

REGULATORY FOCUS BULLETIN

INTRODUCTION

Since its inception in July 1991, the Regulatory Focus Bulletin has served as an important tool for both regulators and providers in North Carolina. RFB is designed to provide clarification of state and federal law, and Nursing Home Licensure and Certification policy in matters relating to the state's nursing facilities. RFB is a joint effort between the NC Department of Health and Human Services, Division of Health Service Regulation and the North Carolina Health Care Facilities Association. Answers and information provided in RFB are agreed upon by both DHSR and the Association and, pursuant to the premise upon which RFB is founded, are binding upon both the regulatory agency and the provider. RFB is the only publication of its type for long term care providers in the country, making it a truly unique contribution in the ongoing effort to ensure quality care in North Carolina's nursing facilities.

Regulatory Focus Bulletin has addressed hundreds of questions on such topics as infection control, nursing practice issues, physical plant requirements, Omnibus Budget Reconciliation Act requirements, and licensure requirements, to name a few. RFB was originally published monthly, with each month's issue addressing any questions raised during that time. Because of the volume of answers provided during its history, RFB was sometimes difficult to utilize. RFB users had to search through back issues looking for answers to important questions.

In early 1993, the RFB committee undertook the ambitious project of organizing over four years of RFB answers into a new, easier-to-use format. The RFB committee also revisited every prior RFB question and answer to determine whether answers were still correct. Those which were no longer applicable because of changes in the law or policy were revised. This process took over six months. The fruit of that labor is the RFB notebook you are now holding.

In this new format, all questions ever answered in RFB have been grouped under one of thirteen topics. The topics are divided by labeled tabs for easy access and pages within each section are numbered sequentially. Each answer is also dated to reflect the date on which the answer was published or revised. In addition, at the back of some sections readers will find yellow pages labeled "For Your Information." These sheets contain information, which DHSR and the Association believe may be helpful to regulators and providers, even though it may not be provided in response to a specific question.

As new questions are answered periodically by the RFB committee, subscribers will receive each answer on an individual sheet which indicates the tab behind which the page should be placed. Each sheet also will be numbered to indicate where within a section it belongs. As law or policy changes and answers need to be revised, subscribers will be provided new answers which indicate the page or pages they are replacing and where to place them in the notebook. Finally, inclusion of the date at the bottom of each page will allow readers to know at a glance when answers were provided.

As always, RFB will continue to provide statutory and regulatory interpretations where appropriate, and to address matters of concern or uncertainty raised by providers or regulators. The issues addressed by RFB are limited primarily to matters within the regulatory purview of DHSR. Occasionally, however, RFB may address an issue not subject to DHSR regulation by relying upon agencies, organizations or experts outside DHSR. In such cases, the source of information provided will be identified.

Occasionally, providers raise questions for which no statutory or regulatory answer exists. In these instances, where appropriate, RFB may offer practice tips or suggested approaches to aid readers. Information of this nature is designed to identify possible approaches only, not to create new mandatory procedures or requirements. Where such information is provided, the text will clearly indicate that it is a suggestion or one of several possible approaches only, not a requirement.

We hope you find the new and improved RFB helpful. Many thanks to the DHSR regulators and the NCHCFA staff and members who spent countless hours reading, researching, negotiating, copying, and collating to recreate RFB in its new format. The 1993 RFB committee dedicates these efforts and this publication to the continuous quest for excellence and quality in the delivery of long term care services.

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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).

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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.

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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.

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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”.

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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.

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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.

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FILE TOPIC: Administration

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

Yes.

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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.

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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.

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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.

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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 21st through the 100th 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.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

A facility was cited for not involving the resident and family "enough" in the care planning process. This specific facility extends an invitation to the resident to attend the care planning process, but since the family usually can not attend, the family meets with the staff after the care plan has been developed to review and make changes to the care plan. The surveyor stated that the family had to be accommodated and present during the care planning process even if it meant holding care planning meetings at 7:00 pm at night.

There is no basis for such a citation. Regarding the care planning process, facility staff should refer to regulations 42 CFR §483.20(d)(3), tag F280. The emphasis on the care planning process is with resident involvement. Meetings should be scheduled to accommodate the resident's schedule/routine. Families should be involved if the resident is agreeable to this involvement or if the resident is incapable or otherwise incapacitated. Care plan meetings do not have to be scheduled to meet a family's working schedule, but this would facilitate their involvement in this process. Alternatives, such as a separate meeting to review, revise, and approve the plan would meet the regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Page Reserved.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

In order to have the care plan easily accessible to the nursing assistants, can the care plan be placed at the bedside on a clipboard or in a folder? For confidentiality purposes the plan would be placed in a colored plastic slip before being put on the clipboard or in the folder. Also, can resident care information, like splints and positioning equipment be posted at the head of a resident's bed?

Yes, if the resident or resident's surrogate, representative, or responsible party gives consent.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Does every medical problem have to be addressed in the resident care plan even if it is not a current problem?

No. Both Licensure and Certification have rules which require that the facility identify resident's current needs/problems, goals, and interventions (PCP) with evaluation of care at least quarterly and revision/updating as needed. A medical diagnosis does not automatically result in a resident "need". Further information should be gathered to clarify if there is a resident problem associated with the diagnosis.

An example of "no resident problem" might be a diagnosis of hypertension with a 5-10 year history of stable/normal blood pressure on medication therapy, and good dietary compliance. All the resident's needs are being met by the medication and diet orders and no nursing or other discipline intervention is needed to compensate for a deficit in the resident's ability to meet his own needs.

The Resident Assessment Instrument (RAI) through triggering mechanisms and resident assessment protocol review indicate which items should be considered through the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are nursing diagnoses required on resident care plans? (Examples: ineffective airway clearance, impaired adjustment to facility, activity intolerance due to immobility)

No. There are no regulatory requirements for the use of nursing diagnoses on care plans. Resident care plans must identify "needs, goals, plans and effectiveness of intervention in a timely manner."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Must resident care plans reflect specific medications and treatments as an approach?

The care planning process dictates the appropriateness of inclusion of medications or treatments. The resident's needs should dictate whether medications and treatments are care planned. It is up to the care plan team, resident and/or family to determine what areas should be addressed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Where should the social work care plan be found - with the interdisciplinary care plan or with individual social history and social work notes?

There is no regulatory requirement for a separate social work plan. Psychosocial needs are to be identified and incorporated into the resident's assessment and interdisciplinary care planning process along with all identified needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for a care planning conference?

There is no regulatory requirement for a care planning "conference". Interdisciplinary care planning may be carried out in many ways. The facility is free to choose the method which is best in any given situation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

May facilities combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs)?

Facilities may combine problems/needs on the care plan as dictated by the resident assessment protocols (RAPs). In fact, in many cases RAP review should link together multiple indicators under one problem/need. The rationale for combining and linking problems should be included in the documented RAP review. Clinical disagreement does not equal non-compliance when the care planning rationales are clearly documented and are within acceptable standards of practice.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan?

No. There is no requirement for acute episodes that do not result in significant or permanent change to be taken to the care plan. Examples of these types of acute episodes are short term alterations in the residents physical and functional condition such as the flu; minor infections including readily resolved and nonrecurrent UTIs and URIs; minor injuries resulting from routine day to day living and not precipitated by a change in condition; non-acute and nonrecurrent GI disturbances; etc.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement for separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review)?

No. Separate discipline specific histories, assessments, and progress notes such as dietary, social work, and activities (other than the MDS and RAP review) are not required. Additional assessment is driven by the individual needs of each resident and the resident assessment protocols, and should follow the same interdisciplinary model. Progress notes are required for goals addressed on the care plan. Should problems be recognized by staff that are not triggered by the MDS, additional assessments and notes by disciplines may be indicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement that each discipline list a problem/need on the care plan?

No. There is no requirement that each discipline list a problem/need on the care plan. There is no requirement that each problem/need have an approach listed for each discipline unless that discipline's intervention is indicated and appropriate.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are individualized approaches, rather than generalized approaches, required for effective care planning?

Yes. Individualized approaches, rather than generalized approaches, are required for effective care planning. Examples of generalized approaches that should not need to be listed on care plans include but are not limited to: "bathe", "dress", "feed", "groom", "nourishments". These terms result in "canned" plans that tend to address all problems generically for all residents with that particular need. Individualized care plans do not plan routine care but plan for the individualized approach necessary to accomplish that routine care. Individualized plans would address issues regarding a resident's bathing needs that are unique for him; what differing types of nourishments should be offered; etc.

Because strengths and weaknesses are considered during the RAP process, it is not necessary to list them on the care plan.

Task segmentation and goal segmentation (short term goals) should be used to individualize the care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is there a requirement that dictates how facilities involve residents and physicians in care planning?

No. There is no requirement that dictates how facilities involve residents in their care planning. Input into the care planning process should be accomplished based on the individuals condition, capabilities, and preferences. This input may be accomplished in private discussions at the bedside or, if the resident chooses, in a conference setting. Similarly, there is no requirement that dictates the manner in which physicians participate in the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Are discharge plans or post discharge plans required for in-house transfers such as level of care changes?

No

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plans

Is it necessary to continue to review at each resident care conference vital parameters if all vital parameters are stable?

No. The regulation states that the comprehensive care plan must be, “periodically reviewed and revised...after each assessment.” The assessment directs the review of the care plan. If vital parameters had been a problem on the care plan they would need to be reviewed to determine if they were still a problem. If vital parameters had been included in a goal, they would need review to determine if the goal had been reached or if the goal needed to be revised or eliminated.

REGULATORY FOCUS BULLETIN

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Care Plan

Do facilities have to create a care plan document for every resident within 24 hrs of admission that includes problem/need measurable objectives, implementation of approaches, etc. in addition to the care plan developed as a culmination of the RAI process?

No, a “care plan document” is not required. The facility should assess and address specific resident areas that need to be managed via MD orders, treatment records, Medication Administration Records, assessments, etc. The records should contain evidence that the care is being provided as needed until the comprehensive assessment is completed.

The references below specifically state that the initial care plan process begins on day 1 and includes problems and immediate interventions.

The **Guidance to Surveyors for tag F281** (May 1999) states “Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan?”

The **Guidance to Surveyors for tag F309** (June 1995) states, “If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided”.

The Long-Term Care Resident Assessment Instrument User’s Manual, Version 2.0 (January 2008) speaks to the formulation of the care plan. It says, “For an Admission assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident’s sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.”

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DIETARY

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Residents are to be served a snack if greater than 14 hours elapse between evening meal and breakfast. What food groups constitute a snack?

The Interpretive Guidelines for 483.35(f) refer to a "nourishing snack" which is an offering of items, single or in combination from the basic food groups. (Meat and poultry; fruit and vegetables; bread and cereal; milk and dairy products).

What is the appropriate manner in which to document a resident's intake of a nourishing snack?

There is no documentation requirement.

Is it acceptable to offer a snack or must a snack be prepared and delivered to each resident?

The regulation states that the facility must offer snacks at bedtime daily.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

How often should a registered dietitian make an entry in a resident record?

Although there is no regulatory requirement that specifies the frequency with which a consulting registered dietitian is to make notes in an individual resident's chart, the need to do so depends entirely upon the condition of the resident and the competencies of the dietary manager. Residents receiving tube feedings, with continued weight loss, renal failure, COPD, diabetes, and other high risk conditions may need to be documented by the dietitian at frequent intervals as dictated by resident needs. Licensure rule .2701(d) states: "The dietitian shall spend sufficient time in the facility to assure the following parameters of nutrition have been addressed and that recommended successful interventions have been met:

1. An analysis of weight loss or gain;
2. Laboratory values;
3. Clinical indicators of malnutrition;
4. Drug therapy that may contribute to nutritional deficiencies;
5. The amount of meal and supplement consumed to meet nutritional needs;
6. Increased nutritional needs related to disease state or deterioration in physical or mental status, i.e., decubitus, low protein status, inadequate intake, or nutrition provided via enteral or parenteral route."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When a physician orders "in between meal snacks" is this interpreted as two times a day or three times a day?

When a physician orders "in between meal snacks" it is not clear to the surveyor whether this means between breakfast and lunch and lunch and dinner or if this should also include between dinner and breakfast. The facility should clarify through policy or physician orders what the intent of the order is and follow this intent.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

May dining rooms have bowls of salt and pepper and sugar packets on the tables for regular diet residents as long as the special diet residents receive the appropriate packets on their trays?

Yes. Regulation does not prohibit this practice; however, facilities must ensure that residents receive the diet prescribed by the physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Can volunteers feed residents?

Yes. The Interpretive Guidelines for Federal regulations found at 42 CFR §483.75(c), tag 493 state, “Volunteers are not nurse aides and do not come under nurse aide training provisions...” The facility must ensure the safety of its residents in all circumstances. Facility risk management measures, such as training volunteers, are not prescribed by regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Can family members feed residents who are either on a regular or a special diet without receiving training as required of nurse aides?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When serving trays in the dining room, is it a requirement to serve all residents at one table, then the next table and so on, or can trays be passed sporadically?

While it is not a regulation that all residents at that table be served simultaneously, it is a possible violation of quality of life if the tray delivery system poses a problem for residents. For example, an unserved resident may be observed trying to take food off another resident's tray or a resident may complain of being hungry and having to wait while a tablemate is already eating.

It is also part of the observations surveyors make for the dining and food service protocol. Surveyors must determine whether residents are being promptly assisted to eat or provided necessary assistance/cueing in a timely manner after their meal is served. They must note whether residents at the same table or in resident rooms, are being served and assisted concurrently.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When feeding a dependent resident is it required that the tray be placed in front of (within view) of them?

There is no written regulation that a tray be placed within view of a dependent resident during feeding. However, it is good practice and common courtesy to allow residents to enjoy the sense of sight and smell as well as their sense of taste during meals. The feeding process should facilitate the mechanics of chewing and swallowing and enhance meal consumption which does occur when the tray is placed in front of the resident. The feeding process also needs to normalize the meal experience as much as practicable to ensure that the resident's rights and dignity are protected. The feeding process should be tailored to the specific needs, desires, and physical condition of each resident and may be addressed in the resident's care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Tube fed residents have a set number of cc intake ordered by the physician. In recording 24 hour intake on I&O records, a variance frequently appears. What is an acceptable variance? Example: 100 cc off in 24 hours on an order of 1800 cc of formula and 500 cc of water.

According to Interpretive Guidelines F328, 42 CFR §483.25(k)(2), "... (Allow flexibility up to 150 cc unless an exact fluid intake is critical for this resident)". This variance is for a 24-hour period.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Is the following procedure acceptable for obtaining food temperatures upon resident receipt? Equipment - food thermometer (that has been cleaned with soap and water) and napkin/paper towel. Upon facility staff serving and setting up the tray for the resident, ask the resident for permission to take food temperatures. With the resident's permission check each food item, wiping the thermometer completely clean with the napkin/paper towel between food items. After the needle ceases to move record the temperature. After obtaining the temperatures wash the thermometer with soap and water, rinse well and dry.

Food temperatures upon resident receipt should be taken from a sample tray. If there is a special case in which a resident's tray is used to test food temperatures, the procedure listed above is acceptable. The thermometer needs to be cleaned once. If this thermometer is used for any application other than taking food temperatures upon resident receipt, the thermometer needs to be cleaned as stated above before putting it in a resident's food.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

What is adequate fluid intake for residents on Intake and Output?

Adequate fluid intake is dependent upon the individual resident's medical condition. The physician, nursing and dietary should perform assessments of the individual's need for fluid. The intake amounts must always be large enough to provide adequate hydration.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

How much time is acceptable between the serving of meals and the feeding of a resident? Is the critical point the time in which the feeding begins or when the resident finishes the meal?

There is not a specific time requirement in this area. Two related regulatory requirements must be considered and adhered to: proper food temperatures must be maintained, and no more than 14 hours may elapse between the evening meal and breakfast.

No regulations specify a maximum amount of time in which residents are to complete a meal. Some residents choose to eat at a slow pace, and have the right to do so.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

When serving trays in a room, is it permissible to give a tray to the self-feeding roommate before giving a tray to the roommate who needs assistance with eating in order to allow the self-feeding roommate to begin to eat as soon as possible? Would it make any difference if the privacy curtain were drawn?

With the following qualification, it is permissible to give a tray to the self-feeding roommate first. The qualification is that serving trays in this way should not be considered a problem by the roommates themselves. If both residents are alert and oriented, the reasons for serving the trays in this way should be explained to the roommates, including the fact that it is a requirement that proper food temperatures be properly maintained. They should be asked individually if they would consider this to be a problem, and whether they would prefer that the privacy curtain be drawn. If there is disagreement, staff should make every attempt to resolve it, and to tailor a solution to the particular situation. If one or both residents are not oriented and discussion is impossible, the trays may be served at different times. In such a case, staff should attempt to determine whether the residents are more comfortable with the privacy curtain drawn or not and act accordingly.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

If a tube fed resident is not receiving the amount of fluid recommended by a dietitian (as derived by an enteral nutritional assessment), what action should the surveyor take?

Failure to follow a dietary consultant's recommendation is not in and of itself a basis for citation. However in response to the example submitted a citation would occur if the surveyor determined upon review of the medical record and staff interview that one or more of the following had occurred:

- (1) There was no documented evidence that the recommendation by the dietitian was communicated to the physician and there was no system in place to ensure effective communication.
- (2) A physician's order had been received as a result of the recommendation but had not been carried out.
- (3) The frequency and severity of the identified situation(s) indicated that the resident's need had not been met.
- (4) There was no documented evidence of follow-up resident assessment should the physician elect not to accept the recommendation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

What are proper food service temperatures to prevent food-borne illnesses?

The Food and Drug Administration instructions to surveyors found on form CMS-804 and Licensure Rule .2701(h) state, “Hot foods shall leave the kitchen (or steam table) above 140 degrees F; and cold foods below 41 degrees F; and freezer temperatures at 0 degrees F or below.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Are there guidelines for cold food storage?

Yes. The Interpretive Guidelines for F371 42 CFR §483.35(h)(2) state that potentially hazardous foods should be stored at 41 degrees F or below and frozen foods kept at 0 degrees F or below. The US DHHS Public Health Service Food and Drug Administration FDA 2005 Food Code provides guidelines for cold food storage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

If a resident's diet is mechanically altered (pureed-chopped) and tolerated well would you mark chewing or swallowing problem L1 on the MDS?

Yes, if the diet was altered for chewing and swallowing problems. The type of diet a resident is on does not determine whether or not there is a chewing or swallowing problem. The resident assessment instrument (RAI) defines a chewing problem as "the inability to chew food easily and without pain or difficulties, regardless of cause." A swallowing problem for example "may include frequent choking or coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

What are the qualifications for a facility's food service supervisor?

Licensure rule .2701(b) states: "The facility shall designate a person to be known as the director of food service who shall be responsible for the facility's dietetic service and for supervision of dietetic service personnel. If this person is not a dietitian, he or she shall meet the criteria for membership in the Dietary Managers Association which is hereby incorporated by reference including subsequent amendments and editions ... If the course has not been completed, this person shall be enrolled in a course and making satisfactory progress for completion within the time limit specified by course requirements."

Contact information for the Dietary Managers Association is:

Dietary Managers Association
406 Surrey Woods Dr
Saint Charles, IL 60174
www.DMAonline.org
630-587-6336

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Considering the exorbitant award to the victim of a hot coffee incident at McDonald's, what is the position on the serving temperature of hot liquids to our frail residents? The agility of our residents certainly should not be as great as someone in the drive through. Should we post a disclaimer "Hot foods served hot?"

No. It is not necessary to post a warning that hot foods, including hot liquids, are served hot. Food must be prepared and served in accordance with principles of sanitation and resident's rights related to food service. Both the licensure rules and federal regulations require food to be served at the preferred temperatures as discerned by the resident and customary practice (Licensure rule .2701(h) and federal regulation 42 CFR §483.35(d)(2), Tag F364). In addition, the licensure rule cited requires food to be served in a form to meet the resident's individual needs and with assistive devices as dictated by the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Weight fluctuations - must a facility notify the physician when an obese resident loses five pounds?

A facility should follow its own policy regarding notification of the physician of weight changes. Interpretive guidelines for F325 and F326 42 CFR §483.25 provide suggested parameters for evaluating significance of unplanned and undesired weight loss.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Can non-perishable (not requiring refrigeration) cans of supplements that are unopened be returned to storage in the dietary department, i.e. shelved or refrigerator storage?

Unless the manufacturer's directions prohibit re-refrigeration, unopened non-perishable cans may be returned to storage from resident areas.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

DATE: March 2012

Does a facility need to dispose of unopened and unused snacks if they have been brought to the resident floor?

If the food item has not been contaminated, it is not expired and it has been held at safe temperatures, then it does not need to be thrown away. The facility's policy should address maintenance of safe and sanitary conditions so that staff, residents and families understand the expectations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Do you need a doctor's order to give dietary supplements to a resident who is on a regular diet?

There is no regulatory requirement for a physician's order for dietary supplements to be added to a regular diet. This practice is dependent upon facility policy and attending physician's preference.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Is it acceptable for facilities to conduct cookouts and serve grilled foods to residents, family members, and staff?

Yes, providing the food is stored, prepared, distributed and served under sanitary conditions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

DATE: March 2012

Is a facility required to add garnishments to a plate to enhance the palatability of a resident meal?

F 364 not only addresses palatability, but also attractiveness. Although the regulations do not require garnishments, if the menu has been planned with a garnish, then the expectation is that the garnish would be added.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

DATE: March 2012

Can a facility “document by exception” a resident’s intake percentage?

The facility should have specific policies and procedures on how the staff documents the record for the resident in all areas, not just dietary. The documentation should be reflective of the problems that are addressed in the care plan and how the resident is attaining these goals. The regulations do not specify modes of documentation. The medical record should contain sufficient information to determine what the plan of care is, how it is being implemented, and whether the goals are being met. At a minimum, there should be a quarterly note that addresses the progress of the plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Dietary

Date: March 2012

Are there regulations that address what a facility needs to do about cleaning, a resident's personal refrigerator, putting dates on the food in a personal refrigerator and checking temperatures of a resident's personal refrigerator?

Facilities should have policies addressing the maintenance of a resident's personal refrigerator when the person is first allowed to bring the appliance to the facility. If facility staff have knowledge of unsafe food storage or risk of food born illness, then the staff must address the issue.

ENVIRONMENTAL

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Life Safety Code requires halls to be free and clear of all obstacles. What if a chair is placed in the hall during the ambulation of a resident who can walk only fifty feet and needs the chair to rest before continuing to walk again?

The situation described would not be a problem. Life safety rules and regulations apply to equipment that has been stored (not in use) in the halls. As with any other item, such as laundry carts, food carts, resident care equipment, etc., items in use are not considered as relating to the rule mentioned.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What diagrams for circuit breakers are required at the electrical panel?

The National Electric Code requires a legible directory at the electrical panel. A legible handwritten directory is acceptable; however, if an illegible diagram/directory is found to be a repeat deficiency, a typed directory has been required in the past in order to solve the problem.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Is the use of a three-way adapter in a resident's electrical outlet against safety and fire regulations?

Yes, as a general rule. There may be exceptions.

Some three-way adapters are listed for the appropriate electrical load that one may wish to connect; however, you must not connect more electrical load to the adapter than it is listed for. A grounding type adapter would be required to be used in a health care setting if allowed by the fire official under section 704 of the North Carolina Fire Prevention Code and the device complies with the National Electrical Code. Generally, the National Electrical Code would allow a grounded adapter in a health care facility if the adapter were listed by an agency such as the Underwriter's Laboratory and if the device is only used with a total connected load that does not exceed the adapter's amperage or wattage rating. A new provision of the 1993 National Electrical Code mandates that all new or replaced receptacles must be "hospital grade" listed at this time.

This would have to be evaluated on a case by case basis as determined by the DFS inspector, the local fire official and/or the local electrical inspector based upon the device, the connected load, and the specific use intended.

It is best not to use these devices because the tendency is to overload them and overloading may cause a fire. These devices may not provide the solid electrical connection needed to prevent shock hazards for the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

When stripping and waxing floors as is done annually, where can we put the furniture from the floors while we are working in the rooms? How can the resident's privacy be assured during this period?

Furniture cannot be left unattended in any corridor that is a path to an exit. Residents who are partially or completely confined to their beds may be moved to areas which provide for privacy (such as a solarium) or privacy screens may be employed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What are the requirements regarding heat detectors in resident room closets of nursing homes?

One condition requiring such installation is in a facility certified for Medicare/Medicaid which, because of construction type, requires complete sprinkler coverage. The facility is required to meet the Life Safety Code which cites NFPA 13 for installation of sprinkler systems. NFPA 13 requires the installation of sprinkler heads in all spaces, including closets. If such a facility was built without total sprinkler coverage, it may be able to meet the Life Safety Code by waiver of the sprinkler system. Fire Safety Survey Report 1985 Code-Health Care (HCFA 2786P) requires in Part III, copy attached, at tag K81, the installation of automatic fire detection devices (heat detectors) in all areas required by the Life Safety Code to be protected by an automatic sprinkler system. Compliance with tags K80 through K83 is required before a waiver of the sprinkler requirement can be granted.

Part III Alternative Provisions for Sprinkler Requirements

If K56 on sprinkler coverage has been answered "NOT MET" and the facility is a one-story protected wood frame or one-story protected ordinary facility, answer the next four items.

K80 Hazardous Areas - All hazardous areas are sprinklered.

K81 Detection Systems - Automatic fire detection devices are installed in all areas required by the Life Safety Code to be protected by an automatic sprinkler system. The detection system is currently listed with UL's Fire Protection List. The system is arranged to close all fire doors in barrier partitions and where possible, shall be connected to the local fire department or central control station. At a minimum, the detection system must activate an alarm system inside and outside the building.

K82 Compartmentation - Resident rooms are separated from each other and all other areas by construction having at least 1 hour fire resistance rating.

K83 Fire Department Response - The response time and capability of the local fire department is adequate, in the judgment of the State fire authority official, to provide an acceptable level of protection for an unsprinklered facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Is the facility required to post “No Smoking, Oxygen in Use” signs on resident doors when the facility is a smoke free facility that has a sign at the front entrance requesting that all smoking materials be extinguished before entering the facility?

No. In healthcare facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking are not required. Facilities may opt to place these signs in the building.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

May housekeeping duties be performed on the nursing units while meal trays are being served?

Yes, as long as no contamination of food occurs and there is no disruption to the areas in which residents are actually eating.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What is a Fire Safety Evaluation System (FSES)? May it be substituted for compliance with the Life Safety code (LSC) in life safety surveys?

Federal regulations require facilities to be in compliance with the Life Safety Code (LSC), which sets federal fire protection standards. Generally, a facility may meet this requirement either by complying with the requirements of the edition of the LSC applicable to the facility or by achieving a passing score on an equivalency instrument known as the Fire Safety Evaluation System (FSES). The FSES is designed to assess whether or not a facility's existing life safety features protect occupants of the facility in a manner equivalent to meeting the literal requirements of the LSC. An FSES evaluation assigns numerical values to specific building and operating features such as sprinklers, exit distances, building height, age of occupants, ability of occupants to evacuate, resident/staff ratios, etc. Then, the FSES uses a mathematical formula similar to a grading system to determine if a building, while not meeting every LSC requirement, has the equivalent safety of a building that does meet all the requirements of the LSC.

If a facility is cited for a life safety deficiency under the LSC, the facility must submit a plan of correction. When submitting its plan of correction, the facility may request an evaluation under FSES. A facility that is evaluated under FSES may have to add to or correct certain features of the building or staffing arrangements to attain a passing score. Sometimes, equivalent safety cannot be attained without repairs or additional features that would cost virtually the same as compliance with the LSC. If the facility elects to be in compliance using FSES, it may have to revise its plan of correction to accommodate the changes needed to achieve passing scores on the FSES and/or correct those deficiencies that are not within the scope of the FSES.

Actual compliance with the LSC may be preferable to compliance using FSES because a facility operating under FSES compliance is more likely to be out of compliance if there is a change in FSES evaluation factors, e.g. staffing or changes in resident population, than a facility in compliance with the LSC.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What should water temperatures be in resident care areas?

Licensure rule .3404(d) states, “A flow of hot water shall be within safety ranges specified as follows:

Resident Areas - 6 1/2 gallons per hour per bed and at a temperature of 100 - 116 degrees F.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What are the proper laundry and dietary water temperatures?

Licensure rule .3404(d) states, “A flow of hot water shall be within safety ranges specified as follows:

Dietary Services - 4 gallons per hour per bed and at a minimum temperature of 140 degrees F, and

Laundry Area - 4 1/2 gallons per hour per bed and at a minimum temperature of 140 degrees F”.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Can air filter machines be utilized in a resident's room?

Yes, if:

1. The machine has no built-in electric heat.
2. The building electrical system has sufficient capacity to safely power the unit(s).
3. The unit is listed and maintained in accordance with the requirements of a nationally recognized test lab such as Underwriters Laboratory. or Intertek.
4. The unit is arranged so as not to produce a trip hazard from the cord.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Can aerosol spray cans be used and stored in residents' rooms, i.e. hair sprays, Lysol and deodorant? These would have the resident's name and room number on them. What about household items?

Interpretive guidance found at tag number F 323 addresses storage of potential hazards in facilities. It says, "Supervision and/or containment of hazards are needed to protect residents from harm caused by environmental hazards. Examples of such hazards can range from common chemical cleaning materials to those caused by adverse water temperatures or improper use of electrical devices.

Chemicals and Toxins. Various materials in the resident environment can pose a potential hazard to residents. Hazardous materials can be found in the form of solids, liquids, gases, mists, dusts, fumes, and vapors. The routes of exposure for toxic materials may include inhalation, absorption, or ingestion.

For a material to pose a safety hazard to a resident, it must be toxic, caustic, or allergenic; accessible and available in a sufficient amount to cause harm. Toxic materials that may be present in the resident environment are unlikely to pose a hazard unless residents have access or are exposed to them. Some materials that would be considered harmless when used as designed could pose a hazard to a resident who accidentally ingests or makes contact with them.

Examples of materials that may pose a hazard to a resident include:

- Chemicals used by the facility staff in the course of their duties (e.g., housekeeping chemicals) and chemicals or other materials brought into the resident environment by staff, other residents, or visitors;
- Drugs and therapeutic agents;
- Plants and other "natural" materials found in the resident environment or in the outdoor environment (e.g., poison ivy).

One source of information concerning the hazards of a material that a facility may obtain is its Material Safety Data Sheet (MSDS). The Occupational Safety and Health Administration (OSHA) requires employers to have a MSDS available for all hazardous materials that staff use while performing their duties. MSDSs are available on-line for numerous chemicals and non-toxic materials, and should be reviewed carefully to determine if the material is toxic and poses a hazard. Poison control centers are another source of information for potential hazards, including non-chemical hazards such as plants."

There are multiple health regulations that address materials that residents can keep in their rooms. Life Safety Code and fire standards have specific guidance regarding electrical equipment, extension cords, etc. that may or may not be allowed. A facility should check with the Construction Section regarding the use of appliances, space heaters, extension cords, etc. before using.

Following is a list of federal and state rules addressing the two areas: medications and household items.

Medications

Federal Requirements

F176 483.10(n)

F425 483.60(a)

F431 483.60(d)

F432 483.60(e)

State Rules

10A NCAC 13D .2306

10A NCAC 13D .2604

10A NCAC 13D .2605

.

Household Items

Federal

No Prefix 483.10(1)

F252 483.15(h)(1)

F253 483.15(h)(2)

F323 483.25(h)(1)&(2)

F454 483.70 LSC

F465 483.70(h)

State Rule 10A NCAC 13D .3400

State Statute 131E-117(14)

The above list is not all inclusive of the regulations and rules but should provide guidance to facilities in evaluating what kinds of medications and household items should or should not be kept in a resident's room and under what conditions they should be kept in a resident's room. Assessment and care planning are an important part in determining the utilization of these items. Also, the resident population of the facility and/or unit population is important in making determinations about the use of these items.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What are the regulations pertaining to cubicle curtains re: 1) replacement requirements; 2) diameter (gauge) of mesh openings; and 3) distance of curtain from sprinkler head?

The Life Safety Code interpretive guidelines indicate that nursing facilities should all have cubicle curtains with 1/2 inch mesh by November, 1996. If facilities do not have 1/2 inch mesh or greater, they can rehang cubicle curtains to the distances specified in National Fire Protection Association NFPA-13, Table 4-2.5.2 (attached).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

Can housekeeping or laundry carts be stored on the floor during meal delivery and feeding?

No. Carts can only be on the halls when in actual use. Carts cannot be stored in the halls.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Environmental

What is the acceptable practice for surveyors to take temperatures (food, water, room, etc.), specifically using their thermometer, the facility's or both?

Water temperature should be taken with a glass bulb thermometer of scientific quality. Food temperature should be taken with a quality meat thermometer. The thermometer may belong to either the facility or surveyor.

How does the facility know the surveyor's thermometer is calibrated correctly, etc.?

The surveyor will allow facility staff to compare the facility thermometer to the surveyor thermometer at the same test location. Calibration can be checked by using an insulated cup with crushed ice/water swirled around for two minutes. The thermometer should read 32 degrees F in this solution.

Should the surveyor take the temperatures in the presence of a staff member?

Yes.

How is a room temperature taken?

Room temperature is taken with a sling psychrometer which has two glass bulb, mercury filled thermometers that are twirled in the air for two minutes.

INFECTION CONTROL

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INFECTION CONTROL

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REGULATORY FOCUS BULLETIN

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.

FILE TOPIC: Infection Control

Regulatory Focus Bulletin will address questions on infection control found in the Federal regulation and North Carolina licensure rules. Most infection control issues are addressed by the Centers for Disease Control and/or the NC Statewide Program for Infection Control. These websites are easy to use. Other informational websites are also provided.

Centers for Disease Control

<http://www.cdc.gov/>

Email Inquiries: cdcinfo@cdc.gov

North Carolina Statewide Program for Infection Control and Epidemiology (SPICE)

<http://www.unc.edu/depts/spice/>

NC Department of Health and Human Services, Epidemiology Section

<http://www.epi.state.nc.us/epi/>

Occupational Safety & Health Administration

<http://www.osha.gov/>

NC Division of Environmental Health

<http://www.deh.enr.state.nc.us/>

REGULATORY FOCUS BULLETIN

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FILE TOPIC: Infection Control

Information on tuberculosis, including but not limited to screening of patients and employees, as well as isolation and reporting can be found at:
<http://www.epi.state.nc.us/epi/gcdc.html> including the NC TB Control Program and the Tuberculosis Policy Manual. You may also seek information on the sites listed on page one of this section.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Do male Residents have to keep the lids on their urinals when not in use?

Aesthetically, lids on urinals should be kept in place when not in use. Absence of lids alone, however, would not justify a citation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can personal care items be stored on the sink area? Private room? Semi-private room? What if each side of the sink area is designated to beds, e.g. the right side of the sink is for bed A and the left side is for bed B?

Yes. In a semi-private room, personal care items should be labeled, if grouped. Items may be stored in the same location in the bathroom as long as storage areas are clean and are consistent with appropriate infection control practices.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can foam overlays and cushions be washed and reused if they are returned to the same resident?

Yes, if the manufacturer's directions are followed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Describe the appropriate protocol for the use of scissors between "clean" dressing changes.

Scissors should be cleaned with an appropriate agent, such as alcohol, before each resident's use and between removal of an old dressing and application of a "clean" dressing.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

There are incidents in other states where facilities are being cited for not having all items covered on the food tray (including dessert or bread) during the transport of the tray from the food cart to the resident. Is this appropriate? Will this be done in North Carolina?

If food carts are covered and positioned outside the resident's room and the tray is removed and taken directly into the resident's room, covering the dessert, breads and beverages is not required.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can alcohol gel pumps be left on top of the med cart during med pass?
The resident's room?

Vulnerable populations should not have access to alcohol based hand rubs.

Reference: The Centers for Medicare and Medicaid Services (CMS), survey and certification letter which can be accessed at: [Survey and Cert Letter 05-33](#) .

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility use styrofoam water pitchers instead of plastic and rather than sanitizing the styrofoam pitchers on a routine basis just discard them?

Yes. However, due to the porous nature of styrofoam, some type of plastic liner should be used. If this liner is the rigid construction type, it should be sanitized on a routine basis.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

If a resident in a semi-private room has a culture positive for methicillin-resistant staph aureus (or any other highly resistant organism) would there be a violation of resident's rights to request a resident in a private room to move to a semi-private room so the private room could be used for an isolation area?

Are there factors that could otherwise influence this move such as payment source, resident/family disagreement with the move, which resident in private room to first consider for the move, privately owned facilities with only a few private rooms (less than 10) used only for private-pay residents? Should they be required to provide the same option rather than an acute care admission?

Licensure rule 10A NCAC 13D .2209(a)(b) states, "The facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. Under the infection control program, the facility shall decide what procedures, such as isolation techniques, are needed for individual residents, investigate episodes of infection and attempt to control and prevent infections in the facility." It is presumed that each facility has a room or rooms identified for isolation should there be such a need. Residents should be advised at the time of admission that certain types of infections necessitate isolation precautions requiring a private room (or single resident use of a semi-private room) and that a room transfer might be needed under those circumstances. If the above has taken place then there is no violation of resident's rights (either the infected resident, the resident in a private room, or the roommate of an infected resident).

Federal regulation 42 CFR §483.12 indicates that a resident cannot be transferred or discharged unless...(iv) the health of individuals in the facility would otherwise be endangered. If "endangered" is interpreted to include increased risk of infection (roommates) or increased compromise of a debilitated individual with an infection, then a room transfer may be acceptable with proper documentation and notification of the resident/family/legal representative.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a nurse aide leave incontinent pads or other linen supplies she intends to use during that shift for a particular resident in that resident's room?

Yes. Small amounts of linen supplies may be left in a resident's room. These supplies, once left in the room, may only be used for that resident, and supplies are not to be "stockpiled."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Clarify items which should not be discarded in resident trash cans.

To ensure a safe environment and prevent the spread of infections, items soiled with bodily fluids such as blood, urine, or drainage from wounds should not be discarded in trash cans in resident rooms. This includes soiled gloves, incontinent pads, diapers and supplies used in the treatment of draining wounds. Transdermal medications should not be disposed of in resident trash cans.

In an effort to control insects and rodents, resident care items such as tube feeding supplies and urinary catheters should not be discarded in resident trash cans. Medicine cups and plastic drinking cups may be discarded in resident trash cans. Significant amounts of medications left in cups should be considered a medication administration issue.

Trash cans should be emptied at least daily or more frequently as needed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Please clarify conditions under which treatment carts may be taken into resident rooms.

There is no restriction on taking treatment carts into resident rooms, as long as nursing staff do not contaminate the cart while it is in the room. [Examples: placing dirty dressings on the cart, going back and forth to cart with contaminated hands, or placing supplies and equipment on the resident's bed then returning them to the cart.] The cart should be secured while in the room so as not to be accessible to other residents in the room. If left in the hallway the cart should be secured so that no medications or biologicals are accessible to residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility be cited for not zipping up the linen covers on linen carts while they are in use?

There is no regulation requiring zippers on linen covers. Linen, however, should be covered. Federal regulation 42 CFR §483.65(c) states, "Personnel must handle, store, process and transport linens so as to prevent the spread of infection." Therefore, an unzipped linen cover would not in and of itself constitute a deficiency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

For routine suctioning (no isolation) must you either use disposable canister liners or gown-mask and gloves?

No, however, this does not exclude the use of personal protective equipment.

Can facilities continue to use the suction machines with glass bottles using facility disinfection policies?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

When residents have extended length oxygen tubing is it permissible that it touch the floor? This is in reference to residents who freely ambulate in their room and need longer tubing. The facility has a policy for wiping down the tubing and changing it weekly. The actual short cannula and nose prongs do not touch the floor. Covers that the facility has made to slip the tubing through were refused by one resident who stated that it made the tubing heavy. Some residents must have the longer tubing to allow them freedom to ambulate and it is impractical to think the tubing won't touch the floor. The floor is cleaned daily. The tubing is a closed system.

For those residents who need extended length tubing in order to ambulate freely in their room or the facility, it is permissible for the extended length tubing to come in contact with the floor. It is not permissible for the cannula or mask to touch the floor.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Do bedpans and urinals have to be labeled/dated?

Dating is not required. Bedpans and urinals should be labeled with the resident's name when used/stored in an area considered multi-use, e.g., residents in semi-private or ward accommodations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can a facility be cited in a situation where a nurse aide is feeding residents at a feeding table and does not wash her hands between the feeding of each resident, if she has not touched a resident?

No. There is no cross contamination from one resident to another if there is not direct contact.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Can cloth towels/washcloths be kept on towel racks in dual-use bathrooms?

Yes, as long as they are not soiled.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

How long can tube feedings hang, and how often do the bags and tubing need to be changed?

There are numerous types of products being used in health care facilities that have varying safe hang times. Follow the recommendation of the manufacturer regarding the particular product in use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

How long can normal saline be used after it has been opened?

Many sterile solutions used for irrigation (i.e., normal saline and sterile water solutions) are labeled as single-use by the manufacturer and contain no preservatives to prevent microbial growth after opening. After opening the container, its contents should be used promptly to minimize the possibility of bacterial growth and pyrogen formation. Any unused portion of irrigating solutions should be discarded and not stored for later use. Facilities should consider using smaller bottles in some situations to prevent waste. Facilities should follow the manufacturer's instructions for use and maintaining and discarding this solution.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

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.

FILE TOPIC: Infection Control

We were of the understanding that in nursing facilities, residents positive with Methicillin-resistant Staphylococcus aureus (MRSA), do not require private rooms. This has been communicated to us by Karen Hoffman, State Infection Control Officer and through articles written regarding guidelines for MRSA Residents in nursing facilities. We are told that surveyors believe these residents must be in private rooms and if not, facilities are being cited. Please clarify.

Placing residents on isolation precautions for Multi-drug Resistant Organisms (MDRO) such as, MRSA, vancomycin-resistant enterococci (VRE), in long term care facilities should be made on a case by case basis depending the risk of cross transmission. Factors that should be taken into consideration are residents with invasive devices (intravenous therapies, tracheostomies, gastrostomy tubes, urinary catheters, open wounds or immunocompromised (<200 total white blood cell counts) residents should not share a room with MDRO infected residents. When the resident is MDRO colonized (positive nasal culture) not symptomatic, then Standard Precautions is generally an acceptable level of precaution. Cohorting individuals may be done when residents have the same MDRO.

Reference: CDC HICPAC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007
http://www.cdc.gov/ncidod/dhqp/gl_isolation.html

CDC HICPAC Management of Multi-drug Resistant Organisms in Healthcare Settings, 2006 <http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf>

NC Guidelines for Resistant Organisms, Specifically MRSA and VRE in Non Acute Care Settings 1997 <http://www.unc.edu/depts/spice/guide.html>

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

On admission, a resident or family member as appropriate, has been informed of the risks and benefits of the flu vaccine. Is it necessary to provide the same information in the fall and each succeeding fall the resident remains in the facility?

§483.25(n) Influenza and pneumococcal immunizations indicates the facility must develop policies and procedures that ensure that—

i. Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

ii. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

iii. The resident or the resident's legal representative has the opportunity to refuse immunization; and

iv. The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Is the facility required to monitor the temperature on a daily basis for individual personal refrigerators that are located in a resident's room?

No. There is no regulatory requirement.

Is the facility required to date and label food that is brought by family members and stored in an individual personal refrigerator located in a resident's room?

No. There is no regulatory requirement.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Is it acceptable to use the same lancing device for fingerstick blood sampling on multiple residents?

The device may be used, but the lancet must be changed for each resident. The best method to use for prevention of bloodborne pathogen transmission is to restrict the use of the lancing device to one resident. Reusing these devices on multiple residents increases the potential for transmission of bloodborne pathogens. This holds true regardless whether this lancing device is spring-loaded or of another type. The CDC cites the fact that HBV circulates in the blood at high titers and can remain viable for at least one week in blood samples that have dried on surfaces.

Although the device may be used on multiple residents, the lancets should never be shared. Lancets and disposable platforms (used to stabilize the device on the finger and control the depth of the puncture) on spring-loaded devices should be changed or disposed of after every use of the device. Optimally, fingerstick devices with disposable platforms should be used only on individual residents. If the device is used on multiple residents, after disposal of the lancet and platform, the device should be cleaned and disinfected at the end of the day and more frequently if visibly contaminated with blood.

If the spring-loaded fingerstick device does not employ a disposable platform, the use of these devices optimally should be restricted to one resident. If this device is used on multiple residents, the lancet should be discarded and the device disinfected between residents.

Some fingerstick devices do not have disposable lancets. The use of these devices should be restricted to use in only one resident and should be discarded when no longer needed by that resident, as the device cannot be disinfected.

The FDA recommends disinfecting the devices per the manufacturer's guidelines. When no instructions for disinfection are provided, the device should be discarded.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Infection Control

Is it a Health Insurance Portability and Accountability Act (HIPAA) violation to post isolation signs on the resident's door and in room?

No, unless the sign exceeded the minimally necessary information, (e.g. details about resident and condition beyond standard of practice for isolation precautions). It is insufficient to post a sign with less information such as "See nurse before entering room."

NURSE AIDES

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Are references required to be checked with previous employer, especially on nurse aides, upon/before employment?

According to the guidelines under 42 CFR §483.13(c), F226, the facility must “have policies and procedures to screen potential employees for a history of abuse, neglect or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Do sitters have to complete the training requirements for nurse aides and be listed with the NC Nurse Aide I Registry?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Does DHSR have the right to verify whether a facility verified the nurse aide's registry number on an application form?

DHSR has the right to verify the facility's documentation, but there are no requirements for this verification to be maintained on an application form. Both Licensure and Certification require facility verification that an individual is listed on the Nurse Aide Registry before allowing the individual to work as a nurse aide except under the conditions identified in 42 CFR §483.75 (e) (5) and Licensure rule 10A NCAC 13D .2304.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What is the requirement in Omnibus Budget Reconciliation Act (OBRA) '87 for Cardiopulmonary Resuscitation (CPR) training for nurse aides and to what level are aides expected to be trained?

Cardiopulmonary Resuscitation (CPR) training for nurse aides is not addressed in OBRA '87. It is addressed in 10A NCAC 13D .2309 (f).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What if the facility does provide at least 12 hours of continuing education each year for nurse aides, but each individual nurse aide does not attend at least 12 hours of continuing education? What recourse does the facility have? Who is ultimately accountable, the nurse aide or the facility?

The facility must provide 12 hours of continuing education to nurse aides annually based on areas of weakness as determined in the nurse aide's performance review and special needs of the residents as determined by the facility staff. The facility is ultimately accountable to see that the staff are fully trained and attend continuing education classes. If nurse aides do not attend required classes, the facility's recourse is an internal matter and would depend on facility policy. The nurse aide must have the required hours to be employed by the facility.

Note: Inservice training can be on an individual basis and can be less than one hour each as long as the total is 12 hours.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

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

Yes, if the facility complies with the CFR §483.35 (h) Paid Feeding Assistant requirement.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

May facilities have contracts with, or otherwise require employees to repay a facility for nurse aide training and competency evaluation programs or competency evaluation programs if the employee does not remain with the facility for a specified period? 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 Nurse Aide Training Competency Evaluation Program or Competency Evaluation Program, the State will provide for reimbursement on a pro rata basis. 42 CFR §483.158 of the final regulations provides information regarding Federal Financial Participation for nurse aide training and competency evaluation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What level of nurse aide can remove a fecal impaction?

Nurse Aide IIs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Can nurse aides give enemas? If so, what level of nurse aide and what type of enema?

A nurse aide I can give a non-medicated enema that does not have a systemic effect.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

May a nurse aide who is trained, but not listed, feed residents?

Yes, provided he/she is an employee of the facility, is enrolled in a DHSR approved training program, has completed a minimum of eight hours of classroom study and demonstrates with the skills check-off list that he/she is deemed competent to feed residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Can nurse aides apply products such as cleansers and skin barrier to incontinent resident's skin? Can these items be kept at the resident's bedside?

Nurse aides may apply products such as skin barriers and cleansers. These products may be kept at the bedside without a physician's order. These products should be stored safely.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Can a student who has successfully completed a state approved Nurse Aide Training program be employed by a nursing facility as a Nurse Aide while waiting to take the Nurse Aide Competency evaluation?

If the individual has worked in the facility for four months or less, a facility may employ an individual who has successfully completed the training component of a state approved training and competency evaluation program, and is waiting to take the competency evaluation. The individual must be a full-time employee and be determined proficient for the tasks he/she is assigned to perform. The training program and the facility must have an agreement (such as a memorandum of understanding) that the training program has a responsibility to be available to answer questions from its students (Federal Register/ Vol. 58 No. 187 Thursday September 26, 1991, page 48896-48897) during the waiting period.

A facility may not employ any individual as a nurse aide in the facility for more than four months, on a full-time basis unless that individual is competent to provide nursing and nursing related services; has completed a training and competency evaluation program or a competency evaluation program approved by the State, and has been determined proficient for the tasks he/she is assigned to perform.

Note: Part-time employees are not eligible to be used by the facility in these instances according to 42 CFR §483.75(e)(2).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

If a provider employs agency personnel as nurse aides, must the provider contact the registry to obtain confirmation of listing?

The facility is ultimately responsible for making sure all the nurse aides it uses are listed on the Registry. Federal regulation 42 CFR §483.75(e)(5) provides as follows:

Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless -- 1) The individual is a full-time employee in a training and competency evaluation program approved by the State; or 2) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Is a facility required to have a documented check-off list in the personnel file of Nurse Aide Is who are hired with experience if they are listed on the registry?

No. Neither the federal regulations nor licensure rules require a check-off list. However, 42 CFR §483.75(e)(8) requires the facility to complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. Also, see licensure rule 10A NCAC13D .2211, regarding personnel standards.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

How soon after a Nurse Aide Training Program Coordinator in an approved program resigns, does the Division of Health Service Regulation have to be notified?

Facilities must notify the Nurse Aide Training and Registry Administration at the Division of Health Service Regulation when there are substantive changes to their training program including changes in coordinators, instructors, and curriculum. To ensure the program remains eligible for Medicaid funding of training program costs, facilities are encouraged to notify the State of anticipated changes prior to the actual change. In abrupt or unanticipated changes, facilities are encouraged to notify the registry as soon as possible.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Is there a rule or regulation to prohibit an unlisted nursing assistant from establishing an employment pattern of less than 120 days in numerous facilities, thus avoiding the competency requirement?

No. Although the rule attempts to discourage such a practice, there is nothing to actually prevent this pattern from occurring. Facilities are encouraged to send employees for competency determination as soon as possible after training is completed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

What are the qualifications for nurse aide training program coordinators and instructors?

Program Coordinator

1. Registered Nurse (RN), currently licensed in North Carolina.
2. Minimum of at two years experience as a registered nurse.
3. At least one year of experience in the provision of long term care facility services, or
 - a) experience supervising or teaching of students in a long term care facility, or
 - b) work experience in a skilled nursing facility which is a distinct part of a hospital.

Primary Instructor

1. Registered nurse, currently licensed in North Carolina.
2. Minimum of two years experience as a registered nurse.
3. Completed a course in teaching adults, or
 - a) experience in teaching adults, or
 - b) experience in supervising nurse aides.

Note: The Director of Nursing in a facility may be the program coordinator but is prohibited from performing the actual training. The program coordinator may also be an instructor if he/she is not employed as the Director of Nursing in the facility, and otherwise meets the qualifications for an instructor.

483.125 (a)(5)(iv) does state that other healthcare professionals may supplement the training and 483.125 (a)(5)(i) states that the course is taught by or under supervision of a RN. The tasks of proficiency checks and student evaluations are the responsibility of the approved RN for the program, not supplemental personnel.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

When a surveyor conducts a complaint investigation, discovers and substantiates an allegation under Tag F 223 when, how, and by whom is the Nurse Aide to be reported to the Health Care Personnel Registry Section?

The administrator shall ensure that the Health Care Personnel Registry Section of the Division of Health Service Regulation is notified within 24 hours of the health care facility becoming aware of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), which includes: abuse, neglect, misappropriation of resident property, misappropriation of the property of the facility, diversion of drugs belonging to a health care facility or a resident, fraud against a health care facility or a resident and injuries of unknown source in accordance with 42 CFR §483.13 which is incorporated by reference.

The facility shall thoroughly investigate allegations of resident abuse, resident neglect, or misappropriation of resident property in accordance with 42 CFR §483.13 which is incorporated by reference, including subsequent amendments, and shall document all relevant information pertaining to such investigation and shall take whatever steps are necessary to prevent further incidents of abuse, neglect or misappropriation of resident property while the investigation is in progress.

Health Care Personnel Registry Section
2709 Mail Service Center
Raleigh, NC 27699-2709
919/855-3968
919/733-3207 (FAX)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nurse Aides

Is there a regulatory requirement regarding the age of training materials for the Nurse Aide Registry?

No. However, all facilities/agencies are encouraged to use current, up-to-date materials in training, whether for nurse aide training programs or in-service education. This was recommended by the Nurse Aide Advisory Committee and is covered in the Committee-approved model curriculum introduction which states, "Use of up-to-date textbooks is an important learning resource for students. We suggest that instructors review several textbooks and select one to use in teaching the course. Several others may be purchased as reference books depending on budget resources. Each section of the curriculum includes a blank section for listing relevant resources for student reading." Instructors are encouraged to use a variety of materials that they have previewed and feel comfortable with. Some prefer one author/publisher over another. The State doesn't recommend any particular text.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When an antihypertensive medication is being administered and the order contains instructions to withhold the medication if the blood pressure readings are not within the specified parameters, does the nurse have to initial, circle the block and explain why the medication was withheld in the nurses' notes, if the blood pressure readings are documented directly on the MAR?

No. If the documentation indicates that the drug was withheld and the reason for the omission is self-explanatory on the MAR (e.g., blood pressure reading), then it is not necessary that the nurse document any further explanation regarding the omission of the drug.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When PRNs, especially laxatives, are administered at the end of a shift and insufficient time has elapsed for the medication to be effective, how should the offgoing nurse handle the documentation of the results? Many times the documentation is left for the oncoming nurse and is frequently forgotten.

The nursing report to the oncoming shift staff must include instructions for follow-up nursing activity from the past shift. If done properly, responsibility for assessment and charting of the effects of the PRN medication is passed to the staff on the next shift. In other words, the staff on the shift in which results are observed should do the charting.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On what basis is a facility cited when a small number of the residents are not out of bed during the hours the surveyors are in the building?

Deficiencies are based on individual residents' needs and choices and are not related to the number of residents in bed at a specific time. A review of medical records, resident care plans, flow sheets, interviews with staff, residents, and families will help determine if a resident's individual needs are being met.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is there a requirement that residents with purulent drainage from a pressure ulcer need to have daily charting?

No. There is no regulation regarding the frequency of documentation for pressure ulcers. Facility policy may address specific charting guidelines. If the purulent drainage constitutes an acute condition (fever or other evidence of an inflammatory/infectious process; sudden onset) or there is a significant change in the drainage (e.g., odor or color) then daily assessment and documentation are usually warranted; otherwise, the drainage may be chronic in nature. Only the nurse(s) directly involved in the ongoing care of the resident can make this judgment.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can "hi-lighters" be used in nurses' notes?

There are no regulations that address this question.

FILE TOPIC: Nursing Service

What is the staffing ratio?

The state licensure and federal requirement do not include staffing ratios that indicate how many residents can be assigned to one nurse or nurse aide. The language in both requirements, CFR 42 §483.30 and 10A NCAC 13D .2303, is “The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.” These requirements can be accessed at <http://www.ncdhhs.gov/dhsr/testrules.htm>. Facilities should staff to meet the needs of its residents for both quality of care and quality of life.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is it required that intake and output records be maintained on all residents with urinary catheters?

No. There is no regulation that requires that intake and output (I&O) records be maintained on all residents with urinary catheters. I&Os should be recorded if the physician orders it or resident's condition warrants it or facility policy requires it.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Measuring contractures - are nurses supposed to be doing this as part of assessment?

No. Measurement of contractures is not a routine part of nursing protocol. A complete nursing assessment and progress notes must include a description of any and all contractures in order to implement necessary interventions. Assessment models (e.g., mild, moderate, severe) should be described in facility policies. Physical therapists and occupational therapists are trained and licensed to measure contractures.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Do injection sites have to be recorded (i.e., Vitamin B₁₂)?

Yes. A complete or thorough nursing assessment for residents receiving injections include the documentation of the injection sites. This applies to all types of injections and for ones prescribed as needed, as well as those given on a routine basis (i.e., every day). Documentation of injection sites is beneficial for evaluating if a resident has an adverse reaction and for rotating sites.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Could you clarify the accepted procedure for administration of eye drops?

According to the interpretive guidance at §483.25(m) for medication errors, the administration of eye drops must achieve the following critical objectives:

- o “Eye Contact: The eye drop, but not the dropper, must make full contact with the conjunctival sac and then be washed over the eye when the resident closes the eyelid; and
- o Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes”.

It is always important to follow manufacturer’s instructions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Is a physician's order necessary for bowel and bladder retraining or restorative feeding program?

No. Specific orders may be needed for a laxative or medication if part of the protocol or when speech/occupational therapy are involved (for reimbursement purposes). Facility administration may choose to require orders for these programs, but that is at the facility's discretion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

If a nurse aide gives a supplemental feeding, can a nurse chart it?

Yes. It is acceptable for a nurse to chart the supplemental feeding, if the nurse verified it with the aide.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Please clarify the definition of "days" in the requirements about time frames for completion of resident assessments and care plans - "working" days or "calendar" days.

OBRA '90 amended the original 4-working day requirement for completion of the resident assessment, which was found in OBRA '87. The current requirements are: that the resident assessment be completed within 14 calendar days of admission, that the care plan be completed within 7 calendar days of the completion of the resident assessment, and that the assessment may be amended through day 21 of residency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What is an acceptable length of time in which to "answer" a call bell?

Regulations do not specify a length of time, however, staff should acknowledge a call bell as soon as possible to determine the urgency of the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

On the intake and output records of residents requiring tube feedings, are facilities supposed to record both the amount of formula and water given, or can these be combined in the intake records?

The facility has to document compliance with the physician's orders that prescribe the amount of formula, water, and/or other fluids the resident is to receive. The facility also has to document total fluid intake for the resident in each 24 hour period. The record of the tube feeding having been administered by the nurse (which is usually kept on the MAR) should show that the prescribed amounts of each fluid were administered. The intake record records the total amount of fluid consumed overall.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

What constitutes an acceptable rehabilitative feeding program?

The regulations do not prescribe how to structure a restorative feeding program. Licensure and certification require resident assessment to determine feeding, skills, and the implementation of interventions to meet the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Clarification for interpretive guidelines, Tag F328 Injections -

1. Do nursing notes indicate, as appropriate, the resident's response to treatment (e.g., side effects, adverse reactions, problems at the injection site, relief of pain)?
2. Does this mean every resident receiving insulin or other routinely administered injection have responses documented in nursing notes or on the MAR? If so, please give an example of a response.
 1. Yes. Adverse reactions, side effects, problems at injection sites would require documentation and follow up in the medical record. This documentation could be entered in the nurses' notes.
 2. No. If a person receiving routine injections has no problem at any given time relative to the injection, then documentation regarding response to the medication is not needed. However, if a problem does occur, assessment and follow up should be recorded.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

FILE TOPIC: Nursing Services

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.

May nurses use signature stamps?

“The North Carolina Board of Nursing has taken the position that the only “signature” which qualifies on any official record or document, including a medical record, must be an original signature. Thus, a signature stamp would not be permitted.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

The quarterly summary form for RAI Version 2.0 now has the potential to elicit responses to items that would trigger a RAP if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

No. Only if the quarterly assessment indicates a significant change in condition has occurred and a significant change assessment is required. If a significant change occurred, a complete reassessment including trigger RAPs would be required. However, members of the interdisciplinary team may use the RAP guideline to aid in the review and revision of care plans quarterly if desired. The regulation requires a quarterly assessment utilizing the RAI Medicare Payment Assessment Form (MPAF) form.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

The guidance to surveyors for F314 states “The staging system presented below is one method...” Would it therefore be acceptable to stage wounds according to the new recommendations of wound care experts, i.e., “healing Stage III” for an area that currently “presents” as a Stage I or II, but was a Stage III? Is it agreed that a Stage III despite current appearances, is always a Stage III and may later break back down quickly to a Stage III?

Yes. The guidelines to surveyors for F314 is appropriate for defining maximum depth of tissue involvement when assessing pressure ulcers prior to the beginning of healing. The guidelines do not address the description of an improved ulcer (reverse staging or staging down).

The fourth National Conference of the National Ulcer Advisory Panel published the following position on the practice of reverse staging of pressure ulcers in *Advances in Wound Care Journal*, Volume 8 #4, July/August 1996.

Reverse staging should never be used to describe the healing of a pressure ulcer.

Healing of pressure ulcers should be documented by objective parameters such as: size, depth, amount of necrotic tissue, amount of exudate, presence of granulation tissue, etc.

The rationale for these statements is that using pressure ulcer staging systems to describe healing must assume that full thickness pressure ulcers heal by replacing the same structured layers as body tissue that was lost. Clinical studies have shown that is not the way the ulcer heals.

Please Note: For the purpose of coding the MDS and Quarterly Review ulcers of all types must be coded by stage. The RAI version 2.0 does not provide for any other type of assessment on this form. CMS is continuing to study this issue.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

It is written that there be documentation of meal intake and supplemental feedings and snacks. However, it does not specify if this documentation must be in the resident's medical record or if a multi-resident form would suffice. Please clarify. Is daily documentation of food intake required for all residents?

Licensure rule 10 NCAC 13D .2701(d)(5) states: “The dietitian shall spend sufficient time in the facility to assure the following parameters of nutrition have been addressed and that recommended successful interventions have been met:...(5) The amount of meal and supplement consumed to meet nutritional needs.”

The facility must have a mechanism for documenting; in the record of each individual resident receiving an in between meal nourishment as a component of a specifically ordered therapeutic diet, whether the resident consumed or refused the nourishment.

The facility must have a mechanism for assessing the resident's food intake in order to record this information in the individual resident's progress notes.

Unless the resident has specially ordered therapeutic supplemental feedings or has nutritional problems or risks addressed in the care plan, there is no requirement for meal by meal documentation of intake.

Please note that the RAI requires intake be assessed for the first 14 days.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

Can a treatment ordered daily or BID be initialed by the nurse when completed as a 7-3 or 3-11 treatment on treatment record rather than a specific time like 11:00 am or 5:00 pm?

The treatment must be recorded and initialed upon completion, however, unless the physician orders the treatment to be done at a specific time, it is acceptable, but not prudent, for the treatment record to reflect a daily or BID treatment as 7-3 or 3-11, rather than an actual time. It would be beneficial for the resident to have times indicated on the treatment record to allow sufficient time to elapse between treatments to ensure the effectiveness of the treatment. The nurse for that shift should initial the treatment as being done for that specific shift or the specified time.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

FILE TOPIC: Nursing Services

DATE: October 1996

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.

What is the time period that is acceptable/permissible for nurses (or other staff) administering medications and/or treatments to sign off (document) administration when it is not done immediately after the act? In other words, how long before blanks or omissions can be filled by staff? Is circling initials with an explanation on back that entry is late, acceptable?

The North Carolina Board of Nursing has provided the following answer to this question:

“Documentation of medications and treatments should be completed immediately after the procedure is done by the nurse. If the nurse fails to document the procedure, but at a later date, that nurse recalls that it was indeed carried out, he/she can enter the documentation in the medical record consistent with facility policy and procedure for late entry. At a minimum, the late entry needs to include the date the information is entered into the medical record and clearly identify the earlier date when the nursing intervention occurred. The exact procedure to follow, such as circling initials with an explanation elsewhere, should be detailed in the facility policy and procedure for late-entry documentation.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

DATE: August 1999

Who must supervise a nurse aide who has successfully completed all course requirements including return demonstrations of clinical skills while they are waiting to take the final competency testing within 120 days?

All students in a Nurse Aide Training Competency Evaluation Program (NATCEP) must be under the general supervision of a licensed or registered nurse when they are performing services for residents. Please refer to the attached letter.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

When the M.D. orders continuous oxygen administration must the nurse document this every shift on the treatment MAR or nurse's notes?

There are no requirements for a nurse to document the use of continuous oxygen every shift on the treatment MAR or nurse's notes. For Medicare reimbursement purposes, refer to the Medicare Provider Reimbursement Manual.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Services

DATE: August 2006

May a Nurse Practitioner serve as Director of Nurses and practice in the facility as well?

No. A nurse practitioner may not serve simultaneously in a dual role as DON and nurse practitioner. The DON is responsible for administering nursing services on a full time basis. The role of the nurse practitioner is as a physician extender in both licensure rule and federal requirement.

Federal regulation 483.30(b)(2) says, "Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis". North Carolina does not have a history of receiving requests or granting waivers for the RN requirement and/or the 24-hour licensed nurse requirement.

483.30(b)(3) says, "The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents".

Full time is defined as 35 hours per week. Registered nurses may share the role of DON. (Licensure does not permit sharing the role of DON. Therefore, this rule takes precedence.)

The licensure rule is more restrictive than the federal regulation.

The licensure rule 10A NCAC 13D .2302 NURSING SERVICES says,

- (a) The facility shall designate a registered nurse to serve as the director of nursing on a full-time basis. (35 hours per week)
- (b) The director of nursing shall be responsible for the administering of nursing services.
- (c) The director of nursing may serve also as nurse-in-charge, only if the average daily occupancy is less than 60.
- (d) The director of nursing shall not serve as administrator, assistant administrator or acting administrator during an employment vacancy in the administrator position.

The clinical services of a nurse practitioner are outlined in section .2500 under physician services in the licensure rule and at 483.40(e) Physician Delegation of Tasks in SNFs in the federal regulation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Nursing Service

DATE: August 2006

What is the regulatory definition of "elopement" versus "wandering" used to determine compliance?

There are no definitions that "determine" compliance. Administrative law judges have supported citations at 483.25(h)(2) related to failure to provide supervision to residents at a level adequate to prevent accidents, as evidenced by repeated elopements and resident-to-resident altercations, often involving severely cognitively-impaired residents and, in some cases, resulting in serious injury. See <http://www.hhs.gov/dab/decisions/dab1726.html>.

According to the interpretive guidance at 483.25(h)(2), "Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless. Non-goal-directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. Moving about the facility aimlessly may indicate that the resident is frustrated, anxious, bored, hungry, or depressed. Unsafe wandering and elopement can be associated with falls and related injuries. Unsafe wandering may occur when the resident at risk enters an area that is physically hazardous or that contains potential safety hazards (e.g., chemicals, tools, and equipment, etc.). Entering into another resident's room may lead to an altercation or contact with hazardous items. While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Facility policies that clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement can help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision. In addition, the resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident."

FILE TOPIC: Nursing Service

May a Director of Nursing be the instructor for Medication Assistants in a facility?

A Director of Nursing can be faculty for the Medication Assistant course but may not teach the basic Nurse Aide course, i.e., Nurse Aide Training and Competency Evaluation (NATCEP).

FILE TOPIC: Nursing Service

Can a skilled nursing facility use mobile ventilators for non-invasive use?

Yes. 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.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is confused and disoriented to the point of not being able to understand what is being communicated to them and the resident has not been adjudicated incompetent although the physician has deemed the resident incompetent, must the resident sign the admission documents or is it sufficient that the responsible party sign?

Each resident who understands the admission paperwork needs to sign the admission documents. If a resident is clearly unable to understand what is being communicated, even if he/she has not been adjudicated incompetent, the facility needs to document this in the medical record, and the responsible party may sign the documents.

When a resident's competence is questionable, as determined by the facility's assessment, it is acceptable for the facility to request signatures from both the resident and the responsible party.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

There is apparent conflict between Resident Rights, 42 CFR §483.10(b)(4), to refuse treatment and frequency of required physician visits, 42 CFR §483.40(c)(1). Since the advent of the Medicare Program in 1966, there has always been the question of requiring physician visits to privately paying residents at fixed intervals. Now, with the aforementioned paradox in mind, the question can be asked if program residents and/or private residents can refuse physician visits at the specified intervals.

There is not a conflict. Regulation 42 CFR §483.10 (b)(4) provides that the long term care facility resident has the right to refuse physician visits that would otherwise be made in accordance with the prescribed schedule in 42 CFR §483.40 (c)(1). It is important to note that 10A NCAC 13D .2501 (b) requires the same physician visitation intervals as the federal requirement. It is expected that a facility should be able to provide evidence of the resident's refusal of such treatment in a manner that would substantiate that the refusal is, in fact, made at the resident's own initiative. Whenever a resident refuses treatment, it is also expected that the facility will assess the reasons for the resident's refusal, clarify the reasons for refusal and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is there a minimum time frame for supervised smoking to assure resident's rights are maintained?

No. Facilities should communicate to residents before admission and through ongoing policies what facility policies are related to smoking. The facility should work with residents who are smokers individually to develop a program that meets the needs of both the resident and the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can the facility use a "bell" for a resident to ring who cannot push the call bell button due to finger contracture or deformity?

A "bell" is one device that can be used in this situation if the resident has the dexterity to use it and it can be heard "on the hall" by the direct care staff

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the water pitcher and cup need to be accessible to residents who cannot pour their own water?

No. Water needs to be accessible for staff to provide fluids. This does not necessarily mean immediately beside the resident's bed

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Do cordless telephones meet the requirements of 42 CFR §483.10(k) which states: "The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard?"

The use of cordless telephones is permissible. Privacy should be afforded to all residents when making or receiving calls unless the resident chooses otherwise.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can a facility be cited for not holding a bed for a Medicaid resident?

A facility is not required to hold a bed for a resident who has been discharged to the hospital unless payment is made by the resident or by someone on his behalf (privately) to retain the bed. However, a resident may have a right to return to the first available bed at the resident's level of care under state or federal law.

Briefly stated, the applicable law and rules are as follows:

(1) Under NC state law 131E -130, all residents, regardless of payor source or level of care, have the right to the first available bed at their level of care if two things occur within 15 days: (a) the resident is ready to be discharged back to the nursing facility within 15 days from the date the resident was admitted to the hospital; and, (b) the facility receives written notification from the hospital of the specific date of discharge (notice must be within the 15 day period). Under this law, returning residents have priority over new admissions to the facility. This law does not apply if the facility cannot provide the resident with the level of care he or she needs (example: the resident has specialized care needs which exceed the level of care offered by the facility).

(2) Under federal OBRA regulations, all Medicaid-eligible residents are entitled to the first available bed in a semi-private room at their appropriate level of care if the resident still needs care of the type offered by the facility. Under the federal rule for Medicaid-eligible residents, there is no time limit or cut-off point regarding this right as there is under state law.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Will a facility be cited if a resident chooses to be dressed in pajamas rather than street clothes?

No. Residents should be allowed the freedom to dress as they choose.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Please clarify Tag F156 section (iii)

...a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

See approved Regulatory Focus Bulletin listing to be posted in nursing facilities, 42 CFR §483.10(b)(7):

STATE CLIENT ADVOCACY GROUPS

Division of Health Service Regulation
Nursing Home Licensure and
Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)855-4520

Division of Health Service Regulation
Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)855-4500 or 1-800-624-3004

Disability Rights North Carolina
3724 National Drive, Suite 100
Raleigh, NC 27612
1-877-235-4210 / 1-919-856-2195
www.Disabilityrightsnc.org

NC Department of Health & Human Services Care Line 1-800-662-7030

Local County Department of Social Services

Medicaid Fraud Unit (Program Integrity)
Division of Medical Assistance
2515 Mail Service Center
Raleigh, NC 27699-2515
(919)814-0181

North Carolina State Ombudsman
Division of Aging and Adult Services
2101 Mail Service Center
Raleigh, NC 27699-2101
(919)855-3433

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does a resident's right to privacy during medical treatments also extend to glucometer and blood sugar checks such that performing these procedures at the nurses' station would be inappropriate?

Yes, privacy should be extended during treatments unless the resident chooses otherwise. For example, if the resident comes to the desk asking to have the blood sugar check done, this is permissible as long as other residents who may witness the procedure are not offended.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible for a nurse (RN or LPN) to put a resident's medication in their food if the resident is combative, confused, and will not take medication orally? If acceptable, is a physician's order needed?

Medications may be mixed with liquids and/or food if the resident refuses to take the medication orally. The nurse needs to be aware of possible food/drug interactions or a listing/resource should be consulted before mixing medications with food. A physician's order to mix with liquid or food is not necessary. The resident's responsible party should be made aware of the facility's intervention.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Will a facility be cited for a violation of resident's rights when a resident or several residents are bathed after lunch?

No. This would not be an automatic citation. Residents are allowed to state a preference for bath time, e.g., many residents may prefer an evening bath. The resident's right to appropriate care would include face and hands washed before and after meals, incontinent care, mouth care and hair combed. These aspects of personal care should be provided even if the bath is not completed until the afternoon or evening.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can resident names be used in taped exit conferences?

No. Resident names cannot be used in an exit conference whether it is taped or not.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights not to receive mail on Saturday?

The facility is required to provide mail to residents each day that the post office delivers mail, including Saturdays. Interpretive Guidance for §483.10(i)(1)-(2) indicates, “Promptly” means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service”.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can surveyors give the names of the residents that were cited as part of a deficiency?

Resident names are to be shared during the survey with the nursing facility staff who have been designated at the entrance conference by the administrator as long as there is not breach of confidence. For example, names of residents who need grooming (nail care, bathing, etc.), residents not turned, repositioned, or released from restraints in a timely manner, acute episodes not followed up, decubiti not assessed or weight loss.

Surveyor interviews of residents are confidential. When a resident requests anonymity, their names are not to be disclosed. A resident's name would not be used, for example, when the resident complained of cold food, staff shortages or call bells not answered.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a Resident's Rights violation for "No Code" residents to wear color-coded identification bracelets?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of residents' rights for residents to be viewed by nonresidents (visitors, family members of other residents, etc.) during mealtime, especially if they must be fed or assisted? This refers to residents whose eating may be difficult or "messy" or who may drool, cough, have problems chewing or swallowing.

No. Grouping of residents with similar abilities may be appropriate during mealtimes. Visitors and family members often visit during this time. It would constitute a violation of residents' rights, however, if the resident preferred privacy during this time. In that case, other provisions should be made to assure residents' privacy.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is confused or combative and refuses to take medications, what should the facility do?

The facility is responsible for evaluating the needs of the resident and the resident's concurrent rights to both receive needed treatment and to refuse treatment. A confused or combative resident may have either right violated in the event assessment and evaluation of the individual situation are not carried out. Refusal of treatment by the confused and combative resident must be consistently documented in the medical record. A plan of care must be developed. Involvement of the resident, family, physician, and resident care planning team may assist in the identification of treatment alternatives.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible to place body diagrams at the head of beds for residents on drainage/secretion precautions and circle or highlight the area of the body that is draining?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights to administer eye drops or medications in the dining room if the resident does not object?

No, it is not a violation of resident's rights.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it permissible for facility staff to awaken residents for routine bathing during the night shift? This would not include those residents who themselves have chosen this as their preferred time, nor those residents who are unable to sleep and staff have determined that this might promote sleep.

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

The N.C. Patient Bill of Rights, Article 30, Right #3, states: "At the time of admission and during his stay a resident is to receive a written statement of services and related charges. A written receipt must be retained by the facility in a resident's file.

Following admission, where services/charges change, how does the facility comply with the requirement of retaining a written receipt?

A "written receipt" would constitute a statement the resident or responsible party signs that he/she has received the written information. How the facility chooses to do this is at its discretion. It is also appropriate that when a facility's services/charges change, during the course of a resident's stay, this information is also provided to residents and/or legal representatives in a written form. A written receipt of this information would be expected and should be in the resident's file.

Is this written receipt to be signed by resident and/or legal representative?

The "receipt" should be signed by the resident if he or she is competent to sign. In the case of a confused or disoriented resident or incompetent resident the responsible party should sign. If there is any question as to the resident's competency it is recommended that both the resident and responsible party sign the receipt.

If "yes", when representative of disoriented resident is out of town and does not return written receipt, what alternative can the facility use? Is it adequate for the facility to document, in the resident's file, that the facility notified resident and/or legal representative?

If a facility has not received a "receipt" from a "legal representative", it is appropriate to send another copy. It can be sent by certified mail. Documentation should then be made in the resident's chart as the continuing status of the requests

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Federal regulations at 42 CFR §483.10(b)(1) provide that a "facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility."

Please identify the "rights" of which the resident must be informed.

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights found at 42 CFR §483.10, §483.12, §483.13, and §483.15.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is a resident's memory or recall of having been advised of the rights listed in 42 CFR §483.10(b) the only evidence a surveyor should consider in determining whether the facility advised the resident of these rights?

No, the surveyor also looks at documentation, such as the admissions packet information that the resident signed when he/she was admitted to the facility. The group is asked about resident rights and how the home facilitates this for residents. Other residents are also interviewed about resident rights on how these are acknowledged and implemented. Surveyors also observe how the facility interacts with residents and determine if resident rights are operationalized daily.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the phrase “in a language that the resident understands” in 42 CFR §483.10(b) mean that facilities must give the statement of resident rights in language taken directly from the regulations or may the facility paraphrase or restate this language for the resident?

The interpretive guideline for this section states that this phrase means the language regarding rights and responsibilities must be clear and understandable. Some facilities and surveyors have felt in the past that residents must be given a verbatim statement of all resident rights using the regulatory language itself. However, to ensure that residents receive this information in a language they can understand, facilities are free to paraphrase the regulations and restate them in layman’s language. There is no requirement that facilities give residents an exact verbatim copy of all resident rights in the same language used in the regulations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

42 CFR §483.10(b) refers to "all rules and regulations governing resident conduct and responsibilities during the stay in the facility?" Does this refer to a body of law or to internal facility rules and regulations?

According to the interpretive guideline accompanying this regulation, the phrase "all rules and regulations governing resident conduct and responsibilities during the stay in the facility" refers to facility policy or facility rules governing resident conduct while in the facility. This phrase does not refer to any body of laws or regulations. It simply means that residents have the right to be notified of policies or rules which they will be expected to honor while residing in the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When advising residents of what services are covered under the Medicaid or Medicare program, is it sufficient if the facility clearly tells the resident what is not covered (i.e., what services the resident will be responsible for) and provides the resident with a statement that all other services are covered by the Medicare or Medicaid program?

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident rights to post the resident plan of care schedule in the facility newsletter or public places within the facility such as bulletin boards?

Posting the dates of the residents' plan of care schedule within the facility does not constitute a violation of resident rights.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can providers prohibit smoking in nursing facilities?

Yes. Please see 131E-114.3 - Smoking prohibited inside long-term care facilities.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When surveyors ask for recent transfers, should the list include room changes within the same certified unit?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the resident's right to refuse treatment include the refusal of a therapeutic diet? Also, if the resident has cognitive loss, can the responsible party request that a therapeutic diet be changed to a regular diet?

The resident has a right to refuse treatment, to refuse to participate in experimental research and to formulate an advanced directive.

The resident's right to refuse treatment includes the right to refuse a therapeutic diet. When a resident refuses treatment, the facility should clearly document: the refusal to reflect the resident's choice, discussion and education regarding the risks of refusing prescribed treatment, and the exploration of alternative therapies. The implications of the refusal should be evaluated by the facility to determine the need for reassessment and modification to the care plan.

A resident or the responsible party (if the resident cannot make a decision), may request a change in therapeutic diet to a regular diet. Ultimately, any changes in the diet must be approved by the physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can a facility charge a Medicare, Medicaid, private pay resident for pre-admission bed-hold days, and for bed-hold days if hospitalized?

The facility may not charge pre-admission bed-hold for Medicaid eligible residents. According to 483.12(d)(3), pre-admission bed-hold charges are prohibited. CMS has no jurisdiction regarding private pay residents.

The facility may charge for bed-hold charges if hospitalized. According to 483.12(b), bed hold policy, charges for a resident who is in the hospital may be paid by the resident or others on the resident's behalf. However, if a Medicaid recipient or surrogate chooses not to pay for the bed-hold, then the resident still has the right to be readmitted by the facility immediately upon the first availability of a bed [42 CFR §483.12(b)(3)]. Bedhold charges per se do not apply to private paying residents—individual facility policy should address how collection of monies are handled for private paying residents who are hospitalized.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Situation: A resident who has not been declared incompetent and has a long standing diagnosis of Schizophrenia is increasingly noncompliant with physicians' orders to the degree that other residents are complaining that their rights are being violated. The resident refuses any form of hygienic care.

1. Are there any special guidelines or procedures to follow when this resident would be homeless if discharged?

The facility should involve the resident, the resident's representative, the entire interdisciplinary team and the physician to work out a plan to deal with these behaviors and address any medication changes. This is not a reason for discharge.

2. Should a PASARR for change in condition be completed?

A PASARR should be completed to reflect a significant change in the resident's behavior and request a Level II screening be completed by mental health. The facility can also petition to the court to have the resident evaluated for commitment procedures.

3. How can a behavior modification program be implemented when the resident will not comply? To what extent can privileges be withheld or rewards utilized in the long term setting?

Behavior modification programs which include withholding of privileges and offering rewards are appropriate in a long term care setting when thorough assessment has been accomplished and a care plan devised for that behavior modification by an appropriate interdisciplinary team. This interdisciplinary team should include a mental health professional when at all possible. The facility team should also consider psychiatric hospitalization to help stabilize the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

How should facility staff handle surveyor requests to enter resident care areas while care is being provided? What should facility staff do if the surveyor wants to examine a particular part of the resident's anatomy?

Residents have the right to be treated in a manner that protects the privacy and dignity of their bodies. Facility staff should protect a resident's privacy and dignity at all times, including those times when a survey team is in the facility.

- Interviews by surveyors. If a surveyor asks to interview a resident or staff member at a time when the resident is undressed, the staff member should request that the surveyor return later when the resident is clothed. Surveyors should not ask to interview residents who are undressed.
- Surveyor asks to observe possible quality of care problem not readily observable. When indicators exist suggesting a quality of care problem that is not readily observable (e.g., leg ulcer covered with a dressing, or a sacral pressure sore), the surveyor should ask for facility staff to assist in making an observation by removing, for example, a dressing or bedclothes. However, if the procedure has the potential to cause pain or discomfort, the surveyor should wait until the next scheduled time of treatment. Such resident care observations should be made by surveyors who have the clinical knowledge and skills to evaluate compliance.
- Surveyor observations of resident's genital or rectal area or female breast area. If a surveyor asks to observe a resident's genital or rectal area or a female breast area to confirm and document suspicions of a care problem, a member of the facility's nursing staff must be present and the resident must give clear consent (see below). Also, only a surveyor who is a licensed nurse, a physician's assistant or a physician can make observations of this type.
- Consent for observations of genital, rectal or female breast area. For a surveyor to observe any of these areas, the resident must give clear consent. If the resident is unable to give consent (e.g., is unresponsive or incompetent) and has a legal surrogate (family member who can act on resident's behalf or other legal surrogate), the surveyor should ask this person to give consent. If there is no consent given by the resident or legal surrogate, a surveyor may only observe a resident's genital, rectal or female breast area if the surveyor has determined there is a strong possibility that the resident is receiving less than adequate care which can only be confirmed by direct observation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the resident have the right to choose his/her own pharmacy and how often can he/she change that request?

The facility is to develop and implement policies and procedures regarding the drug distribution system. The resident should have the right to choose his/her own pharmacy if the dispensed product is compatible with the system employed in the facility and properly labeled. The facility is ultimately responsible for ensuring that medications are available. Frequency of change is not regulated, but is determined by facility policy to assure ongoing availability of drugs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can a family council deny membership to their council because a resident's family member is also an employee of the facility?

The resident is a beneficiary and is entitled to all rights afforded other residents. An employee related to a resident must participate as a family representative, not as a staff member.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

42 CFR §483.10(n) states that a resident has the right to share a room with his or her spouse when married residents live in the facility and both consent to the arrangement. However, if only one spouse is physically and/or mentally able to consent to rooming together, do the spouses have the right to room together?

Yes. Married couples have the right to room together, even if only one spouse is physically/mentally able to consent.

Would it matter if the family members for either spouse did not want the spouses to room together? Assume for the purposes of the question that the incompetent resident does not have a guardian.

No. The opinions of family members are of no legal consequence unless there is good reason to believe that the health or safety of the incompetent spouse would be jeopardized. The facility should pursue this type of problem utilizing the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

Does the licensure rule regarding the reporting and investigation of abuse, neglect, and misappropriation apply only to suspected staff abuse, or does it also apply to resident-to-resident abuse?

The licensure rule requiring reporting of abuse to the DHSR Health Care Personnel Registry Section is limited to allegation of staff abuse, neglect or misappropriation. There is no requirement to report resident-to-resident abuse, neglect or misappropriation to DHSR. However, the facility is responsible for identifying and investigating all incidents of suspected resident abuse, neglect or misappropriation whether by staff or others (including resident-to-resident abuse).

The administrator shall ensure that the Health Care Personnel Registry Section of the Division of Health Service Regulation is notified within 24 hours of the health care facility becoming aware of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), which includes: abuse, neglect, misappropriation of resident property, misappropriation of the property of the facility, diversion of drugs belonging to a health care facility or a resident, fraud against a health care facility or a resident, and injuries of unknown source in accordance with 42 CFR subsection 483.13 which is incorporated by reference.

DHSR has developed a reporting form for facilities to use. It is available online at www.ncnar.org. The facility must make its report to DHSR within five working days of the date the facility becomes aware of the alleged incident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When a DHSR team is conducting a survey, can residents in Medicare and/or Medicaid beds deny access of their records to surveyors?

No. According to federal regulations, a nursing facility can be terminated from the Medicare/Medicaid program if it refuses examination of records necessary for verification of information it furnished as a basis for payment under Medicare 42 CFR §489.53(5) and under Medicaid as a part of the Medicaid agreement with the facility. Since a fundamental prerequisite for payment to a nursing home under Medicare/Medicaid is compliance with requirements for participation, CMS's authority and/or the Medicaid agency's authority to terminate under these regulations extends to the facility's cooperation with the survey agency's certification activities.

State law allows a resident to object in writing to inspection of his/her record by DHSR. However, federal law supersedes state law when a resident is in a Medicare and/or Medicaid certified bed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

What is the nursing home's responsibility in providing information to residents about Medicaid's spousal impoverishment rules?

The facility should advise the resident to contact the local department of social services for information about spousal impoverishment. The facility should provide the resident with that agency's telephone number and, if needed, assist the resident in contacting the agency.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Under federal law, movement of a resident from one room to another within the same certified facility is not considered a “transfer or discharge” but is considered a roommate change. Under federal law, roommate changes are not subject to the 30-day notice requirement applicable to transfers or discharges. Instead, residents must only be given “prompt” notice. However, the North Carolina Patient Bill of Rights at N.C. G.S. 131E-117(15) requires at least a 5-day advance notice to the resident before a transfer or discharge and the interpretive guideline states that this includes movement of a resident from one location to another within the facility. Does this mean the facility must give residents a five-day notice even where the relocation is only a roommate change under federal law and is not a transfer or discharge?

No. G.S. 131E-117(15) requires at least five days’ notice before a transfer or discharge (unless an earlier transfer or discharge is ordered by the attending physician). However, the North Carolina statute does not define a “transfer or discharge” to include movement of residents from one room to another within the same facility (i.e., roommate changes). Nor do any applicable state regulations define transfer or discharge to include movement of residents within the same facility. Therefore, there is no statutory or regulatory basis in state law for equating a roommate change with a transfer or discharge or for requiring a 5-day notice for roommate changes. Therefore, if a facility determines that a planned move of a resident is a roommate change and not a transfer or discharge under federal law, the facility must only give “prompt” notice (which is not defined as a prescribed number of days) and the North Carolina statute does not require a minimum five days’ notice. If the facility determines that the move is a transfer or discharge, it must honor the federal 30-day notice requirement (unless an exception applies under federal law). In so doing, the facility will automatically meet the state’s less stringent 5-day notice requirement for transfers and discharges. A non-certified facility or unit (not required to follow the federal requirements) must give the resident a 5-day notice prior to a transfer or discharge, but is not required to give such notice prior to a roommate change.

It should be noted, however, that federal law does define transfer or discharge to include some roommate changes if the relocation of the resident is across distinct part lines (with some exceptions). All North Carolina facilities which are certified for participation in either the Medicaid or Medicare programs are subject to the federal rules on transfer and discharge, and must comply with federal limits on transfers and discharges in certified beds. The only facilities which are exempt from the federal requirements are those which are not certified for participation in the Medicaid or Medicare programs (this may include the noncertified portion of a facility with certified beds).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

We understand that a resident rights issue exists when a resident is constantly yelling and this behavior is disruptive to the normal daily routine of other residents on her unit and in the facility. What are the guidelines that a facility needs to follow to protect the rights of the other residents?

The rights of other residents include the rights to be treated with consideration, respect, and full recognition of personal dignity; to receive care, treatment and services which are adequate and appropriate; to be free from mental and physical abuse; and to associate and communicate privately and without restriction. The facility must attempt to assess the reason for the behavior, including a complete resident assessment utilizing the appropriate resident assessment protocols (RAPs) to determine the underlying problems (e.g., potential pain the resident is unable to communicate). Causal factors should be relieved whenever possible.

The yelling resident's rights should be balanced against the rights of other residents to peaceful living conditions. If an assessment has been completed, and all possible ways of dealing with the disruptive resident have been exhausted, it may be necessary to transfer or discharge the resident under the regulations found at 42 CFR §483.12 Admission, Discharge and Transfer Rights. Thorough documentation in the medical record of the results of assessment, interventions, etc. is essential.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When a resident requests a discharge to another facility or movement outside of a distinct part to another location in the facility (e.g., from a Medicare/Medicaid bed to a Medicaid bed) are notice of discharge and appeal rights forms required?

No. According to DMA: “Transfer and discharge requirements at section 42 CFR §483.12(a) apply when the facility initiates the transfer or discharge. The purposes of the requirements are to insure that residents remain in the facility in the absence of any of the six criteria at section 42 CFR §483.12(a)(2), and to inform residents of their rights to question the decision of the facility relating to their transfer/discharge. If a resident or resident’s legal representative initiates a transfer or discharge voluntarily, then these requirements do not apply.”

When there are questions regarding specific cases, providers should contact their own attorneys or the attorney for the North Carolina Health Care Facility Association as the DMA Hearing Unit cannot engage in ex parte conversations about how to give notice of transfer/discharge to a specific resident, nor can they give legal advice.

Transfer/Discharge hearings are evidentiary hearings in the sense that witnesses are sworn and the hearing is recorded.

In some cases, providers have lost hearings because of technicalities. In order to make sure cases are not lost due to technicalities, providers should be very familiar with transfer/discharge regulations and any other regulations pertaining to discharge planning. Regulations that speak to transfer/discharge and planning include: 483.10 (o); 483.12(a-b); 483.15 (g)(1) and; 483.20(e).

In addition, providers should make sure that assessments, care plans and other documents that may be relative to the transfer/discharge issues accurately reflect the resident’s condition. For example, if a resident is jeopardizing the health and welfare of other residents, this should be reflected in appropriate assessment data and goal planning. There should be clear documented evidence that the resident is endangering others.

In an emergency situation, like transfer to a hospital, if appeal rights and forms cannot be transported with the resident or the resident has a legal guardian, then the appropriate information should be provided as soon as possible. For example, if the resident leaves the facility late at night, then the information can be sent the next day.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

On rare occasions it is not safe or practical for a resident to have a call bell within complete access. Examples: a resident who wraps the cord around their neck, a resident who wraps it around their arm causing skin tears, or a resident who is completely incapable of using the system as testified to by the physician, family, and caregivers. Can a facility restrict complete access to a call bell under certain circumstances if they develop a policy addressing this issue?

Each resident's ability to have access to the call bell should be reviewed by the resident's care planning committee. When the call bell becomes a safety issue for the resident, or the resident's level of orientation renders him/her unable to understand its use, access should be limited and other methods of assuring communication and safety should be identified.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights for a surveyor to mark the diaper (waistband closure) or underpad in order to monitor the care of the incontinent resident?

We teach surveyors to make observations of care and monitor via observation over time.
We do not mark incontinence products.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does failure to complete any of lines one through eight on the Notice of Transfer or Discharge form automatically invalidate the planned transfer or discharge?

Yes. The resident has the right not to be transferred or discharged unless the proper notice is given. 10 NCAC 26I .0302(b), regarding Transfer and Discharge Requirements states that, "Failure to complete the Notice of Transfer or Discharge form shall result in the notice of transfer or discharge being ineffective."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

We are concerned about our residents that are transferred by EMS and other resident transport services, and are out of the building for an extended length of time. Can we be cited for issues involving personal care while they are with the transport service?

The Division of Health Service Regulation Nursing Home Licensure and Certification Section does not regulate EMS. However, when arrangements are provided under private service agreements, the facility assumes responsibility for meeting the needs of the resident and should include their expectation for the provision of care in the agreement made with the transport service.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does tag # 174 require the facility to install a cordless telephone?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it necessary to always revisit the resident/family information about Advance Directives and the Do Not Resuscitate order when residents are re-admitted to the facility? Would this be determined by how long they are away from the facility before return, or would this be determined by a change in status? How would you define a "change in status?" Is there is a federal requirement that readmissions be "re-given" the admission packet, inclusive of the Do Not Resuscitate order?

Facility policy should address how the facility will treat re-admissions to their facility in regard to advance directives. Refer to interpretive guidance for §483.10(b)(8). DNR orders are not expressly regulated under §483.10(b)(8). The physician writes DNR orders. The facility should have policies regarding the establishment of such orders and when those orders need to be revised based on State law.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Who is the legal surrogate decision-maker for medical treatment choices when a resident is cognitively impaired and has not named a formal health care power of attorney or written a living will?

Ethical guidelines consistently endorse the use of family surrogates to make health care decisions when a resident is cognitively impaired. Procedures for Natural Death in the Absence of a Declaration (§ 90-322) indicates a sequence of family surrogate authority -- a legal guardian, or a spouse, or a majority of relatives of the first degree. This sequence is natural for many families, and should be used in cases of terminal and incurable illness or persistent vegetative state. In other health conditions, the law is not specific, but ethical guidelines and clinical best practices endorse the use of family surrogates who have the best knowledge of the resident's own values and preferences.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is a facility required to accommodate resident food requests outside the routine items ordered for menus? For example: If a resident requests raw broccoli and cauliflower, but the facility does not usually carry the item in stock, are we required to make an individual purchase for that resident or can we ask the family to provide special requests such as this? If 100 residents all had individual requests, where is the cut-off for accommodating preferences?

If the facility can easily accommodate the food request, then it should be honored. It is not expected that the facility has to order a case of raw broccoli to accommodate the resident or make a special trip to the grocery store to purchase the broccoli. Families can be asked to bring in food items that are not a part of the routine items ordered for menus. If many residents are making individual requests, then the facility should establish a resident committee, or use the resident's council to review menu items and make recommendations to establish new menus.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a breach of confidentiality to post a resident's name outside the room next to the entry to the room?

No. However, if the resident or the resident's legal representative/responsible party does not want his/her name posted, then the facility should accommodate the request.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Page reserved.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

A resident is ready for discharge from the hospital back to the nursing home, but there are no beds available for the resident and he/she has to be transferred to another nursing home. Does this resident have the right to the first bed opening in the original nursing home?

Yes, if the resident is Medicaid eligible, then he or she has the right to return to the original nursing home even if he or she had been placed into another nursing home. The nursing home should notify the resident/family of the availability of the bed at the original nursing home. If the resident refuses the bed and chooses to stay at the new nursing home, then the requirement would be satisfied and no further offer would be required.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If survey results are available in public areas without any restriction to access, must the facility also post a notice of the location of these documents?

Yes. Regulation 483.10(g)(11) requires the facility to "make the results available for examination in a place readily accessible to residents and must post a notice of their availability (F167)."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is discharged/transferred to the emergency room or hospital must a notice of discharge be issued?

Yes. Although it is not possible to give the 30-day notice, the federal regulation found at F203 requires that a notice with specified content “be made as soon as practicable” for an “immediate transfer” due to an “urgent medical need.”

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is acceptable practice for dating and using multidose vials?

An open multidose vial may be used up to the expiration date on the label as long as the product does not show any evidence of contamination such as particulate matter or discoloration, unless contraindicated or specified otherwise by the manufacturer. With the advice of the Quality Assurance Committee and medical director, the facility should establish a policy that will ensure a stable and non-infectious product such as dating the vial when initially opened.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

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.

Must insulin be refrigerated?

The temperature for storing insulin should not exceed 75 degrees Fahrenheit. Studies regarding the stability of insulin stored at room temperature provide various time frames, 30 days to 18 months, but none of the studies has been performed for temperatures greater than 75 degrees Fahrenheit. It is the facility's responsibility to develop a policy regarding the storage of insulin and follow the manufacturer's recommendations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

How quickly should a consultant pharmacist submit his/her written report to the facility after monthly reviews?

Federal regulations require documentation of services and for written reports to be submitted to the physician and director of nursing.

Prompt action is necessary if the pharmacist observes a situation which may cause harm to a resident, e.g. adverse reaction to a drug or medication error. The facility and pharmacist do open up liability issues when findings relative to drug regimen reviews are not submitted and/or documented, as well as followed up, in a timely manner.

Licensure rule .2603(a) states that potential drug therapy irregularities or discrepancies must be reported monthly following the pharmacist's assessments.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What are the limitations for borrowing drugs?

Licensure rule .2306(d)(3) prohibits the borrowing of drugs except in an emergency. An emergency in this instance is a matter of professional judgment. When medications are borrowed, there is to be proper documentation and prompt replacement in accordance with the facility's policies. The administrator, director of nursing, and pharmacist should be made aware of problems with medications not being available. The facility should assure policies and procedures regarding the ordering, delivery and the establishment of a reliable drug procurement system and that utilization of emergency drug kits are followed in order to prevent the need to borrow drugs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable "drug not available" policy?

Licensure rule .2601(b) states: “The facility shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for residents in the facility. Resources such as hospitals, wholesalers, and other pharmacies in the community should be contacted to obtain drugs that are not available from the provider pharmacy. If the drug cannot be obtained within a reasonable time period, the physician should be notified.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

May drugs be stored at bedside with a physician's order even if a patient is not capable of self administering a medication?

Yes, for staff convenience if the facility has policies for proper secure storage of drugs at the resident's bedside. These policies are to be implemented for the safety and welfare of all residents in the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable time frame for drugs being available after ordering?

The interpretive guidelines for Tag F425, 42 CFR §483.60 state: “The facility is responsible under 42 CFR §483.75(h) for the “timeliness of the services.” A drug, whether prescribed on a routine, emergency, or as-needed basis, must be provided in a timely manner. If failure to provide a prescribed drug in a timely manner causes the resident discomfort or endangers his or her health and safety, then this requirement is not met.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is an acceptable margin of error in pouring a dose of liquid medication?

Although there are drugs that would not be harmful if the exact dose was not administered, there are many potent drugs that require precise dosage evaluation. Therefore, there is no certain percentage of margin of error that can be accepted for all liquid medications due to the significance of error being based on the medication being poured.

Staff should utilize measuring devices that have increments for the amount to be poured. Depending on the medication, nursing or pharmacy personnel may contact physicians and request a change in the order to a dosage that is more practical to measure accurately.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What constitutes a medication error? At what point should a medication error be written up as an incident?

Licensure rule .2306(d)(1) states: “All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient’s medical record.” Anytime a dose of medicine is given in a manner that deviates from the way the physician ordered it, the manufacturer’s specifications regarding preparation and administration of the drug or from facility policy there is a medication error.

A medication error has occurred if one or more of the following is not correct as specified in the order: the patient, the dose, the drug, the route, or the time of administration. Some documentation of a medication error should exist, and in certain situations, an adverse incident report should be filed. Every facility should establish a policy regarding medication errors, including what steps are to be taken to rectify the problem, if possible, and what sort of documentation is warranted.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Should PRN medications be charted on both sides of the MAR?

Nurses are responsible for charting the medication and amount given, the reason and the effectiveness of a PRN medication. This information is to be documented in the medical record, such as on the back of the MAR or in the nurses' notes. Documentation should be consistent, and any medication administered is to be properly documented on the front of the MAR.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

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.

How long are stock drugs good after they are opened?

Expiration dates on labels are based on stability studies of the drug product in the original unopened container. Even so, drugs are considered to be in date until the manufacturer's expiration date has lapsed, assuming proper storage and packaging as recommended by the manufacturer. Exceptions apply to any drug that a manufacturer has identified as having a shortened expiration date once opened.

To ensure that a drug product meets standards of identity, quality and purity at the time of use, consultant pharmacists should develop, coordinate and supervise proper policies and procedures of individual facilities, including storage and labeling.

Routine medication not dispensed in their original containers should carry an appropriate expiration date as determined by the dispensing pharmacist.

REGULATORY FOCUS BULLETIN

FOR YOUR INFORMATION

FILE TOPIC: Pharmacy

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.

What is the acceptable time period for expiration dates on medication labels that are not in the original manufacturer's packaging, but prepackaged by individual pharmacies in unit dose?

It should be emphasized that pharmacists have a professional responsibility to ensure the integrity of all drug products under their supervision.

The current edition of the US Pharmacopoeia (XII) states that a dispenser must take into account a number of factors in determining reduced expiration dating. Relevant factors include the nature of the drug, the container, and the storage conditions. Current USP policy states "Unless otherwise required, the dispenser may, on taking into account the foregoing, place on the label of a multiple-unit container a suitable beyond-use date to limit the patient's use of the drug. Unless otherwise specified in the individual monograph, such beyond use date shall be not later than (a) the expiration date on the manufacturer's container, or (b) one year from the date the drug is dispensed, whichever is earlier.

The USP also provides that for Single Unit Containers and Unit-Dose Containers for Non-sterile Solid and Liquid Dosage Forms, "In the absence of stability date to the contrary, such date should not exceed 1) 25% of the time remaining between the date of repackaging and the expiration date on the original manufacturer's bulk container, or 2) six months from the date the drug is repackaged, whichever is earlier.

According to available CMS interpretations, the information above is only a guideline for reduced expiration dating for drugs dispensable in multiple-dose containers. Since the language is permissive, the pharmacist is free to estimate a reduced expiration date based on the relevant factors listed above. CMS has also stated through a CMS 1988 memorandum that "bingo" cards (punch cards or "bubble packs") are considered to be unit dose packages. USP standards also consider this type of package to be "unit-dose."

References

1. US Pharmacopoeia, XXII, Rockville, MD, US Pharmacopoeial Convention, 1990.
2. Feinberg, J.L. "Expiration date labeling...", Consult Pharm 1989, 438, 440.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

If a resident wishes to keep an over-the-counter medication at his/her bedside, does the interdisciplinary care planning team need to be aware of such a practice and does a notation need to be placed in the resident's care plan?

Yes. Over-the-counter medication may be kept at the bedside for self administration. Regulation 42 CFR §483.10(n) states that “an individual resident may self administer drugs if the interdisciplinary team, as defined by 42 CFR §483.20(d)(2)(ii) has determined that this practice is safe.” The interpretive guidelines also address documentation in the care plan and the storage of these drugs for self administration.

State licensure regulations require drugs that residents wish to keep at the bedside be stored in a manner to prevent easy access by wandering, confused residents. This storage may include a closed cabinet, private bathroom, or closed drawer. A physician's order is required for residents to self-administer medications and the order should indicate that medications may be stored at the bedside. Facility policy dictates issues such as labeling.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Is it a deficiency to leave expired drugs on the medication cart since the facility has thirty days to return expired drugs?

Expired medications are to be removed from areas storing in-date medications, prior to or at the time of expiration. The facility is to have a designated area for the storage of expired products until the products are disposed of in accordance with the facility's policy. Nurses should check the expiration dates of medications, especially ones not used routinely, prior to the administration or use. Inappropriate storage of expired drugs is regarded as a safety and environmental issue.

Regulation 10 NCAC 13D .2605(a)(4) regarding the removal of expired drugs by the pharmacist within 5 days after the expiration date to the removal of drugs from the facility, not the removal of expired medications from storage areas such as medicine carts or cabinets in medication rooms.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

If a resident is sent to the hospital and admitted but the family holds the room -- are the drugs returned to the pharmacy or do they remain in the patient's medicine drawer on the medication cart? If medications are returned to the pharmacy, can the pharmacist send the same drugs back if the resident returns to the facility with the same medication orders?

Refer to Licensure regulation 10 NCAC 13D .2605(b). Drugs may be held for not more than 30 days after the date of discharge. The storage and disposition of residents' medications is to be in accordance with the facility's policy and procedures. Once the drugs are returned to the pharmacy, the pharmacist needs to use his/her professional and legal judgment regarding the disposition of the medications.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

Due to the conversion of dosage from grains to milligrams, could a facility be cited for giving 300 mg of ferrous sulfate rather than 325 mg although both are 5 grains?

No. Differences among companies exist for ferrous sulfate, ASA, ferrous glucomate and Tylenol. This can lead to confusion in dosage conversions. The facility should be aware of the strength that its pharmacy dispenses, and physician orders should be the same as what is dispensed.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

May drugs have automatic stop orders?

Automatic stop orders should be established for all drugs. The majority of drugs such as antihypertensives will have a stop order that coincides with the renewal of orders (e.g., 30 or 90 days). Other drugs such as antibiotics for acute episodes will have a shorter stop order (e.g., 10 days).

Automatic stop orders should specify the type of product. For example, if the facility's stop order for corticosteroids is 14 days, then all corticosteroid products should be included, unless otherwise stated in the facility's policy.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

What is the acceptable length of time that medications can remain in the facility after a resident is discharged from the facility? (The resident has the intent to return back to the facility from the hospital.)

Thirty (30) days. Licensure rule 10 NCAC 13D .2605(b) states: “Upon discontinuation of a drug or upon discharge of a patient, the remainder of the drug supply shall be disposed of promptly. If it is reasonably expected that the patient shall return to the facility and the drug therapy will be resumed, the remaining drug supply may be held for not more than 30 calendar days after the date of discharge or discontinuation.”

Note: Medicaid residents are allowed one dispensary fee per month.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

DATE: March 1997

Many medications have recommendations to be administered with food to prevent GI related adverse effects (e.g., NSAIDs), and physician orders for these medications read "...with food." Would a package of graham crackers or a package of saltines meet the intent of the order and satisfy regulations for those drugs which require administration with food? (The physician is satisfied with graham crackers or saltines.)

A package of graham crackers contains three 2 1/2" x 2 1/2" crackers and a package of saltines contains two 2" x 2" crackers, and are acceptable amounts of food to be used when administering medications. Although there are no specific parameters given for the amounts of food to be taken with medications, a teaspoon of applesauce would not meet the intent "with food." Three to four ounces of semi-solid food is recommended. The "with food" is intended to prevent possible GI distress and/or aid in drug absorption. Therefore, mealtime would be an appropriate schedule unless otherwise ordered or contraindicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

DATE: September 2004

What are facility responsibilities in regard to residents receiving medications via the Internet, catalogs, or other mail-order vehicles?

The Social Security Act, sections 1819(b)(A)(4)(iii) and 1919(b)(4)(A)(iii), places the responsibility for accurately administering drugs on the facility. This gives the facility the right to define specific standards for labeling, packaging, storing, processing, and administering of drugs. These provisions of the act allow the facility to develop policies to ensure the standards are upheld. Therefore facility policies would determine permissible methods of obtaining medications and biologicals.

1919(b)

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)...

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; ...

1819(b)

(4) PROVISION OF SERVICES AND ACTIVITIES.—

(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of— ...;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; ...

REGULATORY FOCUS BULLETIN

FILE TOPIC: Pharmacy

DATE: August 2006

Must a facility allow a resident to use a pharmacy of choice (proprietary or Veteran's Administration etc.) to dispense prescribed drugs when the pharmacy procedures and practice routinely prevent timely or accurate procurement of the drugs thereby creating a failure to comply with the resident's medical plan of care?

No. The facility must explain to the resident the reasons the resident's choice of pharmacy cannot be utilized so not to be interpreted as a violation of the right to choose.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is it required that physicians sign anything other than orders and progress notes when they visit the facility (e.g., care plans)? If so, please provide the regulation, interpretive guidelines, and/or surveyor probe/procedure.

No. Tag F 386 states, “The physician must write, sign, and date progress notes at each visit, and sign and date all orders.” The interpretive guidelines for this tag state that the physician may transmit orders by facsimile machine if certain conditions are met. One condition is that the physician should have signed the original copy. It is not necessary for a physician to re-sign the facsimile order when he/she visits the facility. The interpretive guidelines for tag F 385 state that a physician must participate in care planning, but do not require that the care plan be signed by a physician.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

When standing orders are initiated per facility policy that have been previously approved by medical staff in an individualized manner on the resident's medical record, is it necessary to fill out and have a physician sign a telephone order slip?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is it necessary to have a specific order for giving a medication with juice?

No, if this does not conflict with the facility's policies, dietary restrictions or physician's orders. There are certain medications that should not be given with juices or other liquids and these should be addressed according to manufacturer's instructions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

What are acceptable procedures for obtaining admission orders?

Medications and other orders should be verified with the attending physician upon admission.

Under what circumstances can orders on a hospital discharge summary or transfer form be acceptable?

Discharge medications on the summary or transfer form are acceptable after verification by the attending physician and transferred to the record containing current orders.

Do admission orders have to be signed by the physician on the day of admission?

Admission orders do not have to be signed by the physician on the day of admission. They can be treated like telephone orders.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Can a stamp be used for the physician's signature on physician's orders?

Yes. When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. Written signatures must be readily available and maintained under adequate safeguards. (42 CFR §483.40(b) Interpretive Guidelines)

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

What is the physician's role in resident care planning? How often must he/she participate or be present?

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

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Is a doctor's order necessary for supplements?

Supplements are defined as those products commercially available or prepared in the facility that are provided to meet a specific nutritional need of the resident.

There is no regulatory basis for requiring a physician's order for supplements. Facility policy must address this issue, and facilities may choose to require such orders. The alternative is to allow the recommendation to be made by the dietitian or by the resident care planning committee.

The following factors need to be considered in determining the appropriate supplement for the resident: the disease process (i.e. diabetes, chronic obstructive pulmonary disease, renal failure, etc.), therapeutic diet if applicable, presence of decubiti, resident's tolerance level, etc.

Bulk (i.e. HS Snacks) nourishments are those items (food and/or drink) which are available and routinely offered to all residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Some facilities are faxing physician's orders to physicians for their signature, and then the signed order is faxed back. Does the original signature need to be on file?

According to interpretive guidelines at §483.40(b), physician orders may be transmitted by facsimile machine if the following conditions are met:

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

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

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Please clarify the frequency of physician visits in nursing facilities now that there is no distinction in the levels of care due to Omnibus Budget Reconciliation Act '87.

Licensure rule 10 NCAC 13D .2501(b) states, “The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

There is apparent conflict between Resident Rights, 42 CFR §483.10(b)(4), to refuse treatment and frequency of required physician visits, 42 CFR §483.40(c)(1). Since the advent of the Medicare Program in 1966, there has always been the question of requiring physician visits to privately paying residents at fixed intervals. Now, with the aforementioned paradox in mind, the question can be asked if program residents and/or private residents can refuse physician visits at the specified intervals.

Federal regulation 42 CFR §483.10(b)(4) provides that the long term care facility resident has the right to refuse physician visits that would otherwise be made in accordance with the prescribed schedule in 42 CFR §483.10(c)(1). It is expected that a facility should be able to provide evidence of the resident's refusal of such treatment in a manner that would substantiate that the refusal is, in fact, made at the resident's own initiative. Whenever a resident refuses treatment, it is expected that the facility will assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services. All of this information needs to be documented.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

If a resident cannot locate a physician to accept him/her as a resident, is the medical director required to add that resident to his/her practice?

No. The medical director is not required to accept a resident into his/her practice because that resident cannot locate a personal physician. Facility staff should make reasonable efforts to assist the resident in locating a physician. 42 CFR §483.75(i)(2)(ii) states, "The medical director is responsible for the coordination of medical care in the facility." The medical director's role would include oversight and supervision of physician services and in this case oversight and/or consultation to facilitate the facility's assistance to the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Define "Physician current orders must be present in the medical record."

Current orders would be any orders that have been prescribed and not discontinued by the physician, automatic stop orders or facility policies.

Can a list of orders be placed on the record to be signed by the physician on his next visit?

Yes, as long as the physician's visit is at least every 30 days for the first 90 days after admission and at least every 60 days thereafter. State and federal regulations require physician visits which include review of the resident's total program of care every 60 days.

Must a list of orders be recopied or reprinted for the attending physician to sign?

There is no specific licensure or certification requirement that physician orders be recopied and reprinted. Licensure rule 10 NCAC 13D .2301(c) states, "All current orders shall be signed and dated by the physician at the time of each visit at least every 60 days." The facility is to have an organized system or procedure that facilitates the review and signing of orders.

Can the attending physician renew orders for signing and dating with a statement "renew current orders?"

A signed and dated statement "renew current orders" is not valid unless preceded by a list of current orders. A recapitulation of current orders is signed and dated every 60 days or each entry (physician's order) is signed and dated every 60 days.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Regulations state that facility policy must include notifying the attending physician when a resident expires. If the resident expires at such a time that someone other than the attending physician pronounces the death, can notification of the attending physician wait until the next routine business day?

Yes. Regulations do not specify timing of notification. Licensure rule 10 NCAC 13D .2901(4) states, “The facility shall have a written plan to be followed in case of resident death. The plan shall provide for the following: (4) notification of the attending physician responsible for signing the death certificate.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Are physical exams by the attending physician required annually?

There is no regulatory requirement for nursing home residents to have annual physical examinations performed by their attending physician. However, the physician's involvement in the resident assessment process is required. The physician's involvement in the annual comprehensive assessment and care planning process is addressed at 10 NCAC 13D .2301(c) and 42 CFR §483.20(d)(2), tag F280.

Please note that in combination homes, the residents of the adult care home portion of the facility are required to have annual medical examinations as referenced in (10 NCAC 13F .7003 (b).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

Please clarify the discrepancy between OBRA regulations (Certification and Licensure) concerning when and what kind of visits PAs/NPs may make and when physicians are required to visit.

Federal regulation 42 CFR §483.40(c) tag F387 states, “The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.”

Licensure rule 10 NCAC 13D .2501(b) states, “Residents shall be seen by a physician at least once every 30 days for the first 90 days and at least every 60 days thereafter. Following the initial visit, the physician may delegate this responsibility to a physician assistant or nurse practitioner every other visit. A physician’s visit is considered timely if the visit occurs not later than 10 days after the visit was required.

Required physician visits, after the initial visit, may alternate between personal visits by the physician and visits by a physician extender (i.e., physician assistant, nurse practitioner, or clinical nurse specialist) so long as the physician extender meets all applicable state licensure or certification requirements for that profession, is acting within the scope of practice for that profession under state law, and is under the supervision of the physician.

NOTE: In North Carolina, clinical nurse specialists do not have the authority to perform medical acts.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Physician Services

If physicians dictate their progress notes, must they make an entry that they visited and “note dictated” in the medical record at the time of the visit?

The physician is obligated to document when a visit is made and what transpired during that visit. There is no time requirement regarding when that note must appear on the chart. Typed notes have the advantage of being legible and often include greater detail than a handwritten entry. As a courtesy to the staff, many physicians make a very brief notation stating a dictated note will follow. Such entries prove particularly valuable if the dictation is delayed or lost. There is no requirement that the physician make a written entry at the time a note is dictated.

RAI

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REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

What is the proper procedure for completing Resident Assessment (RAP) summary sheets?

The purpose of the RAP Summary Form is to provide documentation of the information obtained by using the RAP Guidelines for assessment. Instructions for use are listed at the top of the form which consists of four columns. More detailed instructions are listed below.

Column 1

The first column on the left lists the 18 RAPs.

Column 2

This column contains a series of blocks. Check the box (or boxes) in this column that corresponds to the RAP (or RAPs) triggered by the Minimum Data Set.

Column 3

Following the RAP process outlined in Chapter 4 and the Resident Assessment Protocols located in Appendix C of the Resident Assessment Instrument (RAI) manual, an individualized summary is written for the triggered concern(s). Use the "Location and Date of RAP Assessment Documentation" column to indicate where the RAP summary can be found in the resident's record and date of the summary.

Column 4

This column consists of a series of blocks. It is completed at the time of the development of the care plan. Check the block which corresponds to the RAP (or RAPs) which contains the identified individual problem (or problems) that is addressed on the current care plan. This does not mean that every triggered RAP must be addressed on the care plan. Remember that the summary documentation is going to support the decision regarding proceeding to the care plan or not proceeding to the care plan.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can nurse aides fill out the Minimum Data Set (MDS) form instead of the Registered Nurse Coordinator? The Resident Assessment Instrument (RAI) manual indicates the health professionals who can participate in its completion and several examples of health professionals are listed, but not nurse aides.

A facility has flexibility in determining who should participate in the assessment provided it is accurately conducted. It is the responsibility of the facility to ensure that all participants in the assessment process have the knowledge required to complete an accurate and comprehensive assessment, so in most cases participants are licensed health professionals.

The North Carolina Board of Nursing also defines levels of practice. Nurse aides are not allowed to assess residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does each discipline that participates in the completion of a Minimum Data Set (MDS) have to indicate the sections for which they provided or entered information? What is the regulation (tag number) if a deficiency is cited?

Yes. Federal regulations at 42 CFR §483.20(c)(2), tag F278, require each individual who completes a portion of the assessment to sign and certify its accuracy at AA9.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

My Resident Assessment Instrument (RAI) manual states that heights and weights should be rounded to the nearest whole inch or pound, yet state surveyors tell me I should use the actual height and weight. Which is correct?

The RAI 2.0 manual instructions state: "round height to the nearest whole inch"; "round weight to the nearest whole pound" (page 3-128).

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Must facilities use a specific, designated printed version of the Resident Assessment Instrument (RAI) Version 2.0?

No. Please refer to Chapter 1 in the Resident Assessment Instrument (RAI) User's Manual for Version 2.0. "If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR §483.20(b). This applies to either pre-printed forms or computer generated printouts. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions)." North Carolina allows this flexibility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If a newly admitted resident must return for a temporary stay in the hospital during the first fourteen days of residence, must the completed Resident Assessment Instrument (RAI) information be discarded and a new RAI begun? If a new RAI does not have to be initiated, do you add the remainder of the 14 days to establish the date by which the RAI must be completed? For example, the resident is admitted on January 1 and returns to the hospital on January 10. For purposes of RAI, the resident was assessed for 9 days; therefore there are 5 days after return from the hospital to complete the assessment.

Refer to 2.2 and 2.4 of the RAI Manual

A completed RAI is required by the end of the fourteenth day from admission.

In this example, the assessment was not complete when the resident was sent out and admitted to the hospital. The facility can choose to:

- a) If the resident is admitted to the hospital, a discharge tracking form should be sent (AA8a=8 discharged prior to completion of the admission assessment). If the resident returns to the facility, then the admission assessment should be reinitiated, counting the 14-day period from the new admission date. The portion of the assessment that was previously completed should be stored on the resident's record with documentation indicating the assessment was reinitiated because the resident was hospitalized prior to completion of the admission assessment.
- b) If most of the admission assessment was completed prior to the hospitalization and the resident returns during the 14-day assessment period, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in condition. The ARD (Assessment Reference Date) remains the same in this case, and the comprehensive assessment must be completed by the 14th day from the original date of admission.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If data has been collected for specific sections of the MDS to the extent required to review (work) a particular RAP, is the facility in compliance if this RAP is completed prior to the assessment date, Section A, Item 3 of the MDS? For example, some RAPs are reviewed and completed at the end of seven days and some are completed at the end of fourteen. The fourteenth day is the day the facility enters in A3 as the assessment reference date.

No. The RAI manual states that the assessment reference date is the “designated endpoint of the common observation period.”

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Do facilities have to complete a new face sheet for each Resident Assessment Instrument (RAI) done on an annual basis or due to significant change in condition?

This section is completed at the time of the resident's original admission to the facility and is kept on the active record until the resident is permanently discharged. The face sheet is also required if the resident is readmitted to the facility following a discharge - return not anticipated (AA8a=6).

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does the facility have to indicate on the Minimum Data Set (MDS) quarterly review that the care plan has been reviewed and revised? If so, where is this indicated on the 2.0 version?

No. The facility does not have to indicate care plan review and revision on the MDS quarterly review form. The accurately completed plan in and of itself is the documentation of the review and revision.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does Division of Medical Assistance, Division of Health Service Regulation or the Centers for Medicare and Medicaid Services automatically require a new Minimum Data Set (MDS) when a Medicaid resident's level of care changes from Intermediate Care Facility (ICF) to Skilled Nursing Facility (SNF) or SNF to ICF?

No. Only when the resident's condition has changed to the degree of significant change (see definition in RAI 2.0 manual) must a new Resident Assessment be performed. If a resident's condition does not change significantly and it is the attempted treatment modalities that change, therefore resulting in a change in level of care, the care plan must be revised to reflect the change in treatment/therapies but a new Resident Assessment Instrument (RAI) is not indicated.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

The quarterly summary form for Resident Assessment Instrument (RAI) Version 2.0 now has the potential to elicit responses to items that would trigger a Resident Assessment Protocol (RAP) if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

Quarterly assessments do not require that RAPs be completed. If a significant change was discovered during the completion of a quarterly assessment, a full assessment would be required with the accompanying triggered RAPs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can non-professional staff, e.g., admissions coordinators make entries on the Minimum Data Set (MDS)?

Yes, non-professional staff can input data, but an RN must sign that the MDS is complete.

REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can nursing home staff provide palliative care or treatment designed to promote comfort for residents who are not appropriate for rehabilitative care, and do not qualify for the Medicare hospice benefit?

Persons with 6 months or less to live are generally acknowledged to be "terminally ill," and they qualify for the Medicare hospice benefit. Some nursing home residents will suffer the symptoms of incurable, end-stage chronic disease for more than 6 months at the end of their lives. For example, many nursing home residents eventually die from complications of dementing illnesses such as Alzheimer's or multiple strokes, and others suffer from end-stage heart or lung diseases. In the natural course of these illnesses, some residents will reach an end-stage of disease that is irreversible and incurable. Near the natural end of life, persons with these illnesses will typically be unable to walk or participate in self-care even with aggressive staff encouragement and rehabilitation. They often lose their appetite, reduce intake, and lose weight in the final stages of illness.

Nursing home residents and their families may elect an approach to care that maximizes comfort and minimizes suffering during the final phase of any severe chronic or terminal illness. Nursing home staff, together with residents and families, may create palliative care plans or treatment plans designed to promote comfort when rehabilitation is not possible or appropriate to the resident's wishes and needs. According to OBRA 1987, skilled nursing facilities must "...provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." This set of goals is met for residents who are progressively declining toward death by using care plans that differ from care plans for residents who are expected to improve with rehabilitation. A palliative plan of care is most appropriate when the primary goals of treatment are to ensure comfort, improve psychosocial well-being, and maximize quality of life. The critical steps in designing and implementing an appropriate palliative care plan is individualized resident assessment and careful communication and goal-setting with resident and family.

Facilities should document the following process to arrive at an appropriate palliative care plan for a resident with end-stage chronic or terminal illness, whether or not they are enrolled in hospice care.

- a) Physician documentation of the life-limiting disease diagnosis and end-stage prognosis.
- b) Nursing and therapy team assessment of resident's functional status decline, and the failure of rehabilitative measures to improve functional status.¹
- c) Interdisciplinary care planning with resident and family, to discuss diagnosis, prognosis, and appropriate goals of care; resident and/or family should express the resident's desire for a natural death, and his or her wish to create a care plan focused on quality of life and comfort.
- d) Nursing and social work assessments of palliative care needs -- physical pain and other symptoms, emotional, social, and spiritual sources of suffering.
- e) Chart documentation of palliative care plan of treatment designed to improve comfort and quality of life.
- f) Chart documentation of a discussion of treatment preferences, and physician orders to respect preferences, including Do-Not-Resuscitate orders, Do-Not-Hospitalize orders, orders to forego other life-prolonging treatments such as tube-feeding or antibiotics, orders to give comfort treatments such as pain medication, and other supportive measures.

¹ If the patient is in a Medicare/Medicaid bed, the Resident Assessment Instrument and protocols (RAPs) should be used accordingly. When working "RAPs" triggered by the required MDS, the assessor can note how rehabilitation and restorative measures would not be beneficial nor appropriate interventions for goals such as comfort and psychosocial well-being of the individual.

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A resident is weak, unsteady on her feet, and confused. The physician, family and care team have "weighed the risks and benefits" and decided it would be best to use physical restraints. When the resident begins to regain her strength, her confusion lessens, and the staff feels more comfortable with her ambulating independently, and the staff discontinues use of the restraint. If the resident then falls and breaks her hip, is the staff liable?

It is not within the parameters of the RFB Committee to address legal issues providers may encounter. Initiation and/or discontinuing a physical restraint must be based on the resident's medical needs and must be ordered by a physician. The answer to this question depends on many factors, such as whether the facility was acting in accordance with a physician's order in removing the restraint, whether the physician acted properly in issuing such an order, whether both the order and the resulting action were consistent with the standard of care, and so forth. Physicians and facilities both have a duty to residents to act with care and in accord with the standard of care. Whether that duty has been met depends on the unique facts of each case. It is impossible to predict accurately in any specific case whether a facility will incur civil liability for injuries to a resident.

An individual caregiver's liability is a legal matter determined in litigation on a case by case basis.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A provider is trying to reduce restraints by means of lesser methods. What is the legal implication for the provider if the resident falls under lesser method when a physician's order on the chart calls for a more restrictive restraint? How should the provider handle this potential situation with a physician?

It is not within the parameters of the RFB Committee to address legal issues providers may encounter. However, the facility must assess and implement least restrictive measures, as appropriate. If the physician is insistent that a more restrictive restraint be used, documentation must support the medical necessity, as well as involvement of the resident, family member or legal representative. Where conflicts arise, involvement by the medical director may be necessary.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What if an Alzheimer's resident constantly wanders to the point of exhaustion? Can the resident be restricted at times so he/she can get some rest?

There are times when restraints may be appropriate. The resident care planning process should provide for an assessment need under differing circumstances or resident behavior patterns and care plan accordingly. The care plan should be specific regarding times for restraint usage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a facility be cited for using a restraint that is made by a different manufacturer than one cited in the physician's order?

Restraint orders are to be specific as to type versus brand name of a restraint used. An order such as "Posey Restraint when OOB (out of bed) in chair" is not acceptable because it indicates the manufacturer, not the type of restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Regarding the statement in surveyor guidance regarding "did the resident or legal representative consent to use of restraints and is this documented" - what specific consent is the surveyor looking for?

Specific consent regarding restraint use must be obtained from the resident or legal representative at the time a decision to utilize a restraint is made by the interdisciplinary team. There is no requirement that this consent be documented in any specific format but there must be evidence that discussions have taken place.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a resident be restrained in a non-mobile chair or is the facility required to use only chairs with wheels for restraining?

Regulations do not govern the type of chair selected by the care planning team.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is a geri-chair a restraint if you take the table/tray off? What if the resident can't move but wants the geri-chair table/tray to hold personal items (e.g., tissues)? Would the use of a geri-chair for meals and activities be considered a restraint or an enabler?

When geri-chairs are utilized with or without the table/tray to restrict freedom of movement or mobility, they are considered restraints. In the event that the geri-chair is used as a positioning device for an immobile resident (or the tray used at the resident's request per se), all measures to prevent functional decline must be implemented including, but not limited to, release and repositioning. In both circumstances, the use of the geri-chair must be incorporated into the care planning process.

When geri-chairs are utilized with or without the table/tray, the facility should apply the definition of a restraint. The definition for a physical restraint according to the Medicare State Operations Manual, Appendix PP and the Resident Assessment Instrument manual is, “Physical Restraints” are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body”. So, if the geri chair meets the definition of a restraint, staff should code it as a restraint and the Resident Assessment Protocol will explain the use of the device. There are ways to hold personal items other than a table top on the geri chair. The care plan should also clearly define its use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is acceptable evidence of consultation with appropriate health professionals (i.e., physical therapists, occupational therapists, etc.) in the use of less restrictive supportive devices prior to using physical restraints?

Evidence of consultation with appropriate health professionals includes interdisciplinary notes, assessments and care plans.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A physician's order reads "may restrain with geri-chair with tray and/or vest restraint for resident's safety." Is it possible for the charge nurse to apply a lesser restraint (e.g., soft waist) without a new physician's order?

No. If, after evaluating the resident, the nurse determines that a less restrictive restraint is appropriate, the physician must be advised and a change in the restraint order obtained.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can surveyors "mark" restraints?

No. Surveyors should make continuous observations to determine if the physician's order or care plan approaches are being implemented.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What do you do if a resident's family requests restraints even though they have not been ordered by the physician?

Restraints are applied after a thorough assessment of the need to treat a medical symptom, a trial of less restrictive measures, and only with a physician's order. Restraints are not to be applied solely at the request of a family member.

The facility should consult and educate the family about why a restraint is not used or a restraint is being reduced. The facility should have a systemic method for reducing or removing restraints with family participation. The facility should have clear policies and procedures concerning the use of restraints, reduction and removal. This should be shared with the resident/family/responsible party upon admission and periodically throughout the resident's stay.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can restraints be tied to the siderails of beds?

No. Restraints are not to be tied to siderails. Siderails can slip and fall, causing serious injury to the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a resident is in a geri-chair and is wearing a vest restraint, is this a "double restraint" and therefore a violation of the resident's rights?

There is no regulatory terminology that refers to "double restraints." We would really discourage the use of vests in any situation. If it is determined to be medically necessary, it would be used as an exception. This issue would be surveyed from the perspective of compliance with restraint usage.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Page Reserved.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a resident who is alert and oriented be restrained because the family wants him/her restrained? Can the family refuse restraints on the behalf of an alert and oriented resident?

No. An alert, oriented resident who is his own legal representative has the right to make decisions regarding restraints regardless of family opinion.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

How do we address restraints on care plans?

Interpretive Guidelines for the restraint requirement §483.13(a) at tag numbers F221 describe in detail the factors which the facility should consider in determining when and how to utilize restraints as well as considerations for care planning.

An entire section of the interpretive guidelines for restraints is devoted to assessment and care planning for restraint use.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Page Reserved

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Is a reclining chair a restraint? Do you need to have a physician's order?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The Interpretive Guidelines at §483.13(a), F221 state, "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints." This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints.

If a reclining chair restricts the resident's body so that he or she cannot easily move, and the resident cannot remove the restriction easily, then the reclining chair would be considered a restraint and would require a physician's order. Because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint.

When residents are physically incapable of initiating any voluntary movement and the reclining chair is an alternative to bedrest, the reclining chair is not considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are bed cover retainers restraints?

The bed cover retainers are not considered a restraint when applied to assist the resident in maintaining privacy and dignity by insuring proper covering of the resident. However, when bed cover retainers are applied and limit the resident's freedom of movement or a resident's access to his or her body, then the bed cover retainer would be considered a restraint.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Can a positioning pillow be used at the facility without being considered a restraint? The pillow slides under the arms of a wheelchair and fits snugly but can be pushed out of place with minimal effort. Does the facility need a physician's order to use this type of positioning device?

The federal regulations define a restraint as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body which the resident cannot easily remove, which restricts freedom of movement or access to his or her body. The accompanying Interpretive Guidelines at tag number F221 state, "When coupled with appropriate exercise, therapeutic interventions such as pillows, pads or removable lap trays, are often effective in achieving proper body position, balance and alignment, and preventing contractures without use of restraints."

This language indicates that such pillows, pads, lap trays, etc. may not be considered restraints in some cases. Instead, they may be viewed as alternatives to restraints. However, because of the manner in which the federal regulations define restraint, each resident must be assessed on an individual basis to determine if the device being used meets the federal definition of restraint. If the positioning pillow described in the question is easily removable by the resident, it would not meet the definition of restraint. As such, no physician's order is required for the use of the devices.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

What is to be done when a resident emergency occurs which calls for a physical restraint, but there are no physician's orders for a restraint?

When a resident emergency occurs for which a restraint is necessary to alleviate an immediate and serious danger to the resident or other persons in the facility, minimum effective restraint measures may be applied for brief periods in accordance with nursing judgment when it is not possible to contact the physician to report the significant change in the resident's condition and obtain instructions from the physician. Orders for emergency use must be obtained or confirmed in writing as soon as possible. Refer to federal interpretive guidelines for tag F221. The facility should have policies and procedures that address these situations.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Are siderails considered a restraint? What if the facility has the half siderails like in hospitals and the resident can still get out of bed without putting them down? Do we need a release signed? Is a siderail considered a restraint or a safety device?

Interpretive Guidelines for the restraint requirement §483.13(a) at tag number F221 address side rail usage.

The Resident Assessment Instrument manual also addresses side rails on page 3-198-202.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

A resident's mental capacity is such that they are unable to understand, retain or utilize safety techniques and training so as to prevent self-injury such as falling. The person's gait is unsteady and she is in constant motion. Would the use of a restraint be appropriate under federal guidelines for this resident? The resident is diagnosed with Alzheimer's.

Restraints are only appropriate when required to treat medical symptoms and when less restrictive measures have been ruled out. Restraints can never be used for purposes of discipline or convenience. When determining medical necessity for restraints, causal factors must be considered.

Given the causal factors and the absence of a way to remove them, the risks and benefits of restraint usage must be determined and explained to the resident (surrogate when appropriate). If the risks are great for self inflicted injuries, pain and suffering, i.e., fractures, head and facial injuries, or surgery restraint use may be warranted.

The least restrictive intervention that will enable a resident to attain or maintain his/her highest practicable level of functioning should be employed. Restraints can have negative impacts. Restraints can be an accident hazard, a serious affront to the dignity of the resident, and they can lead to urinary and fecal incontinence, pressure sores, loss of muscle tone, loss of independent mobility, increased agitation, loss of balance, symptoms of withdrawal or depression, reduced social contact, and decreased appetite.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

When is the use of a mechanical or physical device attached or adjacent to the resident's body that restricts movement considered to be an enabler?

Restraining devices are considered to also be enablers when they enhance functional ability in the least restrictive manner.

Examples include but are not limited to:

1. A seated walker when, without its use, the resident's mobility would be further restricted or risk for injury increased.
2. A reclining chair when, without its use, the resident's condition would limit their positioning to a bed or wheelchair.
3. Devices that enable residents to maintain optimal anatomical position to prevent discomfort and/or deformities caused by immobility such as contractures, e.g., positioning is enhanced by supporting the pelvis or upper trunk or extremities.

If these enabling devices are used when residents cannot remove or release themselves, the same assessment and planning process must be used to determine that their use is least restrictive and medically justified as with a device that is used solely to restrict movement. Documentation must support the assessment, planning and evaluation. The facility should code the device as a restraint under Section P4 of the MDS. The resident assessment protocol should then explain the use of the device as an enabler.

For bedrails, it is also helpful to refer to the definition found in the Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Chapter 3, Item G-6, Modes of Transfer. "Bed rail(s) used for bed mobility or transfer -- refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.**

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

DATE: January 1996

What are some examples of restraint reduction?

Restraint reduction must be a result of assessment and planning for each individual resident. If discontinuance of a restraining device is ruled out based on the resident's medical condition, the speed and degree of reduction that is implemented is driven by the individual resident's need.

Examples include but are not limited to:

1. Reducing gradually the amount of time the resident is restrained and increasing the unrestrained periods based on the observations made during the time the restraint is off. Restraints are logically removed during periods of increased observation.
2. Trying an alternative device that is less restrictive such as orthotic devices or a different type of chair in the place of a vest restraint.

Documentation must support the assessment and determination of the resident's medical indication or need for restraints and the rationale for the reduction process chosen. A thorough review of the Resident Assessment Protocol (RAP) for restraints as well as a thorough review of the interpretive guidelines for §483.13(a) Tags F221 and F222 are essential to an appropriate assessment process.

The Carolinas Center for Medical Excellence has resources on line.

<http://www2.thecarolinascenter.org/ccme/>

The regional ombudsman may also provide restraint reduction resources.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

Please define assistance devices and supervision in relation to Tag F323.

The interpretive guidance at §483.25(h)(1) and (2) for accidents and supervision define these terms.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a resident has had a physical therapy evaluation for restraints prior to the time of discharge and is readmitted a month later - does the resident need a new physical therapy evaluation or is it permissible to pull the old physical therapy evaluation from medical records and update it?

There is no requirement for a physical therapy evaluation per se. The determination as to the need for a new resident assessment must be based on the guidelines for significant change and facility policy. The need for repeating the restraint evaluation would be based solely on the interdisciplinary team's findings. This team should include the physician and the resident (and/or family representative). The team will determine whether the previous P.T. evaluation continues to meet the needs of the resident.

If the previous P.T. evaluation is utilized by the team, it may be copied from the old record to be signed and dated as an entry into the new record. It should be reviewed to determine if it is still current to meet the resident's needs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Restraints

If a physician orders a restraint (chemical or physical), can the provider then use the restraint or does the facility have to prove that they have tried less restrictive measures? What if the physician is insistent on the restraint only? What about potential conflict of facility staff practicing medicine?

State law and federal regulation prohibits the use of restraints for purposes of discipline or convenience, and allows restraints to be used only to treat a medical need. State law also requires that the facility conduct an evaluation to ensure that the least restrictive means of restraint are used on those residents who require restraints.

Therefore, before using a particular restraint ordered by the resident's physician, the facility must evaluate the resident to determine whether the resident requires a restraint and, if so, whether there is a less restrictive restraint than the particular restraint ordered by the physician. If the resident's evaluation shows that a restraint is needed, but that there is a less restrictive restraint than the restraint ordered by the physician, the physician should be advised accordingly. If the physician insists that an inappropriate restraint be used, it may be necessary to involve the medical director or others to convince the resident's physician to change his/her order. If the physician still insists on an inappropriate restraint, the facility has the right, after informing the resident or responsible party, to seek an alternative physician. The licensure rules require physicians to follow state and federal requirements for physician's services to insure that the resident receives appropriate care and treatment.

SANITATION

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

What is acceptable procedure for storage of ice scoop holders? Do they have to be covered?

Ice scoop holders should be covered when not in use. A scoop guard or other mechanism that allows for drainage of water is needed to prevent the scoop from sitting in the water where bacterial growth could occur.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Is it acceptable to use a community brush for cleaning toilet bowls and bedpans?

Yes.

Can containers of Clorox and water used for cleaning be stored in bathrooms?

No. Cleansing agents must be properly labeled and stored out of reach of residents.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Can a container for the collection of soiled bibs accompany the food cart at pick up time?

Yes, covered containers of soiled bibs may be in the area of food trays at pick up time.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Are paper towels required to be under collector containers (which are sitting on the floor) when emptying urinary catheters?

No. Appropriate infection control procedures during collection and disposal are required. This includes hand washing after the urine is discarded and the receptacle rinsed and put back in its original location.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

Should dirty items such as emesis basins, bed pans, shaving cups, etc, ever be cleaned in the facility's dishwasher where sanitized eating utensils are cleaned?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

If electric razors are used by more than one resident, what procedures must be followed?

- a) The razor must be wiped between each resident use with a clean cloth moistened with 70 percent by volume isopropyl alcohol or other disinfectant approved by the Environmental Protection Agency for this purpose.
- b) Razors should not be shared between residents where there is a chance of transmission of blood borne diseases due to open face lesions or other similar conditions.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

What is the proper storage and safety of personal care items?

Resident care items (e.g., toothbrushes) should not be co-mingled with other resident care items. An individual's personal care items can be stored together as long as all items are clean. For example, a clean, appropriately covered toothbrush can be stored with other items. A toothbrush may also be stored in a separate bag.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Sanitation

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REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is the survey agency's position on legal disclaimers at the end of the plan of correction?

A facility has the right to include a disclaimer on their plan of correction. A disclaimer does not relieve the facility of its responsibility for submitting a plan of correction and for correcting problems.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Is it a requirement for a surveyor to measure the degree of elevation of the head of a tube fed resident with an angle drawn on a piece of paper? Is measuring elevation a new practice?

It is not required that a surveyor measure for the precise number of degrees of elevation of the head of a resident's bed. Reasonable approximations are acceptable.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Can surveyors place items underneath a resident or between the resident's legs in order to monitor care?

No. Foreign objects are not to be used in order to monitor care.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is the time frame for issuing a survey report to the facility after the exit conference?

Statements of deficiency shall be issued to the facility within 10 working days after the last day of survey.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is an appropriate way to announce the survey team's arrival to the facility?

It is appropriate to announce the team's arrival over the facility intercom system if desired. A suggested format is as follows: "Good morning. It is (date). The survey team from (agency/section) has arrived to conduct a (type) survey. The survey team is led by (name). Will (staff of Administrator's choice) please report to (location)..."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

During a standard survey, can surveyors collect data prior to the date of the previous standard survey and utilize that data in a deficiency?

Yes. Historical data can be utilized in a deficiency, if it is pertinent and helps support the deficiency. However, the deficiency itself should be based on deficient practice(s) that has been occurring, or has occurred, since the last survey and not prior to the previous survey.

What surveyors cannot do is collect data from the previous survey for the sole purpose of elevating scope and harm.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Appendix P of the State Operations Manual defines an interviewable resident as one who “has sufficient memory to be able to answer coherently the majority of questions contained in the Resident Interview and make day to day decisions in a fairly consistent and organized manner.” If the facility identifies a resident as interviewable based on the preceding definition, and later a statement/claim made by the resident in an interview with a surveyor is felt by staff to be inaccurate, is the inaccurate statement automatically discounted because the resident was identified by the facility as interviewable?

No. Every possible effort should be made by surveyors to determine the reliability of information provided by interviewable residents. The surveyor will attempt to corroborate interviews through other sources.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Should surveyors communicate names of specific residents during the survey?

Throughout the survey, surveyors may discuss observations of specific residents, as appropriate, with facility staff. They should maintain an open and ongoing dialogue with the facility throughout the survey process. Generally, individuals who provide information during interviews will not be identified.

http://cms.hhs.gov/manuals/Downloads/som107ap_p_ltcf.pdf

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What is appropriate protocol for surveyors and facility staff during the initial tour of the facility?

Detailed information regarding appropriate procedures and objectives during the initial tour of a standard survey can be found in Appendix P of the State Operations Manual.

During the tour surveyors gather information about concerns which have been preselected; new concerns discovered onsite; and whether residents preselected for the Phase 1 sample offsite are still present in the facility. The surveyor attempts to meet and talk with as many residents as possible in order to identify other candidates for the sample, to get an initial overview of facility care and services, to observe staff resident interactions and to evaluate the impact of the facility environment on the residents.

It is desirable for a staff member to accompany the surveyor during the tour to answer questions and provide information. It is appropriate for the facility staff to remain outside of the resident's room or "down the hall" to provide the surveyor an opportunity to interact with the resident and/or family.

The tour will begin very soon after the entrance and will not be delayed while awaiting staff arrival.

The tour will begin as soon as possible after entering the facility.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Are follow-up survey reports (CMS-2567B forms) considered the most recent survey?

No. The interpretive guidelines state: “Results of the most recent survey means the Statement of Deficiencies (CMS-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent complaint investigations.” Facilities should NOT post the resident roster due to the possibility of violating confidentiality requirements.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

What are the requirements for maintaining a complaint file?

There is no specific requirement for the facility to maintain a grievance file. The regulation does require prompt efforts by the facility to resolve grievances. “Prompt efforts”...to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance.

The facility must show evidence to surveyors that they have acknowledged a complaint/grievance and have evidence they are actively working toward resolution of the grievance or complaint. It is up to the facility to record this information in the manner they choose. Refer to F165 to F166 and Interpretive Guidelines.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Are skin tears included in Item 6 of the resident roster “abrasions...?”

Yes.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

According to an America Health Care Association memo from 1995, we are no longer required to provide surveyors with accident or incident reports. Is this still correct? Can surveyors ask to see the reports if there is a question about a particular resident?

There are too many variables for a “yes” or “no” answer to the first question. The facility is required to show evidence that on a routine basis it monitors accidents and other incidents, records these in clinical or other records, and has in place a system to prevent and/or minimize further accidents and incidents. Refer to Appendix P. If the facility uses accident/incident reports as their only method to record any of the above components, then the surveyors would need to review the reports as evidence of meeting the participation requirements. If the facility uses accident/incident reports and/or additional methods, then the surveyors can review the “other methods” for evidence for meeting participation requirements.

In answer to the second question, the facility has the option of producing necessary evidence regarding a particular incident other than an accident/incident report. When the situation warrants, the facility must also produce evidence of what they are going to do to prevent or minimize further incidents/accidents.

Note: Sometimes an accident/incident report may contain the only evidence of meeting other regulatory requirements. If so, the facility would want to produce the report as evidence of compliance.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Can surveyors inspect any resident's record and have copies of those records when the resident resides in a certified Medicare and/or Medicaid bed (disregard payment source)?

Yes. According to §489.53 CMS may terminate the agreement with any provider if it finds the provider refuses to permit photocopying of any records or other information by, or on behalf of CMS, as necessary to determine or verify compliance with participation requirements.

<http://ecfr.gpoaccess.gov>

Can surveyors inspect any resident's record and have copies of those records when the resident resides in a licensed only nursing home bed?

Yes, according to § 131E-105 (b) representatives of the Department may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been residents of the facility being inspected unless that patient objects in writing to review of that resident's records.

www.ncga.state.nc.us/gascripts/Statutes/Statutes.asp

REGULATORY FOCUS BULLETIN

FILE TOPIC: Survey Protocol

Does the survey Roster Sample Matrix have to be completed by the facility now that surveyors have a computer-generated facility profile?

Yes. The computer-generated facility profile that surveyors have may not be as current as facilities are only required to submit MDS data once a month.