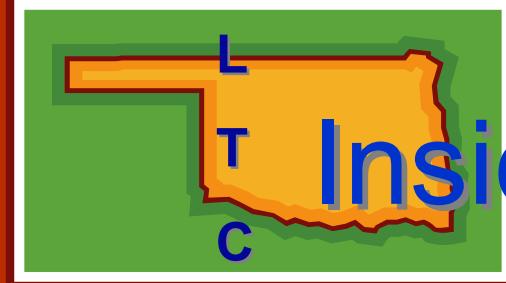




Long Term Care  
Oklahoma State  
Department of Health



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## Greetings Again...

By Dorya Huser, Chief, Long Term Care

"Greetings" is such a friendly word. We hear this in casual conversation. We use this to address our friends. We think of "greeting cards" as something to make folks feel welcome or loved or comforted. I want to talk about what this means to long-term care. When we hire a new surveyor, we do what we call a "meet and greet." Karen Gray, our trainer, arranges for the managers and me to spend some time getting to know our new staff members in a small setting. It is very informal and relaxed. My goal is to learn as much as I can about our new people so that I can help them feel welcome and to invite them to ask me anything they want. I think it is important for me to learn everyone's name and for them to know I am accessible and interested in them because I am. I have learned many interesting things over the years and enjoyed every opportunity to share this time. Other managers have other styles of orientation, but all are geared to quickly help new staff meet co-workers and learn about each other and the program. I believe it is important for us all and validates our interest and sincere appreciation that they have chosen to work in long-term care. I also get to share my vision and goals about our program.

I know there are homes that have similar activities with new residents. It is such a big transition so every little effort that is made to acquaint them with staff and find out what they like and don't like is very significant. Some homes make a point to go visit the new resident as soon as they get to their room and take something to them they know they will enjoy such as a cup of coffee or tea or a treat. They might give them a welcome package with a greeting card included. Isn't it amazing how a little food and attention can go such a long way to

dispelling fears and anxiety and increase the comfort level of everyone? This reduces the awkward moments of trying to adjust.

Residents usually love to tell you about themselves and their family, what they have done in their lives, what activities they enjoy and maybe even what daring adventures they have had. They want you to know who they were all the years before they got to this home. They take great comfort in knowing you want them to be a part of your circle of care and friendship. This can make a big difference in how well they adjust to their new living arrangements and even their health and quality of life. Doesn't everyone like to feel that they belong and that they will get to continue to enjoy many things they have previously? I remember a Social Services Director that knew what movies her residents liked and would let them know if she was showing John Wayne, Clark Gable, Jennifer Jones or Barbara Stanwyck, just to name a few. They really looked forward to show time. Today, with the availability of inexpensive DVD players, you could run a different theater on each wing so folks could have even more choice.

Those residents also want to know more about you. They will tell their friends and family about the aide that talked to them and became familiar with their daily routine, the housekeeper that took care with their belongings and visited with them, the kitchen staff that took the trouble to make them that little cup of warm soup and toast when they preferred that to the regular menu, the maintenance man who not only

learns their name, but tells them a story while he fixes that loose knob on their dresser, the nurse that takes time out of their very busy schedule to visit and assure them she or he will make sure they get what they need along with that soul food, and the Director of Nursing and Administrator that make sure they know who their residents are, who their family is and are never too busy to pay some special attention to all of these special people that need to be able to trust them. They will probably all sleep better. I call this good ammunition the resident now has to show off their newly extended circle of friends.

A little time spent here may be a great trade for addressing problems that arise from unintended neglect, social isolation, depression, boredom and the long list of other items that may consume your time in a negative fashion. Being more proactive, anticipating needs and wants and making productive use of time is more fun. Keeping everyone involved is part of a good family and builds yet another set of rewarding relationships. Staff enjoys it more also. Do you "meet and greet"? Do you nurture the family?

In the Spirit,

Dorya Huser





**"Is your facility prepared for the changes in MDS 3.0?"**

Excellence is not a skill. It is an attitude.

~Ralph Marston

## Are You Ready?

*By Karen Gray, Training Programs Manager, OSDH*

The Minimum Data Set (MDS) 3.0 version went into effect on October 1, 2010 and so have changes to the Long Term Care Survey process. Is your facility prepared for the changes?

The Centers for Medicare & Medicaid Services (CMS) released Survey & Certification Letter, S&C-10-27-NH, on July 30, 2010 describing the temporary changes to Appendix P of the State Operations Manual (SOM), Traditional Survey Process for Long Term Care Facilities (LTC), as a result of the implementation of the MDS 3.0 on October 1, 2010.

The S&C Letter identifies the following key changes, effective October 1, 2010:

- Quality Measure/Quality Indicator (QM/QI) reports will be unavailable until the MDS 3.0 data base has enough information and quarters in place to provide the reports;
- Temporary traditional survey process revisions in Appendix P, Tasks 1 – 5C, will go into effect for all LTC surveys until further notice;
- Permanent revisions to Appendix P:
  - Removal of terminology for Resident Assessment Protocols (RAPs) and replacement with Care Area Assessment (CAAs) terminology, and
  - Reports formerly identified as the OSCAR are now known as the CASPER.
- Revised CMS forms
  - CMS-672, Resident Census and Conditions of Resident Report
  - CMS-802, Roster/Sample Matrix
  - CMS-802S, Roster/Sample Matrix Instructions for Surveyors
  - CMS-802P, Roster/Sample Matrix Instructions for Providers
- Revision of Appendix PP of the SOM, LTC Facility Regulations and Interpretive Guidelines for Surveyors, to remove all references to MDS 2.0 and replace with terminology for MDS 3.0.

### MDS 3.0 Transition

- ⇒ MDS 3.0 assessments must be completed on residents for any assessment scheduled with an Assessment Reference Date (ARD) of October 1, 2010 and forward.
- ⇒ If the ARD is on or before September 30, 2010, then a MDS 2.0 must be completed.
- ⇒ The ARD is the end of the observation or look back period of the assessment. For transition purposes, if the most recent prior comprehensive assessment is a MDS 2.0, then the ARD of the next annual comprehensive



assessment, using MDS 3.0, must be within 366 days of the date located on the MDS 2.0 at Vb2.

- ⇒ For transitions purposes for quarterly assessments, if the most recent annual or quarterly assessment is a MDS 2.0, then the ARD of the next quarterly assessment, using the MDS 3.0, must be within 92 days of the date located on the MDS 2.0 at R2b.
- ⇒ Transmission of the MDS 3.0 has been changed to reflect the requirement for transmission of the MDS data within 14 days, rather than 30 days, after completion to the CMS system rather than to the State Agency.

### Survey Process Changes

- ◆ Due to the inability to run QM/QI reports, an offsite sample selection cannot occur. Surveyors will continue to conduct offsite preparation by reviewing such items as results of complaint investigations, incident reports, previous deficiency citations, CASPER 3 & 4 reports, and complaints received that have yet to be investigated. From these resources surveyors will identify potential areas of concern to investigate during the survey and may identify residents to include on the onsite sample.
- ◆ Upon entrance to the facility, the team will immediately begin the initial tour of the facility (including a brief visit to the kitchen). The surveyors will be interviewing residents, families and staff members during the tour in order to identify concerns and residents for the sample selection. It is important that the staff persons accompanying the surveyors are knowledgeable about the resident's clinical condition and familiar with the resident in order to be able to answer surveyor questions.
- ◆ The facility will be asked to complete, to the best of their ability, the Roster/Sample Matrix (Form CMS-802), including all residents on bed-hold, by the end of the initial tour. If the facility cannot generate this information electronically, it should be completed first and given to the team coordinator by the end of the initial tour.

### CMS Form Revisions

- **CMS-802, Roster/Sample Matrix**
  - \* The resident characteristic field titled "Falls/Fractures/Abrasions/Bruises" has been separated into two fields, one titled "Falls/Fractures" and the other titled "Abrasions/Bruises".
  - \* The resident characteristic field titled "Behavioral Symptoms/Depression" has been separated into two fields, one titled "Behavioral Symptoms" and the other titled "Depression".
  - \* These changes have resulted in the renumbering of the resident characteristic fields on the form itself.
  - \* When the QM/QIs and the QM/QI reports are available again, this form may be revised to accommodate future changes.
- **CMS-802P, Roster/Sample Matrix Provider Instructions**
  - \* Renumbering of the resident characteristic fields as well as changes to MDS item & coding references.
  - \* Some providers previously automated the 802, and all of the fields were filled based on the MDS 2.0 instrument. However, some fields are not reflected in the MDS 3.0, such as "Fecal Impaction" and the form now contains instructions for the provider to code the information manually. Facilities must complete the 802 with the information they have in their clinical records, regardless of the availability of MDS information.

Before everything else, getting ready is the secret of success.

~Henry Ford

...Cont. from pg. 3... Are you ready?

- **CMS-802S, Roster/Sample Matrix Instructions for Surveyors**

- \* Renumbering of the resident characteristic fields as well as removing any references to the QM/QIs. As soon as the QM/QIs and reports are available for use, these instructions will be revised accordingly.

- **CMS-672, Resident Condition and Condition of Residents Report**

- \* No revisions to the form itself.
- \* Revisions include the removal of all items reflected on the MDS 2.0 and now only address those items found on the MDS 3.0.
- \* Some providers have previously automated the 672 and all of the fields were filled in based on the MDS 2.0 instrument. However, some fields are not reflected in the MDS 3.0, such as the item on "Bedfast Residents". At that section the form now contains instructions for the provider to code the information manually. Facilities must complete the 672 with the information in their clinical records, regardless of the availability of the MDS information.

To access the S&C Letter and the temporary survey protocol changes in their entirety go to:

<https://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter10-27-NH.pdf>

## LTC Services Training Opportunities

Karen Gray, Training Programs Manager

## Dining With Friends

Are you looking for new ideas for culture change in your dining program? If so, you can view the Dining with Friends video free of charge on the Connecticut Alzheimer's Association website: [www.alzheimersresourcecenter.org](http://www.alzheimersresourcecenter.org)

OSDH Long Term Care would like to say thank you to everyone who attended our 2010 Provider Training Programs. Your attendance and participation helped make our programs a success. We sincerely appreciate your dedication to providing and improving the quality of care and quality of life to those receiving services in your facilities.

Visit our meetings and events website at [www.ok.gov/health/Protective\\_Health/long\\_Term\\_Care\\_Service/](http://www.ok.gov/health/Protective_Health/long_Term_Care_Service/) periodically to watch for the 2011 training dates.



## HOW WOULD YOU HANDLE IT?

**Jerry Taylor, Enforcement Coordinator**



We had a good response to our initial "How Would You Handle It?" column, and we thank all of you who participated. We can't print all your responses, but we will share a few.

The problem presented in our last issue dealt with a fully alert and oriented resident who refused to leave his room and evacuate to the hallway with a tornado approaching. Regulations do not govern this at all. Here's how you suggested it be handled:

Most respondents felt that you could not force a resident to evacuate if they refused. Here's a few of the responses received:

1) "After advising this competent and oriented resident of the pending situation, I would go on to the next resident that has no choice but to depend on us to get them out of harm's way the best we could. Unfortunately, this resident's right is to make his own informed decision."

2) "We teach staff and volunteers to go room to room to evacuate. If the person can make the decision and refuses, we ask two things. First of all for the resident to cover themselves with a blanket or fire retardant bed-spread if available (these are woven tight and resist debris) and second to go behind a divider curtain or into the toilet away from any windows as the curtains will also impede debris. At that point after instruction we leave the room to help others and **do not** put a pillow on the floor in front of the door. A pillow in front of the door is our universal symbol to show the empty/evacuated room. As we look down the hall we know which rooms are occupied. If [there is] time after all are evacuated we go back to the un-marked rooms and ask again and ensure they are covered. Most will at least sit in the restroom or cover up away from windows if nothing more than to humor staff and still feel in control."

We received one really creative response from an RN who asked to remain anonymous. She suggested that :

3) "if your resident is alert and capable - such as the person described in the original question – anticipate the problem. If you suspect in advance that they are likely to be contrary, don't instruct them to evacuate. Instead, ask them if they will help you evacuate the other residents to safety and get them involved."

That sounds to me like a way to turn lemons into lemonade!

Here's the question for this issue. It happened in one of our facilities about a month ago and we don't have a rule that covers the situation:

*-A resident's hearing aid went missing for some reason. Lost, misplaced, accidentally discarded in the trash..... nobody knew what happened. So the family replaced it with another hearing aid for about \$2,000, then presented the facility with the bill and demanded payment for the new hearing aid. -*

**If this was your facility, how would you handle it?**

Send your suggestions to [ltc@health.ok.gov](mailto:ltc@health.ok.gov) and we'll publish the best ones in our next issue.

**When we can identify a problem and face the problem with confidence and enthusiasm, the solution is on the way.**

- Zig Ziglar

## What Would YOU Do?

# Be Informed/Be Prepared

**Mike Cook, Strategic Planner**

Knowing what kinds of emergencies might affect you internally and externally is a critical element in emergency preparedness. Determine which natural disasters are most common in the areas where you operate. You may be aware of some of your community's risks; others may surprise you.

Preparedness planning can include making referrals to local power companies or energy assistance programs for tips on safely heating facilities and facility safety checks, monitoring inside temperatures, and devising emergency plans in case a power failure occurs.

If your area is prone to long periods of cold temperatures, or if your facility is isolated, plans might also include the stocking of additional amounts of food, water, and necessary medications.

Residents should be instructed to eat well-balanced meals and drink warm beverages.

In extremely cold temperatures, heating systems may be pushed beyond their capacity to maintain warmth in all resident rooms.

Extra measures may be needed; however, portable space heating devices are prohibited in nursing facilities, facilities for the developmentally disabled and residential facilities and are not recommended for use by other providers due to safety concerns.

Portable space heaters have been the cause of accidental fires. Any heating device, other than a central heating plant, shall be so designed and installed that it or its appurtenances (accessories) will not ignite combustible material.

If a heating device is fuel fired, it is to be connected to a vent or chimney and must operate by taking air for combustion directly from the outside. It also shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area.

Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperatures or ignition failure (LSC 2000 Edition), Chapter 18.7.8).

## Outdoor Safety

When the weather is extremely cold, especially if there are high winds, residents/clients should be encouraged to stay indoors or to make any trips outside as brief as possible.

Prevention plans might include tips on how to dress safely for winter weather – always wear several layers of loose-fitting clothing, a hat and scarf to cover one's face and mouth, mittens, and water-resistant coat and shoes.

Help residents/clients understand wind chill – as the speed of the wind increases, it can carry heat away from the body more quickly. When there are high winds, serious weather-related health problems are more likely, even when temperatures are only cool.

Avoid ice – many cold weather injuries result from falls on ice-covered sidewalks, steps, driveways, and porches. Assist resident/clients by keeping these areas free of ice.

Finally, instruct consumers and staff to carefully watch for signs of cold-weather health problems such as hypothermia and frostbite for themselves and their neighbors.

The federal Centers for Disease Control and Prevention (CDC) offers information entitled, "Extreme Cold: A Prevention Guide to Promote your Personal Health and Safety" at: <http://www.bt.cdc.gov/disasters/winter/guide.asp> (exit DHS)

Another CDC document entitled "Winter Storm Facts" is available at: <http://emergency.cdc.gov/disasters/winter/factsheet.asp> (exit DHS)

### **Clear Exits and Exit Door Safety**

Winter ice, snow, and drifting snow can complicate fire egress/exiting. Nursing facilities and facilities for the developmentally disabled must comply with the following exit requirements (also recommended for other providers such as continuum of care & assisted living centers, residential facilities, and adult day care centers):

- ⇒ All exits from a building must be provided with safe access to a street, alley, or parking area (public way) (National Fire Protection Association (NFPA), LSC 2000 Edition, Chapter 7.7.1).
- ⇒ Facilities with an exit that discharges to yards that do not have a public drive around the building shall make provisions to ensure that a cleared path from each exit is maintained that is free of ice and snow to a public way that is at least twenty-eight (28) inches wide for existing facilities and thirty-six (36) inches wide for new buildings, with forty-eight (48) inches recommended.
- ⇒ Facilities that do have a surrounding drive shall keep the drive clear, i.e., free of ice and snow, and shall provide at least a forty-eight (48) inch wide clear path to the drive.
- ⇒ For facilities with non-ambulatory residents, the cleared path will be a "hard surface pathway" of sufficient structural capacity to maintain safe egress of wheelchair or bedridden residents.

**Note:** Local fire departments should also be contacted to ensure there are no local rules that may be more restrictive.

- ⇒ All exit doors shall be checked frequently to ensure that freezing conditions have not caused any exterior concrete, asphalt pads, or thresholds to heave up and block the exit door from opening.
- ⇒ All doors shall be capable of being opened freely and normally to full opening width without sticking in the door frame.

### **Holiday Decoration Safety**

Facilities for the developmentally disabled must comply with the following requirements related to combustibles (also recommended for other providers, such as continuum of care, assisted living centers and adult day care centers).

Many of the holiday decorations that are used can be highly flammable or pose an unusual fire hazard. The references cited in parentheses are from the National Fire Protection Association (NFPA) Life Safety Code (LSC) 101, 2000 Edition.

The following precautions are advised:

- ⇒ Combustible decorations are prohibited unless they are flame-retardant (LSC Chapter 18.7.5.4).
- ⇒ No furnishings, decorations or other objects shall be placed so as to obstruct exits or exit signs (LSC Chapter 7.10.1.7).
- ⇒ No open flame devices, such as candles, shall be used (LSC Chapter 18.7.8).
- ⇒ Christmas trees shall not be used unless flame-retardant (LSC Chapter 18.7.5.4).
- ⇒ Decorative power lighting will be permitted if power circuits do not become overloaded and light strings are listed and in good condition.
- ⇒ The number of light strings in series shall not constitute an electrical hazard and manufacturer's safety precautions must be followed. Please be mindful of the tripping hazards associated with electrical cords or other holiday paraphernalia.

...cont from page 7

## Essential Needs:

- **NOAA Weather Radio**

*A National Oceanic and Atmospheric Administration (NOAA) weather radio with an alert function. The NOAA weather radio can alert you to weather emergencies or announcements from the Department of Homeland Security.*

- **Commercial Radio**

*A battery-powered commercial radio is a good source for news and information from local authorities.*

- **Important Documents**

*Examples would be site maps, building plans, employee contact and identification information, supplier and shipping contact lists, emergency or law enforcement contact information and other priority documents.*

- **Communication**

*Talk to your co-workers about what emergency supplies are provided and which ones individuals should consider keeping on hand.*

## Emergency supplies include the following:

- Water, recommend one gallon of water per person per day, for drinking and sanitation
- Food, at least a three-day supply of non-perishable food
- Battery-powered radio and extra batteries
- Flashlight and extra batteries
- First Aid kit
- Whistle to signal for help
- Dust or filter masks
- Moist towelettes for sanitation
- Wrench or pliers to turn off utilities
- Can opener for food (if kit contains canned food)
- Garbage bags and plastic ties for personal sanitation

## Winter Storm Safety Precautions

*Inform staff of measures that should be taken during severe winter weather such as blizzards, heavy snow, freezing rain, ice storms, or sleet.*

- Keep posted on weather bulletins and communicate to others.
- Have a portable radio available. Make sure extra batteries are available.
- Be prepared for isolation at the facility.
- Make sure all emergency equipment and supplies are on hand, or can be readily obtained.
- Make sure emergency food supplies and equipment are on hand.
- Make sure emergency supply of water is available.
- Make sure emergency power supply is operable, if available.
- Make sure heating system is operable.
- Have extra blankets available and keep residents as warm as possible.
- Make sure adequate staff is available.
- Keep flashlights in close proximity, and extra batteries available.
- Close drapes on cloudy days and at night.
- Travel only when necessary and only during daylight hours, never travel alone and travel only assigned routes.
- Do not make any unnecessary trips outside. If you must venture outside, make sure you are properly dressed, and fully covered.
- Avoid overexertion by doing only what is necessary. Cold weather strains the heart.
- Do not panic; remain calm.

## “What Would You Do”?

By Michelle Raney, R.N. Survey Coordinator and  
Pam Hall, R.N. Survey Coordinator

*Peter Bergman is a 38 year old man with diagnoses consisting of moderate mental retardation, Type II Diabetes, hypertension, generalized anxiety disorder, obesity, and stasis ulcers.*

*Peter has been a client at Hilltop Haven, an Intermediate Care Facility for the Mentally retarded (ICF/MR) facility since July 4, 2005. He has had a stasis ulcer above the inner aspect of his left ankle since December 11, 2009.*

*At this time, the wound has slowly enlarged and is weeping so much that the physician's order is for dressing changes every shift and as needed in order to contain the drainage.*

*It is becoming increasingly difficult to maintain the dressings. Peter has increased anxiety and has been medicated with Alprazolam 0.25 mg. three times per day since January 5, 2010. He is anxious about having a dressing in place and is constantly attempting to remove it, and when he does he picks at the ulcer.*

*Peter goes to the workshop Monday – Friday 9:00 a.m. – 2:00 p.m. He often comes back to the facility with the dressing removed from the wound..*

Tell us what you would do in this situation and give your rationale. E-mail your answers to [ltc@health.ok.gov](mailto:ltc@health.ok.gov)

Here are some regulations in Appendix J of the State Operations Manual that you might want to review before you make your decision: **W196, W201, W202, W320, and W344.**

We will follow up with some of your answers in the next newsletter.



Great minds discuss ideas; Average minds discuss events; Small minds discuss people”

~Eleanor Roosevelt





# I Thought I Had To Report That !

## Tips to Reduce Unnecessary Reporting

By Glenn Box, R.N., Intake and Incident

Since the Oklahoma State Board of Health first approved the original reporting requirements for long term care (LTC) facilities many years ago, LTC has undergone sweeping changes.

So, too, have laws and rules regarding reporting requirements, that now more effectively support and protect the clients and residents in facilities, centers, and homes. The most recent changes have significantly standardized reporting requirements across the care spectrum.

This article will identify and discuss common types of reports that are either now no longer reportable, or have never been reportable to the Oklahoma State Department of Health (OSDH).

Review of incident reports submitted to the OSDH reveals the following patterns of submission by LTC providers, which are **NOT** required :

- Allegations against certified nurse aides of “abandonment”, when no adverse outcomes occur for residents or clients;
- Reports of residents or clients assaulting or striking staff;
- Accidents involving no injuries or minor injuries, or other concerns not otherwise identified as reportable, including those at OAC 310: 675-7-5.1;
- Incidents involving resident or client altercations in which no injury (as defined above), nor abuse or facility/staff neglect, is alleged or suspected to have occurred, and no other category of reporting is identified;
- Changes in resident or client condition, related to an ongoing disease process, and not reflective of abuse or neglect;
- “Informational” or “FYI” reports regarding “disgruntled” employees ;
- Reports of injuries of unknown origin, not otherwise reportable, and not involving concerns of potential abuse or neglect; and
- Non-emergent phone reports of incidents which do not arise from emergency situations, informing the OSDH that a written report will be subsequently submitted.

It has also been noted that many reports are needlessly submitted before adequate time has been taken by the facility to determine if a resident or client has actually been injured to meet the criteria for reporting. If the required information basic to an initial report is not immediately available because of a pending medical evaluation or x-rays, providers are expected to take the time permitted by statute, in order to gather the necessary information to determine if an initial report is necessary.

The purpose of this article has been to identify what is unnecessarily submitted to the OSDH so that provider efforts and resources can be more efficiently focused on the real reason we are all here, and that is to provide the best care for the residents and clients residing in the long term care facilities of Oklahoma !

Hopefully, by reducing unnecessary reporting we can improve the reporting of required incidents, and increase the time available to provide care.

Any article written not only answers questions, but invariably raises them, as well. If you have any questions regarding the information contained in this article, please contact the Intake and Incident Division staff at 405-271-6868. Yours, for better care now, and in the coming year !

The important thing is not to stop questioning. ~Albert Einstein

# Emergency and Standby Power System Requirements for Life Support Equipment

By Louis Smith, Life Safety Code Surveyor

A nursing facility that is considering admitting a resident, who requires the assistance of life support equipment (i.e. ventilator), needs to be aware that more than just a generator is required to meet requirements. The easiest way to identify these requirements is to go through the K tags:

⇒ **K106**: Hospitals and nursing facilities and hospices with life support equipment, have a Type I Essential Electrical System (EES) powered by a generator with a transfer switch and separate power supply. The EES is in accordance with National Fire Protection Association (NFPA) 99, Health Care Facilities, 1999 edition, Sections 3-4.2.1.4 - Automatic Transfer Switch Features and 3-4.2.2 - Specific Requirements.

⇒ **K144**: Generators are inspected weekly and exercised under load for thirty (30) minutes per month and shall be in accordance with NFPA 99, Health Care Facilities, 1999 edition, Section 3-4.4.1 - Maintenance and Testing of Essential Electrical System and NFPA 110 (Standard for Emergency and Standby Power Systems) section 8.4.2.

⇒ **K145**: The Type I EES is divided into the critical branch, life safety branch, and the emergency system and shall be in accordance with NFPA 99, Health Care Facilities, 1999 Edition, Section 3-4.2.2.2 – Emergency System.

The Type I EES in K106 and K145 are essentially a separate electrical system for the facility. It has to transfer automatically into the facility and serve separate panels, wiring, and outlets to ensure the uninterrupted supply of power to critical areas regardless of what happens to the regular electrical service.

K144 requires that generators meet both NFPA 99 and NFPA 110. Both regulations have installation and testing requirements for generators beyond the installation of a generator on a concrete pad outside the facility.

If you are not sure your facility meets the requirements as set forth in NFPA 99 and NFPA 110, please contact us at the Oklahoma State Department of Health (OSDH) at (405) 271-6868. A properly installed EES will be designed by an Electrical Engineer with proper documentation being maintained at the facility, i.e. plans.

**Think Safety**

# Recent Rule Changes

By Jacob Booth, Administrative Assistant

On July 25, 2010 the Oklahoma Legislature signed into law recent rule language changes to Chapter 663, *Continuum of Care and Assisted Living*, Chapter 675, *Nursing and Specialized Facilities*, and Chapter 680, *Residential Care Home*. A comprehensive list of the changes made are listed below:

## CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING

### Subchapter 19. Administration, Records and Policies

310:663-19-4 Policies [NEW]

## CHAPTER 675. NURSING AND SPECIALIZED FACILITIES

### Subchapter 9. Resident Care Services

310:675-9-5.1(c)(1)(E) Resident Assessment [AMENDED]

### Subchapter 13. Staff Requirements

310:675-13-5(i)(6),(7), and (8) Inservice [AMENDED]

## CHAPTER 680. RESIDENTIAL CARE HOME

### Subchapter 3. Licensure Requirements

310:680-3-6(d) Records and Reports [AMENDED]

310:680-3-14 Appropriate Occupancy [NEW]

### Subchapter 9. Dietary Requirements

310:680-9-1(j) Food Service [AMENDED]

If you would like to read the full text of these recent changes please visit the Oklahoma State Department of Health website at:

[http://www.ok.gov/health/Protective\\_Health/Health\\_Resources\\_Development\\_Service](http://www.ok.gov/health/Protective_Health/Health_Resources_Development_Service)

If you have any questions please contact Jim Buck at (405) 271-6868 or send an e-mail to [jimob@health.ok.gov](mailto:jimob@health.ok.gov).



If nothing ever changed, there would be no butterflies.  
~ Author Unknown

**EVACUATION DRILLS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED  
(ICFs/MR) Certified Under the Life Safety Code NFPA 101, 2000 Edition**

Jim Buck, Assistant Chief, LTC

ICF/MR facilities that are certified under Section 32.7.3 or Section 33.7.3 of the LSC must conduct emergency drills no less than six (6) times per year on a bi-monthly basis. These drills must all be full evacuation drills and *all* clients residing in the facility must participate in *each* drill. At least two of these drills must take place during sleeping hours. This requirement is consistent with the requirements of 42CFR 483.470(i)(2)(i) which require actual evacuation of clients during at least one emergency drill each year on each shift.

ICF/MR facilities certified under Section 32.7.3 or Section 33.7.3 of the LSC with a capability classification of "impractical" must meet the emergency drill requirements found at Section 18.7 or Section 19.7 of the LSC. These sections require that the facility conduct fire drills which simulate emergency fire conditions on a quarterly basis. Since these drills are conducted to train staff rather than the clients, the Code does not require full evacuation. However, the facility must *also* meet the ICF/MR regulations at 42CFR 483.470(i)(2)(i) which do require the actual evacuation of clients during at least one emergency drill each year on each shift. These drills are conducted primarily to prepare and train staff and it is critical that the staff from each shift participate in these drills. The facility may not elect to conduct night shift drills during another shift.

The LSC requires that the facility make the determination of "impractical" utilizing the criteria of the Code found in Sections 32/33.2.1.2.2 concerning the characteristics of the client population. The LSC surveyor verifies that the determination was correctly made at the time of the annual survey.

This memorandum addresses the requirements of full evacuation during a drill and is not intended to address the requirements for frequency of evacuation drills. The regulation at §483.470 (i) requires that evacuation/fire drills be conducted at all ICF/MR facilities on a quarterly basis on each shift. While this requirement supersedes the number of evacuation drills required by the LSC under Chapters 32/33 it does not impact the requirements for full evacuation during such drills.

*Self-evacuation during an emergency – Clients residing in ICFs/MR certified under Chapter 32/33 of the Life Safety Code NFPA 101, 2000 Edition (LSC) are expected to be capable of self-evacuation during an emergency.*

*Full evacuation drills – All drills under this Chapter must be full evacuation drills unless the facility is designated as evacuation capability, "impractical."*

*Exceptions to full evacuation drills – With a designation of evacuation capability "impractical" the facility must meet the requirements of Chapter 18/19 of the LSC as regards evacuation drills.*

If you have questions concerning this memorandum please refer to the following address for further clarification: [http://www.cms.gov/surveycertificationgeninfo/downloads/scletter10\\_26.pdf](http://www.cms.gov/surveycertificationgeninfo/downloads/scletter10_26.pdf) or please contact me at (405)271-6868 or [jimob@health.ok.gov](mailto:jimob@health.ok.gov).

Respectfully,

Jim

"The measure of who we are is what we do with what we have"

-Vince Lombardi



## SAFE ADMINISTRATION OF MEDICATIONS For Assisted Living Centers, Residential Care Homes and Adult Day Care Centers

Cindy Fansler, RN

Team Supv. for Assisted Living, Residential Care and Adult Day Care Centers

**The very first requirement in a hospital is that it should do the sick no harm.**

- Florence Nightingale

For the last two years, the Oklahoma State Department of Health (OSDH) has hosted provider training programs for Assisted Living Centers and Residential Care Homes. A topic of interest during each of these sessions has been medication administration.

After each provider training, I've received calls from centers and homes requesting information related to the development and implementation of a safe program for medication administration.

These centers and homes request information on: (1) exactly what is required and (2) ideas about how to put together a policy for different aspects of the medication administration program.

This guidance is to assist centers and homes with this challenging task. It's not to be considered all inclusive but simply a guide to assist with the development and implementation of a safe medication administration program.

To maintain compliance, all the requirements in the regulation, for your facility type, must be followed and implemented. You may copy directly from your specific regulatory set and use them as your own. It's okay. The OSDH does not consider it plagiarizing.

The purpose of policies and procedures for medication administration is to ensure your beneficiaries receive their medications safely, without error, and that medications are administered by qualified staff.

Listed below are the links to the regulations for each facility type. After you have opened the link, scroll down to the subchapter for medication administration.

### **Links to Oklahoma Rules**

*Chapter 663 – Continuum of Care and Assisted Living* (See Subchapter 19-2 for Medication Administration) [http://www.ok.gov/health/documents/HRDS\\_Chapt663.pdf](http://www.ok.gov/health/documents/HRDS_Chapt663.pdf)

*Chapter 680 – Residential Care Homes* (See Subchapter 13 for Medication Administration)  
<http://www.ok.gov/health/documents/HRDS-Chapt680%20ResCare.pdf>

*Chapter 605 – Adult Day Care Centers* (See Subchapters 7-4 and 13-2 for Medication Administration)  
<http://www.ok.gov/health/documents/HRDS%20-Chapter%20605%20Aduldaycarerules.pdf>

### **Potential Policy Titles for Medication Administration**

1. Medication orders, including telephone orders
2. Pharmacy services
3. Medication packaging
4. Medication ordering and receipt
5. Medication storage
6. Disposal of medications and medication-related equipment
7. Medication self-administration by the resident
8. Medication reminders
9. Medication administration
10. Medication administration—specific procedures
11. Documentation of medication administration
12. Medication error detection and reporting
13. Quality Improvement system, including medication prevention and reduction
14. Medication monitoring and reporting of adverse drug effects to the prescriber
15. Review of medications
16. Storage and accountability of controlled drugs



## **Other considerations in policy and procedure development**

### **Who may administer medications?**

*Approved, qualified medication staff - The unlicensed facility staff member, who meets eligibility requirements as required by the state of Oklahoma will have successfully completed the required training and competency testing, and is considered competent by the registered nurse to administer medications to residents of the facility.*

### **Describe the duties of the *qualified medication staff*:**

*The qualified staff will assist with the ingestion, application or inhalation of medications, including both prescription drugs and non-prescription drugs, or using universal precautions for rectal or vaginal insertion of medication, according to the legibly written or printed directions of the attending physician or authorized practitioner, or as written on the prescription label; and making a written record of such assistance with regard to each medication administered, including the time, route and amount taken: Provided, That "administration" does not include judgment, evaluation, assessments, injections of medication, monitoring of medication or self-administration of medications, including prescription drugs and self-injection of medication by the resident.*

A licensed health care professional shall assess each resident to determine what level and type of assistance is required for medication administration. The level and type of assistance provided shall be documented on each resident's assessment.

- ◊ Is the resident able to self-administer medications.
- ◊ For residents who are unable to self-administer or self-direct medications, facility staff may administer medications only after delegation by a licensed health care professional under the scope of their practice.
- ◊ If a licensed health care professional delegates the task of medication administration to unlicensed assistive personnel, the delegation shall be in accordance with the Nurse Practice Act.
- ◊ Medications shall be administered according to the service plan.
- ◊ The delegating authority shall provide and document supervision, evaluation, and training of unlicensed assistive personnel assisting with medication administration.
- ◊ The delegating authority or another registered nurse should be readily available either in person or by telecommunication.
- ◊ Each resident's medication record shall contain a list of possible reactions and precautions for prescribed medications.
- ◊ The facility shall notify the licensed health care professional when medication errors occur.
- ◊ Medication errors should be incorporated into the facility quality improvement process.
- ◊ Medications shall be stored in a locked central storage area to prevent unauthorized access.
- ◊ Medications that require refrigeration shall be stored separately from food items and at temperatures between 36 - 46 degrees Fahrenheit.
- ◊ The facility shall develop and implement policies for the security and disposal of narcotics and other non-narcotic medications.
- ◊ The facility shall develop and implement policies for the security and disposal of narcotics and other non-narcotic medications.

**OSDH**

**"Creating a State of Health"**

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**LTC is on the web!**  
**Visit us at**  
**[www.ok.gov/health/](http://www.ok.gov/health/)**

### **Introduction to Protective Health Services**

The Protective Health Services Program areas provide regulatory oversight of the state's health care delivery service through a system of inspection, licensure, and/or certification. Several other trades/professions are also licensed.

### **Protective Health Services' Mission:**

*To promote and assess conformance to public health standards, to protect and help ensure quality health and health care for Oklahomans.*

Edited by Donna Bell and Joyce Bittner

**PLEASE POST AND SHARE  
THIS NEWSLETTER WITH  
STAFF.**

For suggestions, comments,  
or questions, e-mail us at:

**[ltc@health.ok.gov](mailto:ltc@health.ok.gov)**

