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# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Currently, adult care homes cannot charge the resident for laundry costs. Can you charge the adult care home resident in a combination facility?

No. Adult care home beds in combination facilities are surveyed according to the facility's rule choice (i.e., adult care home or nursing home rule). According to regulation 10A NCAC 13F .0906(c)(1) and (2), "Laundry services must be provided to residents without any additional fee. It is not the home's obligation to pay for a resident's personal dry cleaning and the resident's plans for personal care of clothing are to be indicated on Form DSS-1865, the Resident Register."

The North Carolina Department of Health and Human Services, Adult Care Licensure Section, May 2004 Abstracts Manual, page 400-11 includes a question and answer for this topic that is still in effect. "For a private pay resident, an additional charge/ fee depends on the admission contract. Some facilities will itemize charges and as long as it is disclosed in the contract that there is a laundry charge, this is not an additional charge. If the contract specifies a monthly rate for care and services and does not indicate specific charges for laundry or other services, charging the resident a fee for laundry is an additional fee, i.e., in addition to what the resident had agreed to pay according to the contract. This is not allowed by rule. Special assistance residents cannot be charged any additional fee since the cost of care, services and accommodations is covered by special assistance and Medicaid payments. Private pay residents are being charged for laundry, whether it is up front in a specific charge as may be stated in the contract or included in a flat monthly rate for cost of care and services. "Additional" in the context of the rule means in addition to the established rate or cost. For public assistance residents, that rate is established by special assistance and Medicaid payments. For private pay residents, it is established in the contract".

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Does F159, 42 CFR §483.10(c)(4), Management of Personal Funds, require facilities to distribute financial records through quarterly statements to residents?

Yes. The interpretive guidelines state, “quarterly statements are to be provided in writing to the resident or the resident’s representative within 30 days after the end of the quarter.”

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a resident has \$65.00 in a resident account, is it permissible for interest to apply only on the amount in excess of \$50.00?

Yes. The requirement 42 CFR §483.10(c)(3)(i) says that a resident's personal funds over \$50 (\$100 for Medicare residents) must be deposited in an interest-bearing account, and accrued interest (less bank fees) must be allocated to the individual residents.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What are the responsibilities of the facilities to keep their policies updated?

There is no licensure rule or federal regulation that directly addresses this question. However, it is a standard of practice for facilities to keep their policies updated. Currently, there are two federal requirements that specifically mention policies and procedures (42 CFR §483.13(c) and 42 CFR §483.65).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is there a Medicare or Medicaid regulation that requires information about how to apply for Medicare or Medicaid to be posted in each resident's room?

No. 42 CFR §483.10(b)(10) requires the facility to prominently display written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by Medicare or Medicaid. However, there is no requirement that the information be posted in each resident's room.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is it appropriate for Licensure and/or Certification to request copies of a new facility's policy and procedure manuals prior to the initial survey? If appropriate, what assurance does the nursing home have that these policies and procedures will not be shared with other providers? Will the copyright be respected?

Yes. The initial licensure survey is conducted from the Nursing Home Licensure and Certification Section's office. These copies are either shredded or returned to the facility after review.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What is a reasonable time frame for reimbursement of funds to residents/families? For example, a month's stay is paid in advance by resident/family. The resident is discharged before the month is completed.

Upon discharge or transfer to another facility, an accounting of resident's funds and property must be completed, paid, and delivered within thirty days. Upon the death of a resident, his or her balance in the personal needs fund must be accounted for and turned over to the administrator of the estate within thirty days after death. If no administrator has been appointed, the balance will be disbursed by the Clerk of Superior Court within thirty days after death. The funds and personal property will be disbursed by the Clerk of Superior Court under the provisions of North Carolina General Statute § 28A-25-6. Funds should be sent to the Clerk of Superior Court of the county which was providing the Medicaid assistance. The letter remitting the funds should have the resident's full name, date of death, Medicaid ID number, and the name of the county department of social services that provided medical assistance.

Above statement "4701.36" from Medicaid Manual Long Term Care Facilities, published by Electronic Data Systems Federal Corporation for the North Carolina Division of Medical Assistance.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Does a provider have a right to be notified about, be present and speak about a penalty being discussed at the Penalty Review Committee meeting?

Yes. The facility receives written notification from the Division of Health Service Regulation concerning recommendations to be reviewed by the Penalty Review Committee. This correspondence also includes the date, time and location of the meetings, as well as the facility's options, which include the opportunity to present additional information or verbal testimony to the committees. Please refer to Licensure rule 10A NCAC 13D .2111.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What is the requirement for minimums on the surety bond or self insurance on residents' trust accounts?

No minimum is specified. However, 42 CFR §483.10(c)(7) does mandate that the coverage “assure the security of all personal funds of residents deposited with the facility.” Designate the obligee as the resident individually or in aggregate. DO NOT designate the State on behalf of the residents. For further information refer directly to the interpretive guidelines.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

How long do facilities need to maintain Quality Assurance auditing records before they dispose of them?

Quality Assurance auditing records are to be maintained based on facility policy. There is no regulation that dictates a time frame.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Are facilities required to notify the Board of Nursing of resident abuse by nurses?

Yes. Regarding abuse of residents by licensed nurses, the Board of Nursing refers all employers to the Nurse Practice Act, North Carolina General Statute § 90-171.47. This statute provides as follows: “Any person who has reasonable cause to suspect misconduct or incapacity of a licensee or who has reasonable cause to suspect that any person is in violation of this Article...should report the relevant facts to the Board.”

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Should withdrawals from residents' personal funds for payment of beautician services that are not covered by Medicaid be documented?

Yes. All withdrawals from residents' personal funds accounts, including those for payment of non-Medicaid-covered barber or beautician services must be documented. Reference is made to the Medicaid Manual for Long-Term Care Facilities (Medicaid Provider Manual), Section 4703 (page 4-34), which states:

“For ease of accounting, the facility should maintain a resident personal funds Petty Cash Account with two hundred dollars (\$200.00) more or less, depending on the size of the facility. The use of pre-numbered cash disbursement receipts is essential in accounting for the Petty Cash Account. Use of a Petty Cash Account and a signed pre-numbered cash disbursement receipt will be adequate documentation and will eliminate the need to write a check each time a resident needs money. All withdrawals from the resident personal funds account must be documented with a cash disbursement receipt or a canceled check. Cash disbursement receipts that have the mark of a resident must contain the signature of a witness”.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Federal and North Carolina Licensure requirements require the “use of the services of a Registered Nurse” 8 consecutive hours, 7 days a week. Does the RN have to be physically present in the facility or available and on-call?

The RN must be physically present in the nursing home facility/unit.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is Cardio-Pulmonary Resuscitation (CPR) training required for licensed staff?

Refer to:

**10A NCAC 13D .2309      CARDIO-PULMONARY RESUSCITATION**

- (a) Each facility shall develop and implement a Cardio-Pulmonary Resuscitation (CPR) policy.
- (b) The policy shall be communicated to all residents or their responsible party prior to admission.
- (c) Upon admission each resident or his or her responsible party must acknowledge in writing having received a copy of the policy.
- (d) The policy shall designate an outside emergency medical service provider to be immediately notified whenever an emergency occurs.
- (e) The policy shall designate the level of CPR that is available using terminology defined by the American Heart Association. American Heart Association terminology is as follows:
  - (1)        Heartsaver CPR;
  - (2)        Heartsaver Automatic External Defibrillator (AED);
  - (3)        Basic Life Support (BLS); or
  - (4)        Advanced Cardiac Life Support (ACLS).
- (f) The facility shall maintain staff on duty 24 hours a day trained by someone with valid certification from the American Heart Association or American Red Cross capable of providing CPR at the level stated in the policy. The facility shall maintain a record in the personnel file of each staff person who has received CPR training.
- (g) The facility shall have equipment readily available as required to deliver services stated in the policy.
- (h) The facility shall provide training for staff members who are responsible for providing CPR with regards to the location of resources and measures for self- protection while administering CPR.

History Note:     Authority G.S. 131E-104;  
                  Eff. October 1, 2006.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is a facility required to do tuberculosis screening for respite care residents?

Yes.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is there a requirement for notifying the Division of Health Service Regulation (DHSR) regarding vacancies in positions of administrator and/or director of nursing?

Licensure rule 10A NCAC 13D .2104(c)(1) and (2) requires a facility to notify the Nursing Home Licensure and Certification Section of DHSR within one working day following a change in administrator or a change in the director of nursing.

# REGULATORY FOCUS BULLETIN

## FOR YOUR INFORMATION

FILE TOPIC: Administration

### What are the requirements for calculating emergency water supplies?

42 CFR §483.70(h)(1) states the facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. The interpretive guidance says, “The facility should have a written protocol which defines the source of water, provisions for storing the water, both potable and non-potable, a method for distributing water, and a method for estimating the volume of water required”.

The Department of Environment and Natural Resources includes a provision of how much water per person per day for drinking.

#### 15A NCAC 18A .1313 WATER SUPPLY

(f) The local health department shall be immediately notified if the primary water supply is interrupted for more than four hours. Each institution shall have a plan to obtain a backup water supply in the event that the water supply is lost for more than four hours. The backup water supply plan shall provide for two liters of water per day per person for drinking.

Other agencies that may provide guidance for calculating water supplies include: local emergency management officials in your county, the American Red Cross, the North Carolina National Guard and the Federal Emergency Management Agency.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

May long term care staff other than licensed nurses or Nurse Aide Is feed residents?

Yes, if the facility complies with ...

42 CFR §483.35(h) Paid Feeding Assistants at F373.

(1) State-approved training course. A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if -

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and

(ii) The use of feeding assistants is consistent with State law.

(2) Supervision.

(i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

(3) Resident selection criteria.

(i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

May facilities have contracts with, or otherwise require employees to repay a facility for nurse aide training and competency evaluation programs (NATCEP) or competency evaluation programs if the employee does not remain with the facility for a specified period of time? May nursing facilities charge, or otherwise require employees to assume responsibility, for costs associated with nurse aide training and competency evaluation programs or competency evaluation programs?

No, according to the preamble to the final regulations, “The cost of nurse aide training and competency evaluation is borne by the Medicare and Medicaid programs. It is inappropriate for a facility to ask a nurse aide to repay the facility for an expense for which it has already been paid.” Further, “No programs that charge fees to any nurse aides who are employed by, or who have an offer of employment from, a facility may be approved by the State.”

42 CFR §483.152(c)(1) and 42 CFR §483.154(c)(2) of the final regulations prohibit an aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program, being charged for any portion of the program, including any fees for textbooks or other required course materials. Further, if the individual receives an offer of employment from a nursing facility within 12 months of completing an NAT/CEP or CEP, the State will provide for reimbursement on a pro rata basis. 42 CFR §483.158 of the final regulations provide Federal Financial Participation for nurse aide training and competency evaluation.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Does the facility have to post the physician's name and telephone number in the resident rooms?

No. Federal requirement 42 CFR §483.10(b)(8) states that the facility must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care. The manner in which residents are informed of their physician is at the discretion of the facility.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Can a provider charge a Medicare resident for haircuts and personal laundry costs?

No. The Medicare Skilled Nursing Facility Manual, 230.10(B) states “Routine Personal Hygiene Items and Services. Routine personal hygiene items and services required to meet needs of residents are covered items and services. These include but are not limited to: hair hygiene supplies; combs; brushes; bath soaps; disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or fight infection; razors; shaving cream; toothbrushes; toothpaste; denture adhesive; denture cleansers; dental floss; moisturizing lotion; tissues; cotton balls; cotton swabs; deodorant; incontinence care and supplies; sanitary napkins and related supplies; towels; wash cloths; hospital gowns; over-the-counter drugs; hair and nail hygiene services; bathing; and basic personal laundry.”

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What is a facility's obligation to provide therapy (Physical Therapy/Occupational Therapy/Speech Therapy) that has been ordered by a physician when coverage/funding is exhausted?

The facility is obligated to meet the resident's needs for services. Resident needs and physician orders cannot be ignored due to inadequate funding. The unavailability of funds to purchase needed treatment should be discussed with the resident and/or resident's representative. The Department of Social Services should also be involved in the resolution of financial problems. If a funding source has not been established after exploring all possible funding options, the attending physician should be notified to determine if alternate measures may be employed to meet the resident's needs. However, if there are not acceptable alternatives which adequately meet the resident's needs, the services must be provided as ordered.

Please note: Both Medicare Part B and Medicaid cover physical, occupational, and speech therapies. Since Medicaid is the payor of last resort, Medicare Part B must be billed before the provider can list therapy expenses on the Medicaid Cost Report. Medicare co-payments may be billed to Medicaid when the resident is covered by both.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Please clarify any discrepancy between 42 CFR §483.40(c) Interpretive Guidelines (Physician Services) (Certification) and Licensure rule .2501 concerning when and what kind of visits Physician Assistants/Nurse Practitioners may make and when physicians are required to visit.

In all licensed facilities, residents shall be seen by a physician at least once every 30 days for the first 90 days and at least once every 60 days thereafter. Following the initial visit, required visits by the physician may be alternated with a physician's assistant or nurse practitioner. (See Licensure rule 10A NCAC 13D .2501(b).)

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Must a facility skin-test a resident for tuberculosis if the resident is admitted from a hospital with a documented negative chest x-ray done within the week prior to admission?

Yes. Licensure rule 10A NCAC 03H .2209(d) requires communicable disease screening, including tuberculosis, prior to or upon admission of all residents admitted from hospitals. The Communicable Disease rule 15A NCAC19A .0205(b)(4) requires residents shall be skin tested for tuberculosis and given appropriate clinical, microbiologic and x-ray examination in accordance with the “Diagnostic Standards and Classification of Tuberculosis”, published by the American Thoracic Society, upon admission to a long term care facility. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months.

While a negative chest x-ray may provide some evidence that the resident has no active, pulmonary disease, it does not rule out the possibility that the resident has a tuberculosis infection. Skin-testing can detect tuberculosis infection that has not yet resulted in disease.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a person requesting medical records is a *current* resident or their legal representative, then:

Upon oral or written request, the facility must provide access to all records within 24 hours (excluding weekends and holidays), and copy the records upon request, within 2 working days advance notice to the facility.

If the person requesting the records is a former resident (i.e., has left the facility on a permanent basis) or their legal representative, then:

Federal Requirements for Long Term Care Facilities no longer apply to a former or deceased resident.

The North Carolina Health Care Facilities Association has furnished a summary of Health Insurance Portability and Accountability Act (HIPAA) guidelines to its members. The facility may choose to follow and provide former residents or their legal representative access to their records within 30 days of the receipt of the request, and 60 days if the records are off-site. The 30 and 60-day deadline can be extended for an additional 30 days if the facility gives notice within the initial timeline to the resident explaining the reasons for the delay. The HIPAA regulation specifies that if an executor, administrator, or other person with authority to act on behalf of a deceased resident requests the records/copies of the records, the facility must treat that person as if they are the former resident and grant access to and copy the records requested - within the same timelines specified above. The facility can charge a reasonable cost-based fee for copying records.

As a general rule, if the person requesting the records is a legal representative or administrator, executor, etc, of the estate, the facility should request proof of this status to comply with HIPAA and to prevent the disclosure of protected health information to individuals who do not have a legitimate, legal right to act for the current or former resident.

NOTE: When a resident passes away, the authority of the health care power of attorney or general power of attorney ceases.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a survey team finds past noncompliance that has been fixed, should it be cited?

Past noncompliance may be identified during any survey of a nursing home. Findings of past noncompliance may come to light more frequently during investigations of complaints about the care and services provided to residents in a nursing home.

To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:

- 1) The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
- 2) The noncompliance occurred after the exit date of the last standard recertification survey and before the survey (standard, complaint, or revisit) currently being conducted; and
- 3) There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Ref: S&C-06-01

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a staff member is fired for resident abuse and the facility properly files a report with Division of Health Service Regulation, is the facility also required to notify the State Division of Social Services or the local Department of Social Services?

The answer depends on whether the resident is an adult or child. If the resident is an adult, and not in need of Adult Protective Services, there is no reporting requirement other than the report to the Health Care Personnel Registry Section of the Division of Health Service Regulation. If the resident is a juvenile (under age 18 and unmarried), State law requires any person or institution who suspects that any juvenile is abused (or neglected or dependent) to report the case to the local Department of Social Services. The report may be made orally, by telephone, or in writing.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

How do regulations address the transfer of residents within the same Medicaid certified facility?

Transfer within the same Medicaid certified unit is considered a roommate change rather than a discharge or transfer, unless the move is from a Medicare/Medicaid distinct unit, i.e., SNF/NF unit to a Medicaid distinct unit, i.e., NF unit. If the move is from a Medicare/Medicaid distinct unit to a Medicaid distinct unit, the move is considered a transfer and is governed by the transfer and discharge regulation at 42 CFR §483.12(a). If the move is from a NF to a SNF/NF, this is considered a room change. A resident has the right to refuse a room change if the purpose of the move is to obtain eligibility for Medicare. The resident must receive prompt notice before the room or roommate is changed. However, the regulation does not define the term "prompt" in terms of a minimum number of days. A 30 day notice is not required for a roommate change. Resident preferences and timing should be taken into consideration. If the resident is not being moved for payment purposes, then it is considered a simple room change.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What are the requirements regarding the posting of survey results?

Federal regulation 42 CFR §483.10(g)(1)(2), Examination of Survey Results, states that a resident has a right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be in a place readily accessible to residents (e.g., at eye level for non-ambulatory residents and within reach of all residents). The facility must make the results available for examination and must post either the results themselves or a notice of their availability.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

How are all findings that are referenced on the statement of deficiencies revealed to the facility?

The evidence for a citation begins with a statement of deficient practice that summarizes the issues which led to the determination that the entity was not in compliance with that requirement and contains all of the objective findings. The statement of deficient practice includes:

- (1) the specific action(s), error(s), lack of action (deficient practice);
- (2) when possible, resultant outcome(s) relative to the deficient practice;
- (3) a description of the extent of the deficient practice or the number of cases relative to the total number of such cases;
- (4) the code of the individuals or situations referenced in the extent of the practice, and;
- (5) reference to the source(s) of the information through which the evidence was obtained.

Division of Health Service Regulation sends a separate roster to identify the code of the individuals used in the practice statement.

As surveyors interview the staff to obtain more information and confirm findings, surveyors inform staff of specific issues and concerns. It is expected that there will be open communication between facility staff and surveyors throughout the survey process, initiated by either the facility staff or the surveyor.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Are facilities required to conduct a criminal record investigation for employees?

“No” for existing employees. “Yes” for applicants for employment beginning January 1, 1997. State law, § 131E-265, requires facilities to request a criminal history record check from the Department of Justice on unlicensed applicants for employment. Other existing State law allows, but does not require, facilities to request criminal background checks on current employees (as opposed to applicants).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is there a regulation that requires a nursing facility to have a pay phone on its premises?

No.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Does the Minimum Data Set automation requirement affect residents in licensed only, non-certified beds?

No.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

How much may facilities charge for copying medical records?

According to Federal regulation 42 CFR §483.10(b)(2), “the resident or his or her legal representative has the right to purchase at a **cost not to exceed the community standard** photocopies of the records or any portions of them upon request, and 2 working days advance notice to the facility.” The interpretive guidelines define community standard (in the absence of State law) as “that rate charged per copy by organizations such as the public library, the Post Office or a commercial copy center, which would be selected by a prudent buyer in addition to the cost of the clerical time needed to photocopy the records. Additional fees for locating the records or typing forms/envelopes may not be assessed.”

There is no State statute governing the copying of medical records except in personal injury cases (N.C. G.S. § 90-411).

When copying records for residents or their legal representatives, the federal regulation applies unless the copies are specifically for a personal injury case.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Preface: Rules pertaining to physician services are found at 42 CFR §483.40, tag numbers F385-F390. For the purposes of the rule, physician extenders include physician assistants, nurse practitioners, or clinical nurse specialists and are defined in the interpretive guidelines for 42 CFR §483.40(e) found at tag number F390. The extent of their practice is defined by individual state licensing boards; and they must be under the supervision of the physician.

What are the "required physician tasks" referenced in the rule?

The required physician tasks are:

- Personally approve in writing a recommendation that an individual be admitted to a facility...(F385).
- Physicians must see each resident at least once every thirty days for the first ninety days after admission and at least once every 60 days thereafter (F387).
- Review the plan of care at each required visit, write signs and date progress notes at each visit and sign and date orders (F386).

In SNF distinct parts or dually certified beds (SNF/NF) may a physician delegate the required tasks of visiting the resident for every other visit after the initial visit and other "required tasks" whether the physician extender is employed or not employed by the facility and working in collaboration with the attending physician?

Yes. (F388) (F390)

In a NF distinct part, may any "required task" be delegated to a physician extender who is not employed by a facility?

Yes. (F390)

In a NF distinct part, may tasks other than the "required tasks" be delegated to a physician extender who is employed by the facility, i.e., assessment between required visits, orders, progress notes, etc. other than those required in §483.40?

In a distinct part NF the required tasks, i.e., recommending admission to a facility; and of writing progress notes and signing and dating orders at each visit required once every 30 days x 90 days after admission and once every 60 days thereafter; may not be delegated to a physician extender who is employed by a facility. Other interim tasks, not required by this rule may be delegated to physician extenders employed by a facility, in collaboration with the resident's attending physician. In all cases, delegation to a physician extender does not relieve the physician of the obligation to visit a resident when the resident's medical condition makes that visit necessary (F388).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

In a continuing care retirement community with adult care home (ACH) beds licensed as a part of a nursing home, is it permissible to have a ACH resident in a skilled bed?

Yes. However, you cannot put a nursing home level resident in an ACH bed.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Can a Medicaid recipient who has had a 3-day hospital stay, and meets medical criteria for Medicare coverage refuse to transfer to the Medicare designated unit upon return from the hospital?

Yes. All recipients have a right to refuse transfer to a Medicare-designated unit however, the answer to the second question will explain that they would have to pay for the NF service.

If the resident refuses to transfer, will Medicaid still pay?

No. The following documented excerpt from correspondence received from CMS, November 27, 1996 states: "In most cases involving dual eligibles (Medicare/Medicaid), there is a probable existence of Medicare liability. Providers should bill Medicare before Medicaid, unless there is no Medicare eligibility or coverage and the provider furnishes such confirmation to Medicaid. The Medicare statute (Section 1866(a)(1)(A)) of the Social Security Act (the Act) requires Medicare providers not to charge anyone, including Medicaid, for items or services for which the individual is entitled to have payment made under Medicare (or for which the individual would be so entitled if the provider had complied with the procedural or other requirements under Medicare). A provider's violation of this requirement may cause termination or nonrenewal of the Medicare provider agreement in accordance with section 1866(b)(2) of the Act."

In addition, according to 10A NCAC 22G .0107(c), "In all circumstances involving third party payment, Medicaid is the payor of last resort. No payment will be made for a Medicaid recipient who is also eligible for Medicare, Part A, for the first 20 days of care rendered to skilled nursing residents. Medicaid payments for co-insurance for such residents will be made for the subsequent 21<sup>st</sup> through the 100<sup>th</sup> day of care. The Division of Medical Assistance will pay an amount for each day of Medicare Part A in resident co-insurance, the total of which will equal the facility's Medicaid per diem rate less any Medicare Part A payment, but no more than the Medicare coinsurance amount, effective for such services beginning August 1, 1991. In the case of ancillary services providers are obligated to: (1) maintain detailed records or charges for all residents; (2) bill the appropriate Medicare Part B carrier for all services provided to Medicaid residents that may be covered under that program; (3) allocate an appropriate amount of ancillary costs, based on these charge records adjusted to reflect Medicare denials of coverage, to Medicare Part B in the annual cost report; and (4) properly bill Medicare or other third-party payors or have disallowance of any related cost claimed as Medicaid cost."

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a facility has terminated an employee and has informed the employee they are not to return to the facility due to the facility's determination that the former employee's conduct would jeopardize residents' safety or well-being, and/or disrupts the staff's ability to provide services can the facility refuse the former employee access to visit residents?

Yes. According to 42 CFR §483.10(j)(1)(viii) "Visitation rights are subject to reasonable restrictions... However, this does not mean that any fired employee can be prohibited from visiting a resident in the facility. If there is no reason or evidence that the terminated employee would jeopardize other residents' safety/well-being or disrupt other employees providing services to residents, then the terminated employee should be allowed to visit those residents who request his/her presence."

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Can facilities refuse to allow sitters to provide services to residents in the form of limiting tasks or access to residents based on facility policy? Examples: deny access to resident because of sitter's refusal to be screened for drugs or participate in criminal background checks (if facility policy for sitters) or to limit tasks performed by the sitter such as transferring a fragile or heavy resident.

Yes. The facility is responsible for the care and services of their residents, including protecting them from abuse and neglect.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

When a nursing facility resident is in the hospital overnight or longer, must they re-sign the following components of the admission packet in order to comply with regulatory requirements?

1. Acknowledgement of explanation of resident's rights (assuming none have changed in the interim)
2. Admission agreement
3. Financial responsibility and explanation of charges
4. Consents for treatment
5. Privacy Act notification
6. Medical records releases
7. Ancillary services agreements
8. Medicare and Medicaid eligibility explanations and assignments
9. Explanation of facility rules and policies (assuming none have changed)
10. Resident trust fund information
11. Advanced Directives information

Answer: Federal regulations do not specifically address this issue. However, facility policies and procedures should address whether or not the documents must be re-signed. If a resident has a Medical Orders Scope of Treatment (MOST) form, then the MD, PA or NP needs to review the MOST and sign.

# REGULATORY FOCUS BULLETIN

TITLE TOPIC: Administration

For each document of a resident's medical record in which a licensed or unlicensed caregiver enters their initials in lieu of their signature, must there also be a signature somewhere on that same document that corresponds to those initials?

Yes, unless the facility uses a master signature sheet.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What is the definition of an injury of unknown origin as stated in 42 CFR §483.13 (c) (2)?

The Centers for Medicare and Medicaid Services issued the following clarification in December 2004. See <http://www.cms.hhs.gov/medicaid/survey-cert/sc0509.pdf> .

“An injury should be classified as an “injury of unknown source” when both of the following conditions are met:

- The source of the injury was not observed by any person **or** the source of the injury could not be explained by the resident; **and**,
- The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time”.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What safety requirements are required for securing a resident in a wheelchair in a transport van?

Federal regulations require that measures be taken to keep residents safe and prevent accidents, however, Federal long term care requirements nor State licensure rules specify requirements for securing a resident in a wheel chair during van transportation.

Click on link for more information:

<http://www.ncdhhs.gov/dhsr/nhlcs/pdf/RideSafe.pdf>

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Is there a regulatory requirement that the Matrix Roster be updated weekly by the facility? If so, please give reference.

There is no regulatory requirement for updating the Roster/Sample Matrix (Form CMS-802) on a weekly basis. During a recertification survey, this form is needed by the end of the initial tour (Appendix P P-23).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

The North Carolina statute regarding portable Do Not Resuscitate forms protects medical personnel from liability if they do not resuscitate individuals for whom this form is completed and in their possession. Is there a regulation that requires the form be given to unlicensed personnel such as Nurse Aides, activities staff or friends and relatives who take individuals with such forms in their medical records on social outings in non-medical transport?

No.

# REGULATORY FOCUS BULLETIN FOR YOUR INFORMATION

FILE TOPIC: Administration

NOTE: "FYI is an informational and educational service of the Regulatory Focus Committee to assist you in finding the resources for answers to questions regarding issues not regulated by the Division of Health Service Regulation. The source of the information is included for your reference.

Do health care workers that have been vaccinated for Hepatitis need to be titer-tested post vaccination?

Centers for Disease Control (CDC) recommendations change as research reveals new findings. Refer to <http://www.cdc.gov/> and North Carolina Statewide Program for Infection Control and Epidemiology (SPICE) <http://www.unc.edu/depts/spice/> .

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

Can a facility employ an activity assistant to work one on one with individuals in a role similar to a private sitter?

Yes, with limitations. An activity assistant may sit with a resident and perform duties consistent with an activity assistant's job description as well as be dually trained as a feeding assistant, but may not perform tasks limited to a Nurse Aide I. The resident's care plan should accurately reflect the implemented approaches.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

What information should be considered before a change in the scope of services as it relates to hospice and space leasing, peritoneal dialysis, ventilator dependency, mobile ventilators, out patient rehabilitation, and Alzheimer's and Other Related Dementia Special Care Units?

The state notification requirement is below. Please involve the Division of Health Service Regulation (DHSR) staff early in the scope of services change process.

## 10A NCAC 13D .2104 REQUIREMENTS FOR LICENSURE RENEWAL OR CHANGES

- (c) The facility shall notify the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation within one working day following the occurrence of; (4) changes in magnitude or scope of services;

### **Hospice – Leasing Skilled Nursing Facility (SNF) Space**

- State Certificate of Need (CON) Requirement – A certificate of need may be required before developing or offering the service.
  - Is the service provided in a designated unit?
  - Has the CON Section been contacted?
  - Is a certificate of need or a letter of no review provided?
- Federal Requirement – Medicare State Operations Manual
  - The Centers for Medicare and Medicaid Services (CMS) says hospice programs may lease beds in a nursing home. If a hospice provider is leasing the beds as a hospice unit, then nursing home surveyors would not review this unit during the recertification survey. If there is a complaint in the leased hospice units, then we would survey the complaint using the nursing home requirements.
  - Read 2084A and 2084B - Hospice Provides Inpatient Care Directly which can be accessed at: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/som107c02.pdf>
- Other –
  - Are the beds leased? Obtain a lease agreement.
  - Are the beds contiguous? Obtain form DHSR 4504.
  - During the survey, make sure the residents in these beds were not counted on the census and Minimum Data Set (MDS) forms are not transmitted.

## **Peritoneal Dialysis**

- State CON Requirement - A certificate of need may be required before developing or offering the service
  - Has the CON Section been contacted?
  - Is a certificate of need or a letter of no review provided?
- Federal Requirement –
  - <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter04-24.pdf>.  
See Attachment B.
  - <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter04-37.pdf>
  - S&C 13-40; 04-24 & 04-37
- Policies & Procedures
  - Have new policies and procedures been implemented?
- Other –
  - Obtain a copy of the written contract, agreement, arrangement, polices/procedures and/or plan of care specifying how care is coordinated, to assist with the evaluation of care.
  - Alert the State Survey Agency’s End Stage Renal Dialysis (ESRD) survey team that dialysis is being provided within this Long Term Care (LTC) facility and to any concerns identified during the survey of the LTC facility.

## **Ventilator Dependence Units**

- State CON Requirement - A certificate of need may be required before developing or offering the service
  - Has the CON Section been contacted?
  - Is a certificate of need or a letter of no review provided?
- State Rules
  - 10A NCAC 13D .2506 Physician Services for Ventilator Dependent Patients
  - 10A NCAC 13D .3003 Ventilator Dependence
  - 10A NCAC 13D .3003 Ventilator Dependence refers to 10A NCAC 13D .3005 for staffing
- Federal Requirement
  - §483.25(k)(6) Respiratory Care
- State Construction
  - Has the Construction Section been notified about this change?
  - Has the life Safety code surveyors given approval?
- Policies & Procedures
  - Have new policies and procedures been implemented?

## Mobile Vents

- State CON Requirement – None required.
  - Is a letter of no review provided?
- Federal Requirement - None.
- Policies & Procedures
  - Have new policies and procedures been implemented?

Facility policy should address equipment set-up and maintenance, staff training, resident assessment and monitoring. The medical director should be responsible for the implementation and coordination of the care policy. The facility should code the device according to the latest guidance from the Centers for Medicare and Medicaid’s Resident Assessment Instrument. At the time of this answer, the most recent edition is Version 3.0 Manual, October 2012. The appropriate code for this device is O0100G, BiPAP/CPAP (Bilevel Positive Airways Pressure/ Continuous Positive Airway Pressure). “Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask.” The care plan should reflect the service with measurable objectives and timetables. If at any point, a facility determines the need for the resident to require invasive ventilation, then the resident should be discharged to a licensed facility with a ventilator unit.

## **Outpatient Rehab**

- State CON Requirement - None
  - Is a letter of no review provided?
- State Construction
  - Has the Construction Section been notified about this change?
  - There are no rules regarding the following issues. Consider a separate entrance, visitor space, toilet facilities and secure medical records.
- Federal Requirement –
  - Medicare State Operations Manual §2298A, 2298B, 2302
  - CMS has allowed a separate off-site facility to offer speech, physical, and occupational therapy services to the outside community under their current certification as a nursing home.
  - Skilled Nursing Facilities may treat non-residents of their facility at their established Out Patient Therapy centers; however, there is no provision for them to provide services at another facility and bill Medicare under their SNF number.
- Policies & Procedures
  - Have new policies and procedures been implemented? Are services provided at times that do not conflict with SNF residents' therapies?
- Other – If there is a complaint in the outpatient rehab, then we would survey the complaint using the nursing home requirements.

## **Special Care Unit for Alzheimer's or other Dementia – Moratorium in effect until 7/1/16**

- State CON Requirement - A certificate of need may be required before developing or offering the service
  - Is the service provided in a designated unit?
  - Has the Certificate of Need Section been contacted?
  - Is a certificate of need or a letter of no review provided?
- State Construction
  - Has the Construction Section been notified about this change?
- N.C.G.S. § 131E-114 – Special care units; disclosure of information required.
- Policies & Procedures
  - Have new policies and procedures been implemented?
- Other –
  - Are the beds contiguous?
  - Is this a locked unit?

# REGULATORY FOCUS BULLETIN

FILE TOPIC: Administration

If a nursing home is using contract staff from within North Carolina or from other states, who is expected to retain verification that the criminal record check was completed?

The nursing home is expected to assure and retain verification that a State and national criminal record check, if applicable, has been completed.