ISDH/Residential Care Facility Roundtable

A roundtable discussion was held on Thursday, January 19, 2006, with the following representatives, Susan Albers, IALFA, Sue Hornstein, and Debbie Beers, ISDH.

Questions:

1. Please clarify the definition of "feeding" a resident.

Answer: **Providing food and/or drink in the residents mouth via hand and/or utensil.**

2. Has there been a change in QMA certification letters? Lately, some members have reported that there are no CNA certification numbers listed in addition to QMA numbers on their annual certificates.

Answer: **No change in the letters. A Q.M.A. must be an C.N.A.**

3. Is a CLIA waiver required in Residential Care Facilities when capillary blood glucose tests are completed?

Answer: **Yes, a CLIA waiver is required for any testing of body fluids. Please contact Wanda Proffitt, CLIA Program Director, Indiana State Department of Health, at 317/233-7502, if a CLIA application packet is needed.**

4. What documentation is required relative to advance directives?

Answer: **410 IAC 16.2-1.1-6 gives the definition for advance directives.**
410 IAC 16.2-5-1.2 (i) requires facilities to distribute upon admission the advance directives/your right to decide information.
410 IAC 16.2-5-8.1 (i)(8) requires the emergency information file contain a copy of the advance directives, if available.

410 IAC 16.2 may be accessed at:
http://www.in.gov/legislative/iac/T04100/A00162.PDF

Advance Directives/Your Right to Decide information may be accessed at:
http://www.in.gov/isdh/regsvcs/acc/advance/advanceddirectives.pdf

5. What is the readmission criteria when a resident returns from a hospital (in other words does he/she have to go through readmission)?

Answer: **410 IAC 16.2-5-2 (a), requires an evaluation must be completed prior to admission, semi-annually and upon a known substantial change. Following a hospitalization there may be a substantial change, if so an evaluation must be completed.**

6. Can portable liquid oxygen containers be filled in a resident's room?

Answer: **ISDH has no regulatory authority regarding fire safety in residential care facilities. Please contact the Indiana State Fire Marshall's office.**

7. What are the requirements for a qualified dietary manager (i.e. "experience in management")?

Answer: **The individual must have training and supervisory experience managing employees, as well as experience in the service process and the kitchen itself. This must be documented within the resume, as well as in reference checks.**

8. What is the definition of medication assistance?

Answer: Residents can be assisted with the following:

Opening a bottle
Administering eye drops (steadying only, not touching the bottle or applying pressure)
Applying topical creams and ointments (steadying only)
Providing reminders for insulin (note: facility can publish list of steps so that assistance can be provided in reading the list for the process while the resident self-administers the insulin)
Taking medications (if boxes are locked for the resident's protection, the keys must be located in the resident's room, keys can be retrieved and given to resident by staff, but residents must be able to unlock medication box)
Oxygen (assistance can be provided in filling the tanks and changing tubing on the tanks, but not with actual oxygen flow – resident or family member must be able to flip a switch for administration and change the flow of oxygen)
Catheters, no foley care of any type – one can assist in steadying or provide limited assistance in emptying of catheter bag
Providing and applying band aids (but no dressing changes)

9. Is there an expiration date for home health aide certification?

Answer: **There is none presently, but there will be soon.**

In an unlicensed facility, if a resident/resident/s family individually wants to contract with a private caregiver, who may or may not be a nurse or CNA, to perform some "typical licensed facility level activity" i.e. to check accuchecks for blood sugars perhaps de to resident trembling or poor eyesight, and the family has trained them. Is this allowed to be done in unlicensed assisted living? (The resident and family don't understand why this can't happen as this is "their home." What would prevent them from doing this? Also, would they have to have a written agreement to cover this? What if they (the caregiver) is not licensed or bonded?

Based on the above, the question is raised as to whether the resident or family of same has a right in an unlicensed model to contract privately with someone like the above. Many families want to go this route for cost saving purposes much like you may do in your own home if you found someone or knew someone who had a comfort level with whatever was needed, i.e. regular foley catheter care, etc. Would they need some sort of written contract? They are not necessarily going to have private duty from a private duty section of home care as they may not exist in the geographic are in question or be desired.

Answer: **There is no regulatory oversight in non-licensed residential care facility assisted livings. There may be home health requirements.**

11. Members want to know what is the regulation for oxygen usage by a resident in their room? Are there requirements for storage by the facility if stored outside of the building, i.e. does it have to be stored away from the building and if yes, how far? Are there any regulations about filling a portable container off of it in the facility?

Answer: **410 IAC 16.2-5-1.5 (j) specifies the sanitation and safety requirements. Please contact the Fire Marshall's Office for more specific fire safety requirements.**

12. If a physician has ordered PRN medications and the resident is requesting same, and it is within the parameters of the physician's order, can the facility assist the resident? That is, does the staff need to clear it with the nurse first, or if they are assisting with self-administration, can they act on the request of the resident if it is within the parameters set by the physician?

Answer: **Staff would not be involved if the resident is self-administering medication. Medication administration must be done by a QMA or licensed nurse. PRN medications may be administered by a QMA only upon authorization by a licensed nurse.**

13. I have searched the state regulations and have not been able to find where it talks about having the physician sign the resident's POS sheet every 90 days. I find under the pharmacy section where the pharmacist signs every 60 days. We have a physician that is not going to sign for a resident until he is paid $10.00 each time he receives these for signature. I was going to see how the regulations read before I contacted the physician, but no I cannot find it in our regulations. Can you help me with this?

Answer: **Facility policy should direct how often physician orders are renewed. There is no state residential rule regarding renewal of physician orders every 90 days. Renewal of physician orders will be at least yearly, unless specified differently by the physician. Facility policy may require renewal of physician orders more often than yearly.**

14. Can foley catheters be inserted in Residential Care? The description in the rules is very nebulous. If you can do intermittent cathing for established routines, why can't you do the cath insertion for a foley?

Answer: Please provide clarification for this question.

15. Do licensed people (CNAs, LPNs, RNs) require feeding assistant training?

Answer: **No**

16. Who is supposed to perform "CPR" Training?

Answer: **A certified trainer, i.e., American Heart Association or Red Cross trainer.**

17. Do licensed nurses (LPNs, RNs) require CPR training?

Answer: **Yes**

(05/25/06)

Round Table Questions and Answers
May 2006

1. The reportable unusual occurrence guidance includes misappropriation of resident property. Additionally, facilities are required to have a policy addressing missing or stolen items. Recently, a facility was directed that they must report to the local police department anything (or any amount of money) stolen. When questioned as to amount, the response given by a representative of ISDH was that as little as 59 cents is still considered misappropriation and should be reported. When this was addressed with local police department, they were in adamant opposition, stating that they would not file a report unless the amount was in multiple hundreds of dollars. Please clarify the expectations of ISDH.

Answer: Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The report must be submitted within 24 hours after the preliminary investigation has determined that resident property or funds of any amount or size have been misappropriated.

Theft of any amount should be reported to the local police if it is "confirmed" that theft has occurred, meaning that it is believed that the money was stolen from the resident. If the local police state that the amount is insufficient for police involvement, the same should be documented to exhibit the facility's good faith effort to intervene on behalf of the resident

2. The reportable unusual occurrence guidance requires the reporting of "allegations" of abuse yet the definition for physical abuse states that resident –to-resident abuse would only be reported if there is injury. Thus, if there is an allegation made by a resident in regard to another resident, but there is no evidence of injury, should the "allegation" still yet be reported as there is no verification of injury?

Answer: Yes, the new policy effective 4-1-06 indicates the resident to resident physical abuse with or without injury is to be reported.

This is reportable if circumstances indicate one resident intended harm to a particular resident regard less of the resident's cognitive status.

3. When substandard level of care is identified in a facility, the surveyors request a list of all physicians who provide care for any resident of the facility; however, per review of enforcement guidance, it would appear that the state must issue notices to: "The attending physician of each resident who was identified as having been subject to substandard quality of care".

Answer: Yes, only those physician of residents' affected by the substandard quality of care need to be notified. The facility must provide ISDH a list of those physicians**.**

4. Please address the use of scope and severity of A, B, or C (which would still yet be substantial compliance). Can you provide examples as to what types of deficient practices would be cited within these categories?

Answer: Each deficiency is case sensitive. It is difficult to provide any specific examples**.**

5. Please provide clarification as to any guidance utilized by ISDH to discern whether a scope of "isolated versus "pattern" deficiency is determined.

Answer: The State Operations Manual guidance is followed when determining scope and severity. See attached SOM document

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6. Facilities vary in practice as to mandating a physician's order for fall prevention devices which do not adhere to the resident (such as a personal alarm) and/or devices which are enabling to the resident (such as is the case when side rails are used as enablers versus restrictive devices). As these devices are not a medication or "treatment", per se, does the Department have a stance on whether a physician's order must be in place?

Answer: An enabler and/or personal alarms do not require a physician's order unless the facility's policy indicates a physician's order is required. If the side rail is a restrictive device, a physician's order is required.

7. Along the same line, a facility was cited for not documenting the type, size and number of side rails in the physician's order as well as addressing these three specific aspects on the care plan. In regard to side rail use, if the assessment states use of side rails is enabling, not restrictive, must there be an order? If so, how specific?

   If the use of side rails is restrictive, (keeping in mind that the State rule simply states, "restraint or seclusion shall be employed only by order of a physician, and the type of restraint or seclusion shall be specified in the order") is it anticipated that the order would include the type, size and number of rails?

Answer: A physician's order for a restrictive device must include the type of restrictive device to be used.

8. A facility was recently cited under F 157 for failure to notify the physician of abnormal laboratory values for a resident. The facility had notified the Nurse Practitioner who had a collaborative agreement with the attending Physician on file at the facility. Upon being questioned in regard to nurse practitioner involvement, the physician provided a letter to the survey team stating that he had "reviewed the summary of events and the nurse was correct in notifying the nurse practitioner first as this is the standard operating procedure" per the collaborative agreement. The facility responded to this citation, stating that the licensed nursing staff would receive in-service training relative to facility policy for physician and nurse practitioner notification of resident condition change as well as the collaborative agreement between the physician and the nurse practitioner, including the nurse practitioner's scope of practice."

   Correspondence was received from ISDH (requesting an addendum) regarding the deficiency (F157), stating, "Please refer to F390 regarding physician delegation of tasks in SNFs. Since your facility is SNF/NF dually certified, the physician may not delegate tasks in which the regulation is specific to the physician."

   Please clarify if the stance of the department is to prohibit the nurse practitioner to be contacted in lieu of the physician (keeping in mind that he/she would then be responsible to confer with the physician if deemed necessary, as per collaborative agreement). Such clarification is needed in that contacting the Nurse Practitioner initially is the common industry practice, and preference of physicians.

Answer: Duties to be carried out by the nurse practitioner should be delegated by the physician and written con firmation kept on file with the facility. If physician notification is delegated as a duty assigned to the nurse practitioner and the same is on file with the facility, there should be no concern with said notification via the nurse practitioner. A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. For example, a physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

ISDH/Residential Care Facility Roundtable
Tuesday, June 20, 2006

1. Which of the following are examples of a "self-limiting condition" with "standard disease-related clinical interventions?"

   Stage two pressure ulcer requiring daily cleansing with normal saline, application of a topical prescription ointment and covering with a dry, sterile dressing.
   Pneumonia requiring IV antibiotics once daily through a heparin lock.
   Stoma care of a temporary colostomy, emptying and changing the bag.

   Answer: 410 IAC 16.2-1.1-68 defines self-limiting. Self-limiting is specific to the individual resident.

2. As an AL community, we value the independence and autonomy of our residents, while providing for the safety and well-being of those residents.

   To do this, assess the resident's ability to act and make decisions as a prudent person would do in a like situation. To respect residents' rights, our communities do not secure its doors during the day and although we do monitor the movements of the residents, we do not require alert and oriented residents to alert us to his/her every movement.

   We feel, and have always felt, that this particular practice is within regulatory compliance for AL communities.

   Long term care regulations, on the other hand, require those kinds of facilities to provide a more structured, secured setting even for alert and oriented residents.

   How do we marry the collaborative relationship between the state and the communities to assure the regulations for AL, and not for LTC, are followed during survey?

   Answer: Comprehensive and Residential Care Facilities Rules require meeting the needs of the residents. If for example, a resident is at risk for wandering outside the facility, without regard to their safety needs, intervention(s) to assure the safety and welfare of the resident is necessary. Resident assessment or evaluation will direct the necessary intervention(s).

3. A community is being cited for the CNA and QMA working outside of their scope of practice because they "cared for fallen residents" on night shift on three occasions. The surveyor contended that they were assessing. Why have first aid and CPR certification? In first aid, they are taught to observe for visible injuries, and if present, call EMS. This is also in the community's corporate policies. The community checked with competitors, who also do the same thing. The surveyor felt that the staff should leave the person laying on the floor, even if the resident stated they were not hurt and wanted assistance to get up, until a "licensed nurse" was called in to assess the resident. Guidelines, please.

   Answer: If a resident is unable to get up on their own after a fall, a physical assessment for injury would be appropriate. C.N.A./Q.M.A's are not allowed to assess residents.

   (June 29, 2006)