaluate and monitor areas pertaining to the Health Care rule in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based. Items on the checklist that are recommendations that may prevent problems from developing do not have a licensure regulation referenced.

10A NCAC 13F/G .0902 HEALTH CARE

- (a) An adult care home shall provide care and services in accordance with the resident’s care plan.
- (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.
- (c) The facility shall assure documentation of the following in the resident’s record:
 - (1) facility contacts with the resident’s physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care.
 - (2) all visits of the resident to or from the resident’s physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware.
 - (3) written procedures, treatments or orders from a physician or other licensed health professional; and
 - 4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule
- (d) The follow shall apply to the resident’s physician or physician service
 - (1) The resident or the resident’s responsible person shall be allowed to chooses a physician or physician service to attend the resident.
 - (2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

	Yes	No	Comments
1. The facility provides care and services in accordance with the resident’s care [;am 10A NCAC 13F/G .0902(a)			
2. The facility assures referral and follow up to meet the routine health care needs of the resident 10A NCAC 13F/G .0902(b)			
3. The facility assures referral and follow up to meet the acute health care needs of the resident 10A NCAC 13F/G .0902(b)			

OPTIONAL

	Yes	No	Comments
<p>4. The facility documents the following in the residents record: 10A NCAC 13F/G .0902(c)</p> <ul style="list-style-type: none"> • Facility contact with the resident’s physician, physician service or other licensed health professional regarding resident care • Facility contacts with the resident’s physician, physician service or other licensed health professional when illness/ accidents occur • Documentation of all visits of the resident to or from the resident’s physician, physician service, or other licensed health professional of which the facility is aware • Documentation of written procedures, treatments or orders from a physician or other licensed health professional • Implementation of procedures 			
<p>5. The follow shall apply to the resident’s physician or physician service: 10A NCAC 13F/G .0902(d)</p> <ul style="list-style-type: none"> • The resident or the resident’s responsible person was allowed to choose a physician or physician service to attend the resident • If the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan 			
<p>6. There is a system in place to assure care plans are current and reflect the resident care needs</p>			
<p>7. There is a system in place to identify residents requiring lab work</p>			

OPTIONAL

	Yes	No	Comments
8. There is a system in place to assure residents lab work is drawn			
9. There is a system in place to assure follow up appointments are kept			
10. There is a system in place to receive and carry out new orders			
11. There is a system in place to assure treatments are done as ordered.			
12. There is a system in place to assure FSBS are done as ordered			
13. There is a system in place to assure weights are done as ordered.			

Chapter 7

Personal Care and Supervision

MONITORING PERSONAL CARE & SUPERVISION

Adult Care Licensure Section
Division of Health and Human Services

Objectives

- Demonstrate knowledge of the rules pertaining to personal care, accident and incident reporting, restraints, resident assessment, and care planning.
- Demonstrate the ability to monitor for compliance in these rule areas.

Personal Care & Supervision
10A NCAC 13F .0901

Reporting of Accidents & Incidents
10 NCAC 13F.1212

Use of Physical Restraints & Alternatives
10A NCAC 13F.1501

Resident Assessments & Care Plans
10A NCAC 13F .0801/.0802

**Personal
Care &
Supervision
10A NCAC
13F.0901**

- Provide personal care to residents according to residents' care plan.
- Provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms.
- Respond immediately in case of incident or accident and provide care and intervention according to the facility's policies and procedures.

**Accident &
Incident
Reporting
10 NCAC
13F.1212**

- An adult care home shall notify the County Department of Social Services of any accident or incident resulting in resident **death** or accident or incident resulting in **injury** to a resident requiring referral for **emergency medical evaluation or medical treatment** (other than first aid).

Reportable Incident – Yes or No?

- | | |
|--|---------------------------|
| • Skin Tear? | • No |
| • A Fall? | • If injury occurs |
| • Theft of Personal Belongings? | • No |
| • Leaving the Locked Unit and Going to the Yard? | • If considered elopement |
| • Visit to the Emergency Room for Treatment of Chest Pain? | • No |
| • Abuse of a Resident by a Staff Person? | • Yes |

Use of Physical Restraints & Alternatives 10A NCAC 13F .1501

- An adult care home shall assure that a physical restraint are only used when absolutely necessary and in compliance with all rule requirements.

What are restraints?

• Physical Restraints

- devices **attached to** or **adjacent to** the resident's body that the resident cannot remove easily
- Intended to **restrict freedom of movement** or normal access to one's body

• Chemical Restraints

- medications such as antipsychotics, anxiolytics, and sedatives used to control behavior

• Examples

- Geri-chairs (chairs with locking lap trays)
- Geri-tents
- Side rails used to keep resident in bed
- Posey vests
- Lap belts (that resident cannot remove)

What are enablers?

Enablers are assistive devices used to enhance the resident's functional abilities.

- Side rails used **to increase** a resident's **mobility**
- Geri-chairs used for **positioning**
- Lap belts that the resident **can remove**
- Wheelchair seatbelts that the resident **can operate**
- Pillows used for **positioning**

Monitoring Assessments & Care Plans
10A NCAC 13F .0801/.0802

- Observation
- Interview
- Record Review
- FL-2
- DMA 3050-R
- Progress Notes
- Hospital Records
- Home Health Notes

Resident Assessment
10A NCAC
13F .0801

- Initial assessment must be completed within 72 hours of admission.
- DMA 3050-R must be completed within 30 days of admission and annually thereafter.
- Complete following a significant change within 10 days.

Significant Change
10A NCAC
13F .0801
(c)(1)(d)

- Requires a referral to a mental health professional, RN, MD or other licensed health professional following a significant change.
- This referral must occur within a timely manner consistent with the resident's condition. Not to exceed 10 days from the change and be documented.
- Deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic.

Significant Change – Yes or No?

- Skin Tear? • No
- Antibiotic Therapy? • No
- Change in ability to dress oneself? • Yes
- Change in ability to walk or transfer from wheelchair? • Yes
- Urinary Tract Infection? • No
- Change from continence to incontinence? • Yes

Resident Care Plan 10A NCAC 13F .0802

- An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be **completed within 30 days following admission.**
- The care plan is an individualized written program of personal care for each resident, revised as needed based on further assessments.

Resident Care Plan 10 NCAC 13 F/G .0802(f)

- The facility shall assure the care plan for each resident under the care of a provider of mental health, developmental disabilities or substance abuse services includes resident specific instructions regarding how to contact the provider, including emergency contact.
- See rule 10 NCAC 13 F/G .0801(c) (1)(D) and rule 10 NCAC 13 F/G 10 NCAC 13 F/G .0801(d)

Resident Care Plan shall include:

- Statement of care / services to be provided and frequency.
- Signature of assessor upon completion of care plan.
- Signature of physician within 15 calendar days of completion authorizing services and certifies:
 - The resident under the physician's care.
 - The resident has a medical diagnosis with associated physical/mental limitations that justifies the personal care services in the care plan.

Resources

- DMA 3050 – Adult Care Home Personal Care Physician Authorization & Care Plan
- Self-Instructional Manual for Adult Care Homes

Team 2
Personal Care and Supervision
10A NCAC 13F/G .0901 (b)
Facility Census 60

You are in the facility on May 7, 2015 monitoring Personal Care and Supervision (PC&S).

Resident #14 is in your sample

Let's say you reviewed 4 records and this was the only resident with falls and elopement issues.

Resident #14 was admitted to the facility on March 3, 2015 after being hospitalized for mental status change. From March 3, 2015 to May 7, 2015, the day of the survey, the resident has fallen 11 times and left the facility unsupervised 1 time. One fall required Resident #14 to be transported to the local emergency room.

- A. Explain your investigation process. Start with the tour; pick a sample; who will that include? Record Reviews (what), Interviews (who)? Other contacts?

- B. Is there deficient practice? How did you determine this?

- C. Determine what the level of deficiency will be. How did you determine this?

- D. Write your deficient practice statement below

**ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN**

Assessment Date ___/___/___
Reassessment Date ___/___/___
<input type="checkbox"/> Significant Change ___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ___ DOB ___/___/___ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN ___/___/___

ASSESSMENT

1. MEDICATIONS - Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	(✓) If Self-Administered
				<input type="checkbox"/>

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

<input type="checkbox"/> Wandering <input type="checkbox"/> Verbally Abusive <input type="checkbox"/> Physically Abusive <input type="checkbox"/> Resists care <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Disruptive Behavior/ Socially Inappropriate	<input type="checkbox"/> Injurious to: <input type="checkbox"/> Self <input type="checkbox"/> Others <input type="checkbox"/> Property Is the resident currently receiving medication(s) for mental illness/behavior? <input type="checkbox"/> YES <input type="checkbox"/> NO Is there a history of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Developmental Disabilities (DD) <input type="checkbox"/> Mental Illness	Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? <input type="checkbox"/> YES <input type="checkbox"/> NO Has a referral been made? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>If YES:</u> Date of Referral _____ Name of Contact Person _____ Agency _____
---	--	--

Social/Mental Health History: _____

Resident _____

3. AMBULATION/LOCOMOTION: No Problems Limited Ability Ambulatory w/ Aide or Device(s) Non-Ambulatory
Device(s) Needed _____
Has device(s): Does not use Needs repair or replacement
4. UPPER EXTREMITIES: No Problems Limited Range of Motion Limited Strength Limited Eye-Hand Coordination
Specify affected joint(s) _____ Right Left Bilateral
 Other impairment, specify _____

Device(s) Needed _____ Has device(s): Does not use Needs repair or replacement
5. NUTRITION: Oral Tube (Type) _____ Height _____ Weight _____
Dietary Restrictions: _____

Device(s) Needed _____
Has device(s): Does not use Needs repair or replacement
6. RESPIRATION: Normal Well Established Tracheostomy Oxygen Shortness of Breath
Device(s) Needed _____ Has device(s): Does not use Needs repair or replacement
7. SKIN: Normal Pressure Areas Decubiti Other _____
Skin Care Needs _____

8. BOWEL: Normal Occasional Incontinence (less than daily) Daily Incontinence
 Ostomy: Type _____ Self-care: YES NO
9. BLADDER: Normal Occasional Incontinence (less than daily) Daily Incontinence
Catheter: Type _____ Self-care: YES NO
10. ORIENTATION: Oriented Sometimes Disoriented Always Disoriented
11. MEMORY: Adequate Forgetful - Needs Reminders Significant Loss - Must Be Directed
12. VISION: Adequate for Daily Activities Limited (Sees Large Objects) Very Limited (Blind); Explain _____
Uses: Glasses Contact Lens Needs repair or replacement
Comments _____

13. HEARING: Adequate for Daily Activities Hears Loud Sounds/Voices Very Limited (Deaf); Explain _____
 Uses Hearing Aid(s) Needs repair or replacement
Comments _____
14. SPEECH/COMMUNICATION METHOD: Normal Slurred Weak Other Impediment No Speech
 Gestures Sign Language Writing Foreign Language Only _____ Other None
 Assistive Device(s) (Type _____) Has device(s): Does not use Needs repair or replacement

Resident _____

INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

RESIDENT INFORMATION: In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

DATE OF MOST RECENT EXAMINATION: Includes a yearly physical by the resident's attending physician.

ASSESSMENT:

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.
2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.
 - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.
 - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

TOP OF SECOND PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.
4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.
5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.
6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.
7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.
8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.
10. **ORIENTATION:** Check appropriate box.
11. **MEMORY:** Check appropriate box.
12. **VISION:** Check appropriate box. Expand on concerns in comments area.
13. **HEARING:** Check appropriate box. Expand on concerns in comments area.
14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

TOP OF THIRD PAGE: RESIDENT _____ : Place name as on Medicaid ID card in this blank.

CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

ACTIVITIES OF DAILY LIVING: Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

ASSESSOR CERTIFICATION: Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

PHYSICIAN AUTHORIZATION: The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.

Chapter 8

Food Service

Quality Without Question: Focus on Food Service



**Division of Health Service Regulation
Adult Care Licensure Section**

Objectives

To demonstrate an understanding of:

- The responsibility outlined in the nutrition and food service rules
- How to use observation, record review, and interview to assess quality of services provided to residents
- Effective interventions to improve the quality of food service management

Food Procurement and Safety

- **.0904 (a)(1)** The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination
- **.0904 (a)(2)** All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination



Sanitation Inspection

- **.0306 (a)(4)** Adult Care Homes shall have a NC Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and a NC Division of Environmental Health sanitation score of 85 or above at all times in facilities with 13 beds or more



Sanitation Inspection

- Look for posted sanitation grade
- Ask for copy of sanitation report
- Compare sanitation report to what you observe in kitchen and dining room



Meet Cook and Kitchen Staff

- Introduce yourself and let staff know why you are there
- Develop a rapport with kitchen staff
- Try to put staff at ease



Ask Questions

- What are you cooking today?
- Where is your diet list?
- Can I see your regular and therapeutic menus?
- Do you have any residents who need feeding assistance or eat in their rooms?
- Do you have any residents who require thickened liquids?



Diet List

- **.0904 (e)(3)** The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff
- Diet list must be current, list each resident, and the therapeutic diet as prescribed by the physician



Therapeutic Diet List for Butterfields Assisted Living

- **NO CONCENTRATED SWEETS**
Carolyn A.
Myrtle W.
- **MECHANICAL SOFT**
John G.
Lyle B.
- **PUREED**
Foster C.
- **RENAL**
April B.
- **2200 CALORIE ADA**
May G.



Menus

- **.0904 (c)(2)** Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff
- Menus should not be in the Administrator's office on a shelf!
- Regular menus **do not** have to be signed by a Registered Dietician



Therapeutic Menus

- **.0904 (c)(6)** Menus for all therapeutic diets shall be planned or reviewed by a Registered Dietitian. The facility shall maintain verification of the Registered Dietitian's approval of therapeutic diets which shall include an original signature and registration number of the Dietitian.



Substitutions

- **.0904 (c)(3)** Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets, and documented to indicate the foods actually served to residents
- Substitutions must be documented on a substitution log



Substitutions

Substitutions must:

- Stay in the same food group
- Examples:
 - Only citrus fruit or juice is a substitute for citrus fruit or juice
 - Orange juice – substitute – grapefruit juice
 - Collard greens – substitute – turnip greens
 - Oatmeal – substitute - grits



Why did we ask questions?

- We need a sample of residents
- We want residents on therapeutic diets, thickened liquids, and residents who require feeding assistance
- We want the most challenging residents



Refrigeration Units

- Refrigerated units should be at a temperature not to exceed 45°F
- Raw meat/fresh eggs are not stored over ready to eat foods in refrigerator
- Leftovers appropriately stored, labeled, and dated
- No spoiled food in refrigerators



Thawing Foods

- **Food should be thawed using the following techniques:**
 - Under potable running water of a temperature of 70°F
 - Part of conventional cooking process



Thawing Foods

- In a microwave oven only when food will be immediately transferred to conventional cooking equipment as part of a continuous cooking process or when the entire, uninterrupted cooking process takes place in the microwave oven
- May be thawed in the refrigerator



3-Day / 5-Day Food Supply

- **.0904 (a)(4)** There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets

3-Day Supply of Perishable Food

- Perishable food is usually foods that require refrigeration
- If your menu calls for milk, orange juice, butter, etc. ensure you have enough of each item to cover all residents for 3 days

3-Day Supply of Perishable Food

Example:

- Milk: 1 cup (8 ounces) twice a day
- Your facility has 20 residents
- $20 \text{ (residents)} \times 16 \text{ oz/day} = 320 \text{ ounces}$

3-Day Supply of Perishable Food

- There are 128 ounces in 1 gallon of milk
- $320 \div 128 = 2.5$ gallons of milk needed/day
- If you need a 3-day supply you will need $2.5 \text{ (gallons)} \times 3 \text{ (days)} = 7.5$ gallons of milk

5-Day Supply of Non-Perishable Food

- Non-perishable food is usually food that does not require refrigeration
- Examples: canned fruit, vegetables, cake mixes, cereal, etc.

Food Preparation and Service

- **.0904 (b)(1)**: Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service
- Ensure you have sufficient staff for the number of residents you have in your facility

Food Preparation and Service

- **Ensure all equipment is working properly:**
 - Leaking refrigerators/freezers
 - Leaking sinks/dishwashers
 - Refrigerators/freezers should have thermometers



Dishwasher

- Dishwasher should be equipped with wash, rinse, and sanitizer. If sanitizer is not available, dishwasher should be equipped with a booster of 170°F



3 Compartment Sink

Applies to facilities with 12 or more beds

- 1st Compartment – Wash water
- 2nd Compartment – Rinse water
- 3rd Compartment – Sanitize
 - Chlorine – 50 PPM
 - Iodophor products – 12.5 PPM (Iodine - not commonly used)
 - Quaternary ammonium products – 200 PPM (sanitizing solution requires a test strip)



What is the Cook Doing?

- **While we are checking out the kitchen we still have one eye on the cook!**
 - Is she frying/baking/broiling?
 - What types of seasoning is she using?
 - Does she have no added salt or no added sweet products to prepare her meal as stated on the menus?
 - Did she wash her hands?
 - Is her hair covered?



Observation of Meal Service

- **.0904 (b)(2):** Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers
- Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident



Observation of Meal Service

- **.0904 (b)(3):** Hot foods shall be served hot and cold foods shall be served cold
 - Hazardous foods requiring cooking shall be cooked to heat all parts of the food to a temperature of at least 140°
 - Mechanical soft, pureed diets ensure that there is a continuous heat source until the plate is served to the resident



Observation of Meal Service

- **What are we writing?**
 - Document start and end times of meal service
 - How long it takes to plate the meal until it reaches the resident
 - What the resident actually receives
 - How staff interacts with residents



Residents who Require Feeding Assistance or Eat in their Rooms

- How long did it take for the resident to receive his meal?
- How long did it take until feeding assistance was offered to the resident?



Feeding Assistance

- **.0904 (f)(1):** Sufficient staff shall be available for individual feeding assistance as needed
- **.0904 (f)(2):** Residents needing help in eating shall be assisted upon receipt of the meal and assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect



Feeding Assistance

- **Things we are looking for:**
 - Did staff wash their hands?
 - Did staff identify food to the resident?
 - Do staff sit at eye level?
 - Prompting/cueing/positioning?
 - Time allowed for chewing/swallowing?
 - Alternate foods/liquids available?



Before / After Meal Service

- Interview staff, residents, and family members (if available)
- We are trying to get the whole picture
- We will never know if we do not ask the questions



Record Review

- Pull charts for sampled residents
- What are we looking for?
 - Current FL-2 Form: signed by physician, resident diagnoses, current diet orders
 - Current Care Plan: signed by physician, Activities of Daily Living, etc.
 - Information pertinent to resident and diet



Pulling it all Together

- Compare current physician diet order with facility's diet list and menus with what was actually served to resident
- **All Four Must Match!**

Citations and Recommendations

- Diets not served as prescribed by physician
- Problems with menus or kitchen
- Problems or concerns noted:
 - Before, during, and after meal service
 - From staff and/or by residents

Managing Therapeutic Diets

- **.0904(e)(1):** All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician
- Where applicable, therapeutic diet orders shall be specific to calorie, gram or consistency unless there are written orders which include the definition of any therapeutic diet identified in facility's therapeutic menu
- Approved by a registered dietitian

A therapeutic diet is the same as a medication order





Therapeutic Diet Examples

- **No Added Salt (NAS):** 3-5g sodium
- **Diabetic Diets:**
 - No Concentrated Sweets (NCS)
 - No Added Sugar
 - Carbohydrate Controlled
 - 1500 Calorie ADA Diet



Therapeutic Diet Examples

- **2-Gram Sodium** (2000 mg)
- **Low Fat/Low Cholesterol** (Heart Healthy)
- **Mechanical Soft**
- **Pureed**
- **Renal** (Liberal)



No Added Salt (NAS)

- Used to manage high blood pressure and fluid retention
- Use of table salt is restricted and salt may be limited in cooking
- Typically provides between 3–4 grams of sodium daily (3000–4000 mg)
- Follow menu and corresponding recipes



No Added Salt (NAS)

○ **Tips on Reducing Salt:**

- Choose low or reduced sodium and no salt added foods
- Use fresh or frozen fruits and vegetables
- Rinse canned vegetables
- Use spices instead of salt
- Use canned soups prudently



No Added Salt (NAS)

- Recommended sodium intake for a healthy American is < 2300 mg (1 tsp salt)
- Recommended sodium intake for an older adult is \leq 1500 mg
- Recommendations from *Dietary Guidelines for Americans 2005*



No Concentrated Sweets (NCS)

- Simplest version of a diabetic diet
- Signed by a Registered Dietitian
- Typically offers same as a regular diet except it eliminates concentrated sweets (e.g., regular desserts, sodas, table sugar)
- Follow menus and corresponding recipes

No Concentrated Sweets (NCS)

- **NCS Diets eliminate:**
 - Sugar
 - Corn Syrup
 - High Fructose Syrup
 - Honey
 - Molasses
 - Maple Syrup
- **Tip:** Use canned fruit packed in juice/water

Controlled Carbohydrate Diet

- Focuses on portion control and counting carbohydrates in foods
- Not avoiding sugars and carbohydrates just controlling them
- People with diabetes should eat about the same amount of food at the same time of day to keep blood sugar levels stable

Controlled Carbohydrate Diet

- **Major foods containing a significant amount of carbohydrates:**
 - Concentrated sweets
 - Grains (breads, cereals, pastas, rice, corn)
 - Starchy vegetables (corn, potatoes, peas, winter squash)
 - Dried beans, fruits and milk



Controlled Carbohydrate Diet

○ **Tips:**

- Portion control is key
- Follow menus closely
- Use correct measurements
- Follow recipe



Low Fat / Low Cholesterol

- Used for residents with high cholesterol or heart disease
- Restricts fried foods or foods high in fat
- Follow menu and corresponding recipes
- Lower intake of saturated fats



Low Fat / Low Cholesterol Diet

○ **Tips:**

- Choose lean meats with fat trimmed (turkey, fish, poultry without skin)
- Skim or 1% milk
- Cheese labeled with $\leq 2-6$ grams of fat per ounce
- Unsaturated vegetable oils (olive, corn, safflower, canola)



Low Fat / Low Cholesterol Diet

o **Additional Tips:**

- Limit margarine and butter
- Low fat dressings
- Fresh, frozen, dried fruits and vegetables
- Whole grain instead of white flour
- Avoid fried foods



Low Fat / Low Cholesterol Diet

Healthy Americans:

- o Total fats: <30% of total calories
 - Saturated fats: <10% of total calories
 - Monounsaturated: <15% of total calories
 - Polyunsaturated: <10% of total calories
- o Cholesterol: <300 mg daily



Low Fat / Low Cholesterol Diet

Residents with arteriosclerosis or problems with cholesterol:

- o Total Fats: 25-30% of total calories
 - Saturated fats: <7% of total calories
 - Monounsaturated: <10% of total calories
 - Polyunsaturated: <10% of total calories
- o Cholesterol: <200 mg daily



Renal Diet

- Designed for individuals who have chronic renal failure (kidney disease) or End Stage Renal Disease (ESRD) and may be on dialysis
- Follow menu and corresponding recipes



Renal Diet

- **Typically restricts:**
 - Protein
 - Sodium
 - Potassium
 - Phosphorous
 - Fluids may be restricted on an individual basis



Renal Diet

Tips:

- Follow the Menu
- If a resident is on fluid restriction, ensure staff is knowledgeable of restriction and how to document appropriately
- If a resident goes out to dialysis ensure that lunch and appropriate snacks are sent
- Lunch menus must be signed by a Registered Dietician



Combination Diets

- "We Do Right" Adult Care Home has individual menus for NAS, NCS, and LF/LC
- Send this information to each resident's physician asking physician to choose a diet for their residents



Combination Diets

- According to your menus, residents on NCS diets should get 2% milk, NAS diets should get whole milk and LF/LC diets should get skim milk
- Facility should contact RD and get a new menu for a combination diet or
- Contact physician to let him know your facility does not offer combination diets



Mechanical Soft Diets

Used for residents who have:

- Limited chewing or swallowing ability but able to tolerate variety and texture of foods
- Digestive problems or sore mouth/throat from treatments like chemotherapy or radiation to head, neck or abdominal areas
- Poorly fitting dentures, no teeth, or other dental problems



Mechanical Soft Diets

- To achieve correct consistency use knife, blender, food processor or meat grinder
- Types of consistency: chopped or ground
- No raw fruits or vegetables allowed



Pureed Diets

- Used for residents who have difficulty chewing or swallowing
- All foods are pureed/blended
- Purees should be able to hold shape at room temperature without weeping



Clear Liquid Diet

- Clear liquid diet will supply fluid and energy
- Primarily used before and after tests or surgery
- Items should be liquid at room temperature and clear
- Examples: apple juice, broth, popsicles, tea and gelatin



Full Liquid Diet

- Designed for residents who are unable to chew, swallow or digest solid foods
- Examples:
 - Ice cream, milk
 - Pudding, cream soup
 - Items allowed on clear liquid diet



Thickeners

- Used when residents have swallowing disorders
- Dysphagia occurs when there is a problem with any part of the swallowing process
- Types of consistency: nectar, honey or pudding



Thickeners

- Ice should never be used with thickened liquids because it changes consistency of beverage
- If a resident is on thickened liquids, we expect to see thickened liquids on medication cart

General Aspiration Precautions

- Resident should sit upright when eating (45°)
- Each portion should be <1 teaspoon
- Place food well into mouth
- Resident should swallow several times after each portion is served

Achieving Compliance and Quality Improvement

- **How do I get and stay in compliance with rule areas?**
 - PUT SYSTEMS IN PLACE!
 - Know who is responsible for what

Bottom Line

We are ALL here for the residents, to ensure they get adequate and care and services



FOOD SERVICE MONITORING ACTIVITY

LUNCH TIME OBSERVED at Butterfields Assisted Living, Cricket, N.C.

Directions for Activity: Compare the meal observed to the resident's FL-2 to the Therapeutic Diet List, and to the Menu. Use the food service monitoring tool to document observations and record findings from record review. Determine if the facility is out of compliance with rule areas and write, if any the deficiency/deficiencies for this food service monitoring visit.

Assume food portions are appropriate.

1. Resident Margaret M. has one white scoop, one brownish white scoop, and one greenish white scoop of food. She also has a dessert bowl with yellow pudding and is served a cup of coffee and water. Interview with staff reveals the food was fried fish, mashed potatoes and coleslaw.
2. Resident April B. has fried fish, mashed potatoes, coleslaw, 4 hushpuppies, a bowl of pears, and two glasses, which appear to be water. Interview reveals that one glass of liquid is Sprite and the other glass is water.
3. Simon L. has baked fish, baked potato, coleslaw, roll, a dish of lemon pie, and a glass of tea and a glass of water.
4. May G. has a serving of fried fish, baked potato, coleslaw, 6 hushpuppies, a dish of Lemon Pudding, a glass of tea and a glass of water. Interview with staff reveals that the Tea is Sugar Free.
5. Myrtle has a serving of fried fish, baked potato, coleslaw, 6 hushpuppies, a dish of lemon pie, a glass of milk and a glass of water.

MODIFIED DIET LIST FOR BUTTERFIELDS MANOR

1500 CALORIE ADA

CAROLYN A.
MYRTLE W.

1800 CALORIE ADA

JEWEL C.
ANNIE C.
HOMER G.
ANN M.

2200 CALORIE ADA

MAY G.

LOWFAT LOW CHOLESTEROL

MARGARET M.
THEODORE I.

RENAL

APRIL B.

PUREED

FOSTER C.
GRANT T.
GENEVA H.

MECHANICAL SOFT

JOHN G.
LYLE B.
SIMON L.
JANET P.

BUTTERFIELDS ASSISTED LIVING

	Portion Size	REGULAR	NO ADDED SALT (3-4 GM)	MECHANICAL SOFT	PUREED	RENAL	NO CONCENTRATED SWEETS
B R E A K F A S T	6 oz	Orange juice	Orange juice	Orange juice	Orange juice	Apple juice	Orange juice
	1	Egg scrambled	Egg scrambled	Egg scrambled	Pureed Egg, scrambled	LS Egg scrambled	Egg scrambled
	1	Bacon			Pureed Bacon		Bacon
	2	Pancakes	Pancakes	Pancakes	Pancakes	Pancakes 2	Pancakes
	1	Margarine	LS Margarine	Margarine	Margarine	LS Margarine	Margarine
	1	Syrup	Syrup	Syrup	Syrup	Syrup 2	SF Syrup
	8 oz	Milk	Milk	Milk	Milk	Milk	Milk
		Coffee	Coffee	Coffee	Coffee	Coffee	Coffee
L U N C H	3oz	Fried Fish	LS Fried Fish	Baked Fish	Pureed Fried Fish	Fried Fish 1 oz.	Fried Fish
	1 med	Baked potato	Baked potato	Bake potato	Mashed potato	Noodles ½ c	Baked potato
	½ c	Coleslaw	Coleslaw	Coleslaw	Pureed Coleslaw	Coleslaw	Coleslaw
	4-6	Hushpuppies	Hushpuppies	Roll	Roll	Hushpuppies 4	Hushpuppies
	1sl	Lemon Pie	Lemon Pie	Lemon Pie	Lemon Pudding	Pears ½ c	SF Lemon Pudding
		Coffee, tea, milk	Coffee, tea, milk	Coffee, tea, milk	Coffee, tea, milk	Sprite Koolaid	Coffee, tea, milk
D I N N E R	3 oz	Cubed beef steak	Cubed beef steak	Chopped Cubed beef steak	Pureed cube steak	Cubed beef 1 oz	Cubed beef steak
	½ c	Mashed potatoes	Mashed potatoes	Mashed potatoes	Mashed potatoes	Rice ½ c	Mashed potatoes
	½ c	Mixed vegetables	Mixed vegetables	Mixed vegetables	Pureed Mixed vegetables	Cauliflower ½ c	Mixed vegetables
	1	Roll	Roll	Roll	Roll	Roll	Roll
	½ c	Sliced oranges	Sliced oranges	Sliced oranges	Pureed pears	Pineapple ½ c	Sliced oranges
	1	Margarine	LS Margarine	Margarine	Margarine	Margarine	Margarine
	8 oz	Milk	Milk	Milk	Milk		Milk
		Coffee, tea	Coffee, tea	Coffee, tea	Coffee, tea	Tea, Ginger-ale	Coffee, tea

NOTE: BACON CAN BE PUREED WITH EGGS SF (sugar-free) pudding should be made w/skim milk
Water should be served with each meal

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME B.		FIRST April	MIDDLE	2. BIRTHDATE (M/D/Y) 9/28/24	3. SEX F	4. ADMISSION DATE (CURRENT LOCATION) 1-2-08	
5. COUNTY AND MEDICAID NUMBER 02 245-00-7000			6. FACILITY Butterfields		ADDRESS Cricket, N.C.		7. Provider NUMBER 99999
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bowers				9. RELATIVE NAME AND ADDRESS Frances W. (daughter) 3 No Lane , Upton, NC 28806			
10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER <input type="checkbox"/> HOSPITAL		11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> X <input type="checkbox"/> OTHER	
13. DATE APPROVED/DENIED							

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. Dementia	5.
2. End Stage Renal Disease (ESRD)	6.
	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
<input type="checkbox"/> CONSTANTLY	<input checked="" type="checkbox"/> AMBULATORY	<input type="checkbox"/> CONTINENT	<input type="checkbox"/> CONTINENT
<input checked="" type="checkbox"/> INTERMITTENTLY	<input type="checkbox"/> SEMI-AMBULATORY	<input checked="" type="checkbox"/> INCONTINENT	<input checked="" type="checkbox"/> INCONTINENT
INAPPROPRIATE BEHAVIOR	<input type="checkbox"/> NON-AMBULATORY	<input type="checkbox"/> INDWELLING CATHETER	<input type="checkbox"/> COLOSTOMY
<input type="checkbox"/> WANDERER	FUNCTIONAL LIMITATIONS	<input type="checkbox"/> EXTERNAL CATHETER	RESPIRATION
<input type="checkbox"/> VERBALLY ABUSIVE	<input type="checkbox"/> SIGHT	COMMUNICATION OF NEEDS	<input checked="" type="checkbox"/> NORMAL
<input type="checkbox"/> INJURIOUS TO SELF	<input type="checkbox"/> HEARING	<input type="checkbox"/> VERBALLY	<input type="checkbox"/> TRACHEOSTOMY
<input type="checkbox"/> INJURIOUS TO OTHERS	<input type="checkbox"/> SPEECH	<input type="checkbox"/> NON-VERBALLY	<input type="checkbox"/> OTHER:
<input type="checkbox"/> INJURIOUS TO PROPERTY	<input type="checkbox"/> CONTRACTURES	<input type="checkbox"/> DOES NOT COMMUNICATE	<input type="checkbox"/> O2 <input type="checkbox"/> PRN <input type="checkbox"/> CONT.
<input type="checkbox"/> OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	<input checked="" type="checkbox"/> PASSIVE	<input checked="" type="checkbox"/> NORMAL	<input type="checkbox"/> DIET Renal
<input checked="" type="checkbox"/> BATHING	<input type="checkbox"/> ACTIVE	<input type="checkbox"/> OTHER:	<input type="checkbox"/> SUPPLEMENTAL
<input type="checkbox"/> FEEDING	<input type="checkbox"/> GROUP PARTICIPATION	<input type="checkbox"/> DECUBITI – DESCRIBE:	<input type="checkbox"/> SPOON
<input checked="" type="checkbox"/> DRESSING	<input type="checkbox"/> RE-SOCIALIZATION		<input type="checkbox"/> PARENTERAL
<input type="checkbox"/> TOTAL CARE	<input type="checkbox"/> FAMILY SUPPORTIVE		<input type="checkbox"/> NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		<input type="checkbox"/> GASTROSTOMY
<input type="checkbox"/> 30 DAYS	<input type="checkbox"/> CONVULSIONS/SEIZURES		<input type="checkbox"/> INTAKE AND OUTPUT
<input type="checkbox"/> 60 DAYS	<input type="checkbox"/> GRAND MAL	DRESSINGS:	<input type="checkbox"/> FORCE FLUIDS
<input type="checkbox"/> OVER 180 DAYS	<input type="checkbox"/> PETIT MAL		<input type="checkbox"/> WEIGHT 108##
	<input type="checkbox"/> FREQUENCY		<input type="checkbox"/> HEIGHT 5'2"
17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
<input type="checkbox"/> BLOOD PRESSURE	weekly	<input type="checkbox"/> BOWEL AND BLADDER PROGRAM	
<input type="checkbox"/> DIABETIC URINE TESTING		<input type="checkbox"/> RESTORATIVE FEEDING PROGRAM	
<input type="checkbox"/> PT (BY LICENSED PT)		<input type="checkbox"/> SPEECH THERAPY	
<input type="checkbox"/> RANGE OF MOTION EXERCISES		<input type="checkbox"/> RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Aruceot 5 mg 1 po daily	7.
2. Ativan .5 mg q 6 hr prn anxiety	8.
3. Ambien 5 mg 1 po hs prn sleep	9.
4. Hemodialysis Mon Wed Fri	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION: PPD negative 1/1/98

21. PHYSICIAN'S SIGNATURE

22. DATE

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LONG TERM CARE SERVICES

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ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME M.		FIRST Margaret	MIDDLE	2. BIRTHDATE (M/D/Y) 7/02/17	3. SEX F	4. ADMISSION DATE (CURRENT LOCATION) 1-08-08	
5. COUNTY AND MEDICAID NUMBER 02 245-00-7000			6. FACILITY Butterfields		ADDRESS Cricket, N.C.		7. Provider NUMBER 99999
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bowers				9. RELATIVE NAME AND ADDRESS Frances W. (daughter) 3 No Lane , Upton, NC 28806			
10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER <input type="checkbox"/> HOSPITAL		11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> X <input type="checkbox"/> OTHER	
13. DATE APPROVED/DENIED							

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. COPD	5.
2. Hypercholesterolemia	6.
3. Parkinson's	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	<input checked="" type="checkbox"/> AMBULATORY	<input checked="" type="checkbox"/> CONTINENT	<input checked="" type="checkbox"/> CONTINENT
INTERMITTENTLY	SEMI-AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSTOMY
WANDERER	FUNCTIONAL LIMITATIONS	EXTERNAL CATHETER	RESPIRATION
VERBALLY ABUSIVE	SIGHT	COMMUNICATION OF NEEDS	<input checked="" type="checkbox"/> NORMAL
INJURIOUS TO SELF	HEARING	VERBALLY	TRACHEOSTOMY
INJURIOUS TO OTHERS	SPEECH	NON-VERBALLY	OTHER:
INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	O2 PRN CONT.
OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	<input checked="" type="checkbox"/> PASSIVE	<input checked="" type="checkbox"/> NORMAL	DIET Pureed
BATHING	ACTIVE	OTHER:	SUPPLEMENTAL
<input checked="" type="checkbox"/> FEEDING	GROUP PARTICIPATION	DECUBITI – DESCRIBE:	SPOON
DRESSING	RE-SOCIALIZATION		PARENTERAL
TOTAL CARE	FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		GASTROSTOMY
30 DAYS	CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	GRAND MAL	DRESSINGS:	FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT 147#
	FREQUENCY		HEIGHT 5'5"

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE	weekly	BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Atrovent MDI 2 puffs qid	7.
2. Albuterol MOI 2 puffs qid	8.
3. Lopid 600 mg 1 tid	9.
4. Sinemet 50/200 mg 1 daily	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE

22. DATE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME G.		FIRST May	MIDDLE	2. BIRTHDATE (M/D/Y) 5/14/27	3. SEX F	4. ADMISSION DATE (CURRENT LOCATION) 1-1-08	
5. COUNTY AND MEDICAID NUMBER 02 245-00-7000			6. FACILITY Butterfields		ADDRESS Cricket, N.C.		7. Provider NUMBER 99999
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bowers				9. RELATIVE NAME AND ADDRESS Marvin G. (son) 15 No Lane, Upton, NC 28806			
10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL		11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> SNF <input type="checkbox"/> ICF		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> OTHER	
				13. DATE APPROVED/DENIED			

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. Essential Hypertension (HTN)	5.
2. Weight Loss	6.
3. Borderline Diabetic	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY <input checked="" type="checkbox"/>	AMBULATORY <input checked="" type="checkbox"/>	CONTINENT <input checked="" type="checkbox"/>	CONTINENT <input checked="" type="checkbox"/>
INTERMITTENTLY <input type="checkbox"/>	SEMI-AMBULATORY <input type="checkbox"/>	INCONTINENT <input type="checkbox"/>	INCONTINENT <input type="checkbox"/>
INAPPROPRIATE BEHAVIOR	FUNCTIONAL LIMITATIONS	COMMUNICATION OF NEEDS	RESPIRATION
WANDERER <input type="checkbox"/>	SIGHT <input type="checkbox"/>	VERBALLY <input type="checkbox"/>	NORMAL <input checked="" type="checkbox"/>
VERBALLY ABUSIVE <input type="checkbox"/>	HEARING <input type="checkbox"/>	NON-VERBALLY <input type="checkbox"/>	TRACHEOSTOMY <input type="checkbox"/>
INJURIOUS TO SELF <input type="checkbox"/>	SPEECH <input type="checkbox"/>	DOES NOT COMMUNICATE <input type="checkbox"/>	OTHER: <input type="checkbox"/>
INJURIOUS TO OTHERS <input type="checkbox"/>	CONTRACTURES <input type="checkbox"/>	EXTERNAL CATHETER <input type="checkbox"/>	O2 PRN CONT. <input type="checkbox"/>
INJURIOUS TO PROPERTY <input type="checkbox"/>	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
OTHER: <input type="checkbox"/>	PASSIVE <input checked="" type="checkbox"/>	NORMAL <input checked="" type="checkbox"/>	DIET 2200 Calorie ADA <input type="checkbox"/>
PERSONAL CARE ASSISTANCE	ACTIVE <input type="checkbox"/>	OTHER: <input type="checkbox"/>	SUPPLEMENTAL <input type="checkbox"/>
BATHING <input type="checkbox"/>	GROUP PARTICIPATION <input type="checkbox"/>	DECUBITI – DESCRIBE: <input type="checkbox"/>	SPOON <input type="checkbox"/>
FEEDING <input type="checkbox"/>	RE-SOCIALIZATION <input type="checkbox"/>		PARENTERAL <input type="checkbox"/>
DRESSING <input type="checkbox"/>	FAMILY SUPPORTIVE <input type="checkbox"/>		NASOGASTRIC <input type="checkbox"/>
TOTAL CARE <input type="checkbox"/>	NEUROLOGICAL		GASTROSTOMY <input type="checkbox"/>
PHYSICIAN VISITS	CONVULSIONS/SEIZURES <input type="checkbox"/>	DRESSINGS:	INTAKE AND OUTPUT <input type="checkbox"/>
30 DAYS <input type="checkbox"/>	GRAND MAL <input type="checkbox"/>		FORCE FLUIDS <input type="checkbox"/>
60 DAYS <input type="checkbox"/>	PETIT MAL <input type="checkbox"/>		WEIGHT 97# <input type="checkbox"/>
OVER 180 DAYS <input type="checkbox"/>	FREQUENCY <input type="checkbox"/>		HEIGHT 5' <input type="checkbox"/>

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE	weekly	BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING	Fingerstick BS ac breakfast	RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Weigh weekly	7.
2. HCTZ 25 mg 1 po Q am	8.
3. Glucerna Shake 1 can po tid	9.
4. Diabeta 5 mg 1 po bid	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE

22. DATE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME W. Myrtle		FIRST	MIDDLE	2. BIRTHDATE (M/D/Y) 2-17-24	3. SEX F	4. ADMISSION DATE (CURRENT LOCATION) 1-1-08	
5. COUNTY AND MEDICAID NUMBER 02 245-00-7000			6. FACILITY Butterfields		ADDRESS Cricket, N.C.		7. Provider NUMBER 99999
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bowers				9. RELATIVE NAME AND ADDRESS Jay W.(husband) 3 No Lane, Upton, NC 28806			
10. CURRENT LEVEL OF CARE		11. RECOMMENDED LEVEL OF CARE		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN	
<input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF OTHER <input type="checkbox"/> HOSPITAL		<input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF OTHER		13. DATE APPROVED/DENIED		<input type="checkbox"/> SNF HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> <input type="checkbox"/> OTHER	

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. Blind	5.
2. Insulin Dependent Diabetes	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	<input checked="" type="checkbox"/> AMBULATORY	<input checked="" type="checkbox"/> CONTINENT	<input checked="" type="checkbox"/> CONTINENT
INTERMITTENTLY	SEMI-AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSTOMY
WANDERER	FUNCTIONAL LIMITATIONS	EXTERNAL CATHETER	RESPIRATION
VERBALLY ABUSIVE	<input checked="" type="checkbox"/> SIGHT	COMMUNICATION OF NEEDS	<input checked="" type="checkbox"/> NORMAL
INJURIOUS TO SELF	HEARING	VERBALLY	TRACHEOSTOMY
INJURIOUS TO OTHERS	SPEECH	NON-VERBALLY	OTHER:
INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	O2 PRN CONT.
OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	<input checked="" type="checkbox"/> PASSIVE	<input checked="" type="checkbox"/> NORMAL	DIET No Concentrated Sweets
BATHING	ACTIVE	OTHER:	SUPPLEMENTAL
FEEDING	GROUP PARTICIPATION	DECUBITI – DESCRIBE:	SPOON
DRESSING	RE-SOCIALIZATION		PARENTERAL
TOTAL CARE	FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		GASTROSTOMY
30 DAYS	CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	GRAND MAL	DRESSINGS:	FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT 164#
	FREQUENCY		HEIGHT 5'1"
17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE	weekly	BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Novolin N 70/30 25 uq am	7.
2. Novolin R sliding scale	8.
3. 150-200= 2 units	9.
4. 201-250=4 units	10.
5. 251-300=6 units	11.
6. 301-350 = 8 units, > 350 call MD	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE

22. DATE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

INSTRUCTIONS ON REVERSE SIDE

PRIOR APPROVAL

UTILIZATION REVIEW

ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME L.		FIRST Simon	MIDDLE	2. BIRTHDATE (M/D/Y) 12/12/28	3. SEX F	4. ADMISSION DATE (CURRENT LOCATION) 1-10-03	
5. COUNTY AND MEDICAID NUMBER 02 245-00-7000			6. FACILITY Butterfields		ADDRESS Cricket, N.C.		7. Provider NUMBER 99999
8. ATTENDING PHYSICIAN NAME AND ADDRESS Dr. Bowers				9. RELATIVE NAME AND ADDRESS Madge L. (wife) 9 No Lane, Upton, NC 28806			
10. CURRENT LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF OTHER <input type="checkbox"/> HOSPITAL		11. RECOMMENDED LEVEL OF CARE <input type="checkbox"/> HOME <input checked="" type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF (REST HOME) <input type="checkbox"/> ICF OTHER		12. PRIOR APPROVAL NUMBER		14. DISCHARGE PLAN <input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input checked="" type="checkbox"/> <input type="checkbox"/> OTHER	
13. DATE APPROVED/DENIED							

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. Hypothyroidism	5.
2. Weight Loss	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	<input checked="" type="checkbox"/> AMBULATORY	<input checked="" type="checkbox"/> CONTINENT	<input checked="" type="checkbox"/> CONTINENT
INTERMITTENTLY	SEMI-AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSTOMY
WANDERER	FUNCTIONAL LIMITATIONS	EXTERNAL CATHETER	RESPIRATION
VERBALLY ABUSIVE	SIGHT	COMMUNICATION OF NEEDS	<input checked="" type="checkbox"/> NORMAL
INJURIOUS TO SELF	HEARING	VERBALLY	TRACHEOSTOMY
INJURIOUS TO OTHERS	SPEECH	NON-VERBALLY	OTHER:
INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	O2 PRN CONT.
OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	<input checked="" type="checkbox"/> PASSIVE	<input checked="" type="checkbox"/> NORMAL	DIET Mechanical Soft
BATHING	ACTIVE	OTHER:	SUPPLEMENTAL
FEEDING	GROUP PARTICIPATION	DECUBITI – DESCRIBE:	SPOON
DRESSING	RE-SOCIALIZATION		PARENTERAL
TOTAL CARE	FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		GASTROSTOMY
30 DAYS	CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	GRAND MAL	DRESSINGS:	FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT 143#
	FREQUENCY		HEIGHT 5'8"

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE	weekly	BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1 Synthroid 112 mg 1 po q am	7.
2 Check Pulse, hold if BP > 85	8.
3.	9.
4.	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE
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Weekly Menu Planning Worksheet: Regular Diet

DHSR ACLS 3/10

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
Breakfast													
Milk 8oz.	<input type="checkbox"/>												
Fruit 1/2 cup	<input type="checkbox"/>												
Protein 2-3oz.	<input type="checkbox"/>												
Vegetable 1/2 cup	<input type="checkbox"/>												
Bread/Starch	<input type="checkbox"/>												
Snack		Snack		Snack		Snack		Snack		Snack		Snack	
Lunch		Lunch		Lunch		Lunch		Lunch		Lunch		Lunch	
Snack		Snack		Snack		Snack		Snack		Snack		Snack	
Dinner		Dinner		Dinner		Dinner		Dinner		Dinner		Dinner	
Snack		Snack		Snack		Snack		Snack		Snack		Snack	

***Serve 1 egg at least 3 times/week at breakfast ***Serve deep leafy green or yellow vegetables 3 times/week

- Yes No Fruits, vegetables, protein, and milk requirements are met through meals only?
- Yes No Protein substitute used no more than 3 times per week?
- Yes No At least 8oz. of water is served with each meal, plus beverage of choice?

MENU SUBSTITUTION FORM

.0904 (c)(3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.

DATE: _____

DATE SUBSTITUTION MADE: _____

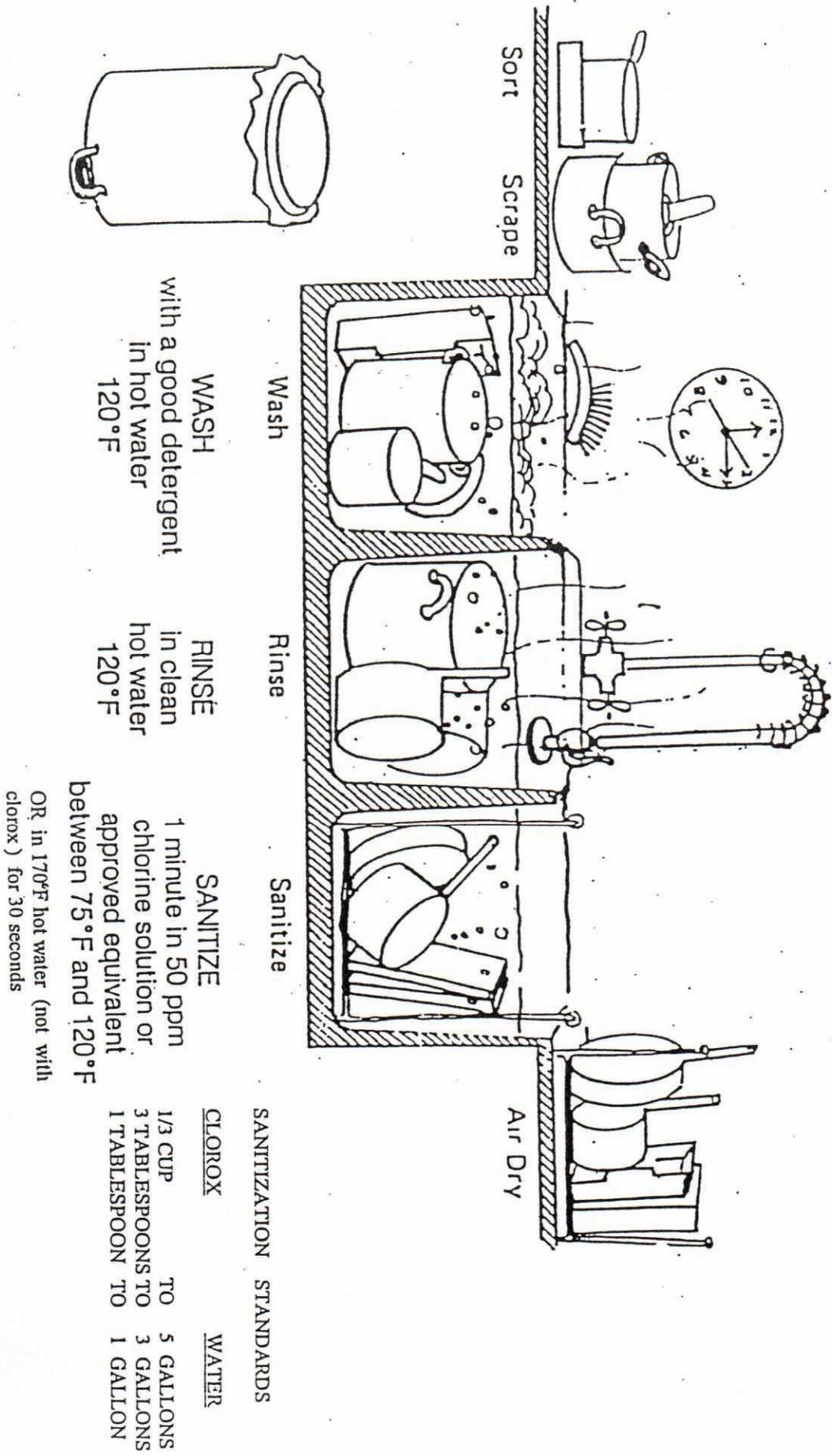
MEAL SUBSTITUTION SERVED: breakfast/lunch/supper
(Circle one)

DAY: _____ **CYCLE:** _____

SUBSTITUTION MADE BY: _____

_____ **was served in place of** _____

Exhibit 10.6 A three-compartment sink for manual washing, rinsing, and chemical sanitizing



(For dish machines, follow manufacture's recommendations.)

Purees

The proper texture is ---

- ** fluffy, like whipped potatoes
- ** pudding like, moist food uniform in texture, which clumps together

Purees should—

- Taste good and be appealing to the eye
- Hold its shape at room temperature without weeping
- Have no lumps, no pieces, and no strings
- Be held and served at appropriate temperatures

Non-Commercial Thickening and Thinning Agents

1. Instant mashed potatoes, real whipped potatoes better
2. Cooked vegetables, such as carrots and potatoes
3. Cooked fruits, such as pears and peaches, applesauce
4. Blended or ready to eat adult oatmeal, cream of wheat, cream of rice, and grits
5. Flour, cornstarch, tapioca, and eggs if cooked after adding
6. Breadcrumbs, use ¼ cup per four ounce serving
7. Instant pudding, whipped topping, canned pudding, and marshmallow cream
8. Liquid non-dairy creamer, cheese, sour cream, dry milk powder, blended cottage cheese, cream cheese, and plain yogurt
9. Gelatin in cold foods, use no more than 1 TBSP per 4-ounce portion. Do not allow to chill.

Commercial Thickeners

1. Follow instructions on each product label to prevent clumping
2. Designed to thicken all foods and liquids

Puree Production

1. Use a food processor or blender.
2. Use all standard practices of sanitation to prevent bacteria growth.
3. If foods have skins or seeds, strain before thickening.
4. Serve all foods as listed on the Puree Menu.

Meat and Entrees

1. Addition of stock, broth, gravy, or au jus, preferred over water.
2. If milk added, heat milk before adding to solids.

Breads

1. Serve as listed on the Puree Menu. May be pureed with entrée if listed as pureed on the menu. Serving size must then be adjusted.
2. If bread is served in a slurry, 1 TBSP thickener in 4 ounces liquid or 1 TBSP gelatin may be dissolved in 2 cups liquid. Do not chill. Allow to soften 15 minutes before service.

Best Practices in Food Service

○ **INSIDE THE KITCHEN:**

- Who is responsible for ensuring all equipment is properly working?
- Who is responsible for ensuring all equipment has had routine service?
- How often will this be monitored?

○ **HOT FOODS HOT AND COLD FOOD COLD**

- What system is in place to ensure that all food served to residents is at the appropriate temperature?
- Do you keep food temperature logs?
- Who is responsible for the temperature logs?
- Who checks to ensure the temperature logs are being documented?

○ **TEMPERATURE CONTROL BEFORE FEEDING ASSISTANCE IS PROVIDED**

- Who is responsible for ensuring that the meal is served at the proper temperatures for residents who receive feeding assistance?
- Who is responsible for ensuring the resident requiring feeding assistance is offered his/her meal in a timely manner?

○ **MENUS:**

- What system/training has been put in place to ensure staff are able to read and follow menus?
- Are all kitchen staff trained to read menus?
- Who is responsible for documenting substitutions?
- Who is responsible for ensuring the substitution is an adequate substitution?
- Who is responsible for ensuring substitutions are being documented?
- Who is responsible for ensuring the facility has therapeutic menus for all therapeutic diet orders in your facility?

Best Practices in Food Service

- Who is responsible for updating menus when a new diet order comes into the facility?
 - Who is responsible for ensuring your regular menus meet the requirement?
 - Who is responsible for ensuring diet orders have been clarified?
 - Who is responsible for informing the kitchen staff of new diet orders?
- **DIET LIST:**
- Who is responsible for ensuring the diet list is current?
 - Who is responsible for ensuring if the diet order changes the diet list changes to reflect the subsequent order?
 - Who double checks the diet list for accuracy?
- **THICKENED LIQUIDS AND SUPPLEMENTS**
- Who is responsible for preparing thickened liquids?
 - What training has been provided to ensure staff are preparing thickened liquids accurately?
 - Who is responsible for providing supplements?
 - Who is responsible for documenting supplements were administered?
- **FEEDING ASSISTANCE:**
- Who is responsible for providing feeding assistance?
 - Has staff been properly trained on providing feeding assistance?
 - Who is responsible for ensuring there is an adequate amount of staff to provide feeding assistance to all of your residents?
- If you have to ask the question, then you know we are going to ask the question
- It is OK to put monitoring and tracking systems in place

POST TEST FOR FOOD SERVICE ORIENTATION

Circle the best answer for each question.

1. Sanitation of kitchen surfaces is different than “clean” in that it means it has been treated to kill what? A. harmful bacteria B. rodents C. flies D. animals
2. Kitchen equipment such as blenders and meat slicers should be sanitized: A. once a month B. once a week C. once a day D. after each use
3. Dishes can be sanitized by using: A. soap and water B. a fan to air dry C. water temperatures of 170 degrees or sanitizing chemicals such as bleach D. a drying rag.
4. Food can be stored on the floor as long as it is in dry storage area and the floor is clean. True or False
5. What is the appropriate temperature for refrigerators? A. 50 degrees or below B. 0 degrees C. 45 degrees or below D. 32 degrees or below
6. Which food may contain harmful bacteria? A. raw chicken B. fresh eggs C. raw meat D. all of these may contain harmful bacteria
7. Cross-contamination occurs *only* when *hands* are not washed after handling raw meat or poultry. True or False
8. An acceptable way to thaw hamburger would be to: A. let it sit on the counter B. in a sink full of water C. in a pan in the bottom of the refrigerator D. outside on a hot day.
9. Your hands should be washed after which of the following: A. touching raw meat, poultry or seafood B. after a trip to the restroom C. after touching garbage or other unclean surfaces. D. All of these

10. After hot foods have been prepared and are ready to be served, they should be held at what temperature to ensure bacteria do not grow rapidly? A. 0 degrees Fahrenheit
B. at least 140 degrees Fahrenheit C. 35 degrees Fahrenheit D. 500 degrees Fahrenheit
11. You should **not** work in food service if you have which of the following? A. a cold or the “flu” B. an infected wound C. both A and B D. a bad hair day
12. Therapeutic diets are made up by chefs. True or False
13. What appliance is needed to prepare pureed diets? A. oven B. sharp knife
C. a blender or food processor D. toaster
14. Which diet provides meats chopped or ground for residents who have problems chewing?
A. No Concentrated Sweets B. Renal C. No Added Salt
D. Mechanical Soft
15. Which diet limits sweets such as regular cakes, pies, candy and regular sodas and drinks?
A. Renal B. No Concentrated Sweets C. Puree D. No Added Salt
16. Which diets may require that foods be prepared separately from regular foods because of salt? A. Renal and 2-gram Sodium B. puree and mechanical soft C. Finger Foods
D. Dysphagia
17. A Low Fat/Low Cholesterol menu may call for low-fat preparation methods, such as baking instead of frying. True or False
18. Which diet is used for residents with swallowing problems? A. No concentrated Sweets B. Dysphagia C. Low Cholesterol Low Fat D. No Added Salt
19. What equipment is needed to prepare thickened liquids using a powdered thickener? A. measuring cups B. measuring spoons C. microwave D. both A and B
20. Where can you find directions for how much thickener should be added to a 4-ounce beverage to achieve nectar thickness? A. on the label of the canister or packet of thickener
B. the menus C. the recipe book D. the phone book

21. A teaspoon of thickener will work in *any amount* of beverage. True or False
22. Therapeutic diet menus are the same in all facilities. True or False
23. It's OK to pick *any* day from the menus for meal preparation? True or False
24. When making substitutions on therapeutic diets, what is an easy way to know what other foods can be substituted? A. look at a different day under the same therapeutic menu column. B. ask the residents C. just use your imagination D. pick something the same color
25. There is no need to follow recipes when preparing therapeutic diets. True or False
26. You can order residents around only if they are not doing what you want them to do.
True or False
27. It is the cook's responsibility to provide alternative foods if a resident refuses the meal served and to honor each resident's food preferences. True or False
28. Loud music of your liking should only be played occasionally in the dining room.
True or False
29. You can tease residents just like you would your own friends. True or False
30. You should always be helpful to residents except when you are not feeling well or too busy.
True or False

I have read the Food Service Orientation Manual and completed the Post Test.

Signature of person who completed food service orientation **Date**

I verify that the person whose signature is above received the Food Service Orientation Manual and completed the Post Test.

Signature of Administrator or Administrator/Supervisor-in-Charge **Date**

The Post Test with signatures is to be maintained in the facility.

Chapter 9

Activities

Monitoring Activities in Adult Care Homes

Adult Care Licensure Section

Objectives

- At the end of this session, each participant will understand:
 - The importance of providing meaningful activities to adult care home residents
 - How to monitor activities to ensure compliance with regulations

Activity Program

- **10A NCAC 13F and 13G .0905**
 - Each home shall develop a program of activities designed to promote the residents' active involvement with each other, their families and the community



Activity Director Qualifications

- **10A NCAC 13F and 13G .0404**
 - Shall meet minimum educational requirement: at least a high school graduate, GED or alternative exam. (August 1, 1991)
 - Complete activity course within 9 months of employment (July 1, 2004)



Activity Coordinator Responsibilities

- Document personal information about each resident's interests and capabilities
- Use the information to develop individual and group activities
- Prepare a monthly calendar



Activity Coordinator Responsibilities

- Evaluate and document the overall effectiveness of the activities program every six months
- Assure there are adequate supplies, supervision, and assistance to enable each resident to participate in activities
- Encourage resident participation



Activity Programming

- Minimum of 14 hours of planned group activities per week to promote:
 - Socialization
 - Physical interaction
 - Group accomplishment
 - Creative expression
 - Increased knowledge
 - Learning of new skills



One to One Interactions

- Promote:
 - Enjoyment
 - Sense of accomplishment
 - Creative expression
 - Increased knowledge
 - Learning of new skills.



Monitoring Should Include:

- Observation
- Interview
- Record Review



Observations

- Do you see residents actively engaged in activities?
- Are there sufficient space, supplies, and staff?
- What does the calendar list for today?
- What activities are being offered to residents with dementia?
- What activities are offered to residents who are bed ridden or room bound?



Staff Interviews

- How do you coordinate and provide out of facility activities?
- What methods are used to encourage and assist resident attendance?
- What activities are offered at night and on weekends?
- What are the qualifications of the activity director?



Resident and Family Interviews

- What activities do you attend?
- What activities offered meet your interests?
- How do you know about the activity schedule?
- Do you attend out-of-facility activities? If not, why?
- What activities are offered on weekends?
- What activities would you like to be offered here?



Record Reviews

- Is there documentation of residents' interests?
- Do the activities reflect individual residents' history and documented interests?
- Is there documentation of the 6-month evaluation of the activity schedule?

Chapter 10

Appendix

Additional Resources

Medication - 10A NCAC 13G/F.1000

Guidelines for Completing Form 4605

4612 - Medication Management Self Survey

4615 - Medication Storage Inspection Worksheet

4627 - Medication Samples Acquisition Log

4628 - Medication Error Report

4629 - Medication Administration Record (MAR) Inspection Worksheet

4641 - Medication Management Quality Assurance Checklist

4642 - Medication Administration Observation Worksheet

4646 - Adult Care Licensure Fundamental Rules Form

4647 - Adult Care Licensure Fundamental Rules Form Worksheet

Medication Release Sample Form

Controlled Substances

Correct Preparation and Administration of Medications

Crushing or Chewing Medications

Guidelines for Medication Samples

Guidelines for the Development of Medication Administration Policies and Procedures

Hyperglycemia Symptoms

Measuring Medications

Measuring Tips

Medication Distribution Systems

Medication Safety Rules

Medication Storage

Over the Counter (OTC) Drugs

Prescription Label Requirements

Psychotropic Medications

Types of Drug Orders

Use of Inhalers

Personal Care & Supervision - 10A NCAC 13G/F .0901

LHPS Personal Care Task Rule

Monitoring LHPS Guidelines

Monitoring Personal Care and Healthcare Guidelines

Personal Care and Supervision Self Survey Module

Quick Reference Guide to Significant Change Examples 2016

Food/Nutrition - 10A NCAC 13G/F .0904

Food Service Manual for Adult Care Homes

Resident Assessment Self-Instruction Manual for Adult Care Homes

Building/Physical Environment - 10A NCAC 13G/F .0300

Accurately Measuring Water Temperature Handout

Hot Water Safety Issues

Hot Water Temperature Self Survey Module

Resident Rights - 10A NCAC 13G/F .0909/GS 131D-21

Bill of Rights for Adult Care Home Residents

Other Optional Forms:

Common Medical Abbreviations

Adult Care Abrupt Closure Process 2014

4633 - Behavior Specific Rules

4611 - Contact Information

Resident Selection Form

4632 - Special Care Units

Surveyor Worksheet (Notes)

General Statutes