Long Term Care
Oklahoma State Department of Health

Insider Chat

Volume 3, Issue 1 May 15, 2012

Dorya Huser, Chief
Long Term Care

Inside this issue:

The Battle of Spring!

Isn't this a great time of year!! Sun is shining, flowers are blooming, warm breezes swish around you, stars sparkle brightly, birds are chirping, folks are singing and happy because winter is over, children are playing, and thoughts are on those new projects you are ready to start. Don't forget the warm lemon chiffon pie you just baked and is cooling on the window sill. You are just covered up – almost smothered by those warm fuzzies and inspirations.

Wait a minute!!! That's not right!! Weeds are growing, lawn needs mowing, flower beds need hoeing, windows need washing, house needs repairs, got to go to work, build a tomorrow (whatever), and kids are about to be out of school and need supervision. Good grief! Who thinks of this stuff? And I don't have time to bake!!

So, you have a big decision. Are you a flower or a weed? Are you a busy bee or a procrastinator? Are you creative or mired in stagnant sludge? Do you karaoke or do you whine? Do you know what you want for tomorrow? Do you do all you can today to improve what is around you? Are you good to yourself? Can you see that reflection off the water looking back at you and saying "what's next?" Are you ready to be a big bright daisy and grow taller than before?

In the Spirit,
Dorya

VII

"The Long Term Care division of the OSDH would like to acknowledge and thank the facilities that have participated in a QIS Mock Survey":

Meadowlake Estates – Oklahoma City
Baptist Village – Oklahoma City
Corn Heritage Village -Weatherford

"Tell me and I forget. Teach me and I remember. Involve me and I learn."

-**Benjamin Franklin**

The Seven Tasks of a QIS Survey
Mike Cook, QIS State Lead

The Quality Indicator Survey (QIS) is a revised long-term care survey process that was developed under Centers for Medicare & Medicaid Services (CMS) oversight. The QIS was designed as a staged process for use by surveyors to systematically and objectively review a wide range of regulatory areas and subsequently focus on selected areas for further review. In this article, we will explore the seven tasks of a QIS survey. This will give you a quick look into what new QIS surveyors spend a week in training to cover.

Offsite Preparation (Task 1)
The purpose of this task is to setup the survey in ASPEN Survey Explorer for QIS (ASE-Q). ASE-Q consists of 2 interfaces. One interface is the Minimum Data Set (MDS) Viewer which allows the surveyor to review records on residents for the last 180 days. The second interface is the QIS Tool used to conduct the survey. Once the survey has been setup, the next steps are to obtain and review information about the facility and record it into the QIS tool; make team assignments for mandatory tasks; gather the documents and supplies that are needed to conduct the survey; and, synchronize all of the laptops so each surveyor has their facility task assignment.

Onsite Preparation (Task 2)
Task 2 is similar to the purpose of Task 1. When the team arrives at the facility, they will gather additional information during the Entrance Conference and Initial Tour. The information gathered will be recorded in the QIS tool. In addition to gathering information, the team will reconcile the residents with the current resident census and then make assignments of the Stage 1 sampled residents who were randomly selected by the QIS application. Once again they will synchronize this information on the laptops. Finally, during the Initial Team Meeting the team discusses all the information gathered.

Stage 1 Survey (Task 3)
The objective of Stage 1 Survey is to conduct preliminary investigations of the quality of life and quality of care of Stage 1 sampled residents using prescribed protocols and a structured set of questions. This systematic process ensures the results are consistent and comparable across surveyors and sites. The questions cover a wide range of care areas covered by the regulations. Surveyors collect resident-specific information in Stage 1 from the data sources of observations, interviews, and record reviews. Information gathered in Stage 1 is used to determine which care areas will be comprehensively investigated during Stage 2.

Mandatory Facility Tasks (Task 4)
Facility tasks are completed across Stage 1 and Stage 2. During Stage 1, surveyors begin completing their assignments of the eight Mandatory Facility tasks in addition to completing the Stage 1 resident assignments. During Stage 2, they will finish completing the eight Mandatory Facility Tasks and complete any of the five Non-Mandatory Facility Tasks that are triggered from Stage 1. Some of the Facility Tasks are dining, infection control, immunizations, kitchen, medication administration & medication storage.

Transition Stage 1 to Stage 2 (Task 5)
The purpose of Transition is to discuss the concerns from Stage 1,including concerns that suggest possible immediate jeopardy or harm, to determine which Care Areas require in-depth investigation during Stage 2. QIS will select residents for the Stage 2 sample, but the team will finalize the sample. Additionally, the team may need to initiate residents to review for certain Care Areas if these areas are not included in the Stage 2 sample.

Stage 2 Survey (Task 6)
Stage 2 Survey conducts in-depth directed investigations of triggered or initiated Care Areas. Pathways guide the investigation using observations, interviews, and record reviews as applicable depending on the Care Area being investigated. During Stage 2, surveyors finalize the Mandatory and Non-Mandatory Facility Tasks that triggered or were initiated. Finally, as surveyors complete the Care Area investigations or facility tasks, they will determine and document the facility's compliance with the applicable Critical Elements for each of the assigned Care Areas and tasks.

Stage 2 Analysis and Decision Making (Task 7)
The primary purpose of Task 7, Stage 2 Analysis and Decision Making, is to discuss the Potential Citations and accompanying documentation resulting from the facility task and Stage 2 investigations to determine whether noncompliance exists, make team decisions about the scope and severity for the citations and conduct an Exit Conference with the facility to report Potential Citations. In our next article, we will take an in depth view of the steps and process that make up a specific task. The Long Term Care division of the OSDH would like to acknowledge and thank the facilities that have participated in a QIS Mock Survey:
Meadowlake Estates – OKC
Baptist Village – OKC
Corn Heritage Village – Weatherford
The mock survey process provides a unique learning environment for facilities and new QIS trainees. The facility is afforded the opportunity to participate in the new QIS process without undergoing a full QIS Survey of Record. The QIS trainees in turn are given the opportunity to test their classroom skills before they can participate in the Survey of Records required to become fully certified. This combination provides an excellent educational experience for all.

If your facility would like to participate in a Mock Survey, please contact:

Mike Cook
QIS State Lead
Protective Health Services
Long Term Care
Okla. State Dept. of Health
Phone: 405-271-6868

Emergency Preparedness & Response Services

Mike Cook

Strategic Planning & Compliance Officer

During the past several years some of the costliest disasters of this century have occurred in the United States resulting in countless deaths and injuries. Oklahomans have felt the effects of heat waves, cold waves, power outages, ice storms, floods, grass fires and tornadoes.

Preparing for disasters is not new to Long Term Care facilities; being prepared by having a comprehensive disaster preparedness plan, practicing for disasters in your facilities and updating your plan frequently can help save lives and reduce injuries.

Because the state is subject to the adverse effects of natural or technological disasters, the facility should develop an emergency action plan capable of providing for the safety and protection of residents, staff and visitors.

Procedures should be developed to insure that residents who are cognitively impaired, physically impaired, hearing impaired or speech impaired are properly informed and alerted as necessary.

As we enter into the severe weather and grass fire season, it is important to take precautions and be mindful of the hazards associated with this time of year. Below are suggestions to make your facility ready for whatever Oklahoma weather might throw your way.

1. Review, exercise and re-evaluate existing plans, policies and procedures.
2. Coordinate plans with the local emergency management agency.
3. Review and update inventory and resource lists.
4. Determine communication system.
5. Ensure the availability and functioning of facility emergency warning system.
6. Test reliability of emergency telephone roster for contacting emergency personnel and activating emergency procedures.
7. Develop procedure for testing generators and equipment supported by emergency generators.
8. Ensure ample days supply of food and water for residents and staff.
9. Schedule employee training programs on the operations of the emergency plan.
10. Develop and maintain Standard Operating Procedures including procedures and tasking assignments, resources, security procedures, personnel call down lists and inventories of emergency supplies.
11. Plan for Evacuation and Relocation of residents
12. Identify community resources such as volunteers, churches, clubs and organizations, emergency medical services, law enforcement, fire departments, businesses, hospitals and local government departments/agencies.

"If you don't like the weather in Oklahoma, wait a minute and it'll change."

~Will Rogers

Management of Resident's Personal Funds in Long Term Care Facilities

Christina Bundy, R.N. and Paula Terrel, R.N., Coordinators of Nursing Facilities

The Federal regulations at 42CFR, Part 483.10(c)(2-5), F159, Management of Personal Funds, documents the regulation as:

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility….

Deposit of Funds

The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) . . . .

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Accounting and Records

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his legal representative...

Notice of Certain Balances

The facility must notify each resident that receives Medicaid benefits--

When the amount in the resident's account reaches $200 less than the SSI resource limit for one person…and

That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

The Interpretive Guidelines add the following information:

If pooled accounts are used, the interest must be prorated per individual on the basis of actual earnings or end-of quarter balance.

Residents should have access to petty cash on an ongoing basis.

Banks may charge the resident a fee for handling their funds. Facilities may not charge residents for managing resident's funds because the services are covered by Medicare or Medicaid.

Generally accepted accounting principles means the facility employs proper bookkeeping techniques, by which it can determine, upon request, the amount of individual resident funds and, how much interest these funds have earned for each resident, as last reported by the banking institution.

Proper bookkeeping techniques would include an individual ledger for each resident on which only those transactions involving his or her personal funds are recorded. The record should have information on when transactions occurred, what they were, as well as maintain the ongoing balance for every resident.

Anytime there is a transaction the resident should be given a receipt and the facility retains a copy.

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.

-continued next page….

Management of Resident's Personal Funds…

-continued from prev page

During the previous 12 months from April 2011 through March 2012, the Oklahoma State Department of Health (OSDH), long term care surveyors cited 25 deficiencies related to facility management of resident funds.

Reasons for citations are listed in their order of frequency:

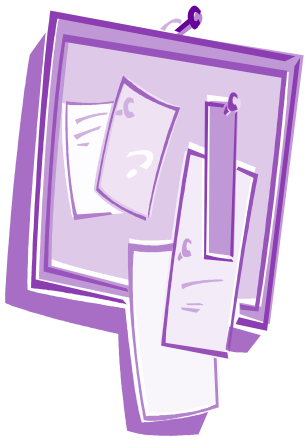
~ No quarterly statements – 18 times
~ No individual ledger – 6 times
~ Money not deposited in an interest bearing account – 6 times
~ Limited access to money – 5 times
~ No written authorization to manage resident funds – 2 times
~ Inaccurate records – 1 time
~ Failure to deposit the resident's funds in the bank – 1 time
~ Failure to provide receipts for transactions – 1 time
~ No authorization for use of the resident's money – 1 time
~ Failure to dispense the money to the resident when discharged – 1 time
~ Failure to provide notice when the account balance was within $200 of the resource limit – 1 time

The Federal regulations at 42CFR, Part 483.10(c)(6), F160, Conveyance upon death, documents the regulation as:

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

During the previous 12 months from April 2011 through March 2012, the OSDH, long term care surveyors have cited five deficiencies related to the failure to convey the resident funds within 30 days after death.

eCapitol News PRESS- House approves bill requiring generators in large assisted living facilities



(PRESS) Legislation approved by the Oklahoma House of Representatives would require Oklahoma assisted living facilities with 50 or more beds to have a backup generator for emergency power in case of a disaster.

House Bill 2002, by state Rep. Joe Dorman, includes a provision allowing a facility to request an exemption if they could show financial hardship. The legislation also requires continuum of care facilities, such as nursing homes and assisted living centers to file an emergency evacuation plan with their local fire department or county emergency management director.

"This bill originated with a constituent who was concerned about our current law after a facility where his relative was staying lost power during an ice storm," said Dorman (D-Rush Springs). "We have worked on it carefully to ensure that facilities that don't have the means can receive an exemption. We held a legislative study that showed that about a third of the facilities in the state did not have a backup generator. I think we can do better, especially with the winter storms we've seen in recent years."

The study included a representative from the Oklahoma Department of Health Long Term Care Service who stated the agency strongly supports onsite sheltering as opposed to the transfer of residents to another facility during a natural disaster.

"Moving residents to another facility or shelter in times of disaster is not the best way to look out for their safety," Dorman said. "The evacuation plans can help facilities and fire departments properly plan the best way to deal with a disaster."

House Bill 2002 was approved by a vote of 82-13 and now proceeds to the Senate for consideration.

Conducting a thorough investigation in the ICF/MR

Pamela R. Hall, RN and Michelle Raney, RN, Coordinators of Nursing & Specialized Facilities

"W154 The facility must have evidence that all alleged violations are thoroughly investigated and"; "W155 must prevent further potential abuse while the investigation is in progress."

Whether an incident involves mistreatment, neglect, abuse or an injury of unknown source, the facility must do a thorough investigation in order to find out what happened, if possible, and to prevent any future recurrence. The preliminary report shall, at a minimum, include who, what, when, and where.

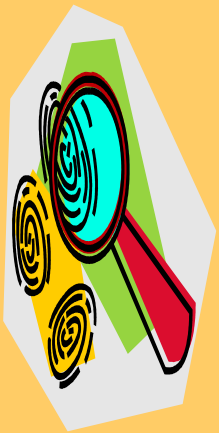
The first thing that should come to mind after an allegation has been brought to your attention is protecting the client/and or clients immediately and throughout the investigation. What measures were taken to protect the client during the investigation?

Starting the investigation: Develop a list of known and possible witnesses to the reportable incident. Interview staff, clients, and/or visitors, and anyone who has or might have knowledge of the incident. Interview staff that was taking care of the client at the time of the incident. Don't forget all possible witnesses such as dietary staff and housekeeping staff. Interview staff on other shifts that may have seen or heard something. Make attempts to narrow down the time of the alleged incident. Interview the client in the same room, or clients in the vicinity of where the incident occurred, if at all possible. Obtain signed, written statements from the reporter of the incident and all other identified witnesses.

Interviews and statements: If an employee has been identified as an alleged abuser, you should interview this person and obtain a signed, written statement. Review the employee's personnel file for previous disciplinary actions, background checks, etc. Review all of the witness statements for the accuracy of pertinent dates, times, location, and people involved. Interview coworkers and/or clients to gain knowledge of their experiences with the alleged abuser. Document any action taken to protect the client, such as suspending the alleged abuser during the investigation and maintaining time cards to reflect this.

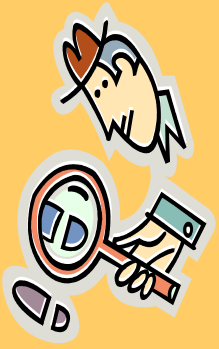
Sexual Abuse: If the allegation involves alleged sexual abuse, did a nurse immediately examine the client? Were the findings documented? Was the police notified? Was it necessary to have a physician examine the client? What other immediate actions were taken? Documentation must be available to verify all areas of the investigation.

Neglect: If the allegation involves neglect, attempt to identify all staff involved. How were they involved and what was the outcome to the client? If applicable, review facility policies if the incident may be related to unsafe technique. Was the incident due to failure to train staff correctly or malfunctioning equipment? Review and maintain the manufacturer's recommendations related to the use of special equipment. Review nurse's notes and all other facility records that may contain information relative to the incident. What interventions were in place prior to the incident?



As you can see, there are many factors that play a role in a thorough investigation. One of the most important things to remember is to **document anything and everything** that is done in relation to the incident. What corrective action has been put into place to keep this from reoccurring? Appropriate corrective action is defined as that action which is reasonably likely to prevent the abuse, neglect, mistreatment or injury from recurring.

All reportable incidents must be made to the Oklahoma State Department of Health (OSDH) within 24 hours. The results of your investigation must be sent to the OSDH within five working days.



Fire Watch and You-
Health Care Facilities Policies and Life Safety Code

Nathan Johns, MBA, Life Safety Code Supervisor

The operational integrity of a fire alarm system cannot be ensured without proper maintenance and testing. Thus, the *Code* requires that an approved (that is, acceptable to the authority having jurisdiction) maintenance and testing program be operational on an ongoing basis. As part of the program, it is equally important to retain system acceptance records and subsequent operational test records so comparisons can be made to initial system specifications.

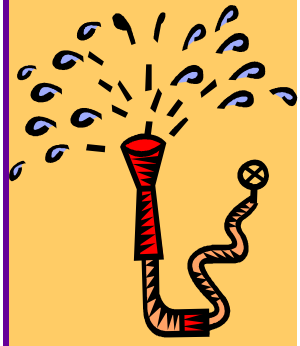
All health-care facilities are required to have written policies to address the following requirements of the NFPA 101, Life Safety Code (2000 edition).

AUTOMATIC SPRINKLER SYSTEM OUT OF SERVICE

Section 9.7.6.1 Where a required automatic sprinkler system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. If your facility has an automatic sprinkler system and it must be turned off for more than four hours, you must notify OSDH LTC and implement a fire watch. Note that personnel conducting the fire watch during this period can have no other assigned duties.

FIRE ALARM SYSTEM OUT OF SERVICE

Section 9.6.1.8 Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. If your fire alarm system must be turned off for more than four hours, you must notify OSDH LTC and implement a fire watch. Note that personnel conducting the fire watch during this period can have no other assigned duties.

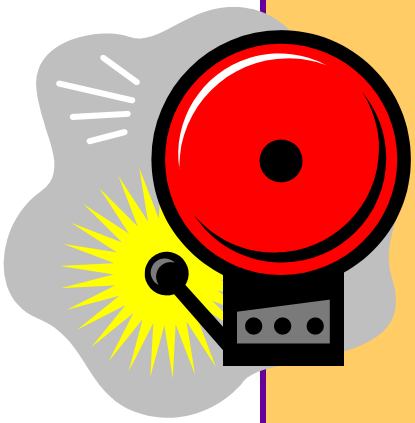


***NOTE - A.9.6.1.8** - A fire watch should at least involve some special action beyond normal staffing, such as assigning an additional security guard(s) to walk the areas affected. These individuals should be specially trained in fire prevention and in occupant and fire department notification techniques, and they should understand the particular fire safety situation for public education purposes. (Also see NFPA 601, Standard for Security Services in Fire Loss Prevention.)*

FIRE SAFETY PLAN

Section 19.7.2.2 A written health-care occupancy fire safety plan shall provide for the following:

(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Response to alarms
(4) Isolation of fire
(5) Evacuation of immediate area
(6) Evacuation of smoke compartment
(7) Preparation of floors and building for evacuation
(8) Extinguishment of fire



LTC Service Provider Training Opportunities

Karen Gray, Training Programs Manager

"My grandfather once told me that there are two kinds of people: those who work and those who take the credit. He told me to try to be in the first group; there was less competition there."

~Indira Gandhi

2012 Provider Training Dates

Wednesday, June 27, 2012	Lon Term Care - Moore Norman Tech Center, OKC
Thursday, July 26, 2012	Long Term Care - OU/Perkins Auditorium, Tulsa
Thursday, August 16, 2012	Residential Care - Moore Norman Tech Center, OKC
Thursday, September 13, 2012	ICF/MR - Moore Norman Tech Center, OKC
Tuesday, October 16, 2012	Assisted Living - Moore Norman Tech Center, OKC

Registration is currently open for the June and July LTC provider trainings. Registration for the other programs will not open until approximately **four weeks** prior to the training date. Registration forms will be mailed to each facility announcing when registration is open. Watch our website for registration information as well.

http://www.ok.gov/health/ProtectiveHealth/LongTermCareService/Long Term Care Meetings & Events/index.html

If you have suggestions for topics you would like to have us address at any of the trainings email your suggestions to: ltc@health.ok.gov

"Never point a finger where you never lent a hand."

~Robert Brault

National Background Checks

James Joslin, Chief, HRDS

In April of last year, the Department was awarded a grant from the Centers for Medicare & Medicaid Services (CMS) of up to $2.75 million dollars to cover 75% of the costs for the exploration and development of a fingerprint based national background check program.

The OSDH in partnership with provider groups in the long-term care (LTC) industry, the Department of Human Services (DHS), and the State Bureau of Investigation (OSBI) have spent the last five months reviewing current laws and rules applicable to the background check process, industry practice, and finance models for funding a fingerprint based background check program.

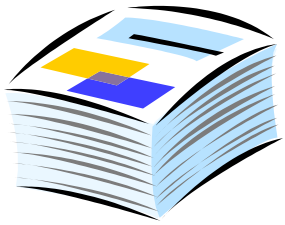
As a result of these efforts, legislation was introduced (HB2582) that would create the statutory authority to implement a fingerprint based National Background Check for certain classes of LTC providers for the purpose of protecting our vulnerable populations in LTC settings. Our goal is the reduction of occurrences of abuse, neglect and misappropriation in these settings through more informed hiring practices. The proposed program would rely on a single Web portal for checking sex offender and other disqualification registries, digital transmission of fingerprint scans through the Federal Bureau of Investigation (FBI) and the OSBI, and e-mail notification to employers of applicant eligibility status. The system further relies on what is referred to in the law enforcement industry as "rap-back notification." This allows the FBI and OSBI to notify the OSDH of a change in an applicant's criminal history status without further fingerprinting should the applicant change employers within the LTC community enrolled in this system. This proposal is modeled on a system currently in operation in the state of Michigan.

The proposed legislation would authorize fingerprint based background checks on all prospective direct patient access employees of LTC facilities and providers and others, the state elects for inclusion. As proposed, the term employer would include:

- Nursing, Residential Care, Adult Day Care, and Assisted Living facilities
- Home health agencies
- Hospice agencies
- Intermediate care facilities for the developmentally disabled
- Providers of personal care services under Medicare & Medicaid
- Providers of Medicaid Home and Community-based waiver services
- Sooner Care nurse aide scholarship program recipients
- Staffing agencies contracting with these agencies and providers
- Independent contractors contracting with these agencies and providers

The legislation relies on a finance model that converts existing name based background and sex offender registry checking fees of $19, coupled with a $10 one-time applicant scanning fee, into funds that the State may use to leverage additional Medicaid funds. With these funds, the Department would pay for those applicants requiring fingerprinting. Combined with initial grant start up funds and a diminishing fingerprint load, the finance model is conservatively projected to finance this system into the year 2020. The ability to leverage Medicaid funds has been conservatively estimated on 22% of all hires but is expected to apply more broadly, allowing greater stability in long term financing. For more information see the grant website here: http://onbc.health.ok.gov

"Our goal is the reduction of occurrences of abuse, neglect and misappropriation in these settings through more informed hiring practices."



*"Once upon a midnight dreary, while I pondered, weak and weary, over many a quaint and curious volume"…*of incident reports!

Laura Crowley, RN, Intake & Incidents

"Once upon a midnight dreary, while I pondered, weak and weary, over many a quaint and curious volume"…… of incident reports!

Do you feel like you are buried in incident reports? We understand how you feel. During 2011, OSDH received over 36,000 documents related in incident reporting. However, we understand the purpose and the value of incident reports so we are glad to receive the reports for incidents required to be reported to OSDH.

What is the purpose of incident reporting? Incident reports provide the facility with working documents of unusual occurrences for tracking and trending. Incidents can be tracked in several ways, by type of incident; residents affected or involved in the incident; staff members involved; time of day; weekends versus weekdays; and on and on.

By tracking and trending you can look for patterns to emerge. When you are able to see a pattern, it is easier to develop and implement appropriate corrective and protective measures. For an example, if you find most falls are occurring at a particular time of day or shift, you will want to examine what typically happens during that time of day or shift. Is that a time when staff is making final rounds and may be delaying in answering call lights? Is that when many staff members are taking breaks? What are residents doing at that time and what is staff doing? You may determine residents are being left unattended while multiple staff members take breaks; maybe you will decide staff members need to rotate break times. Could the nurse watch for call lights for a period of time when the CNAs are making their final round? Could shifts overlap with final rounds being combined with initial rounds? The problems you may identify could be as varied as the corrective/protective measures. You know your facility, staff and residents so you are in a key place for making decisions to improve care.

The pattern may be for a specific resident with multiple falls, in which case you would interview the resident if he/she is able to participate; maybe the roommate can tell you what has been happening. Does the resident fall at the same time of day or night; always from the wheelchair; usually incontinent at the time of the fall; fall in the same location…? Think about those factors, but also consider the resident's life history. Particularly for residents who experience confusion, the resident may be thinking he/she needs to get up for work; to prepare meals; care for children, etc. If you see the resident has a history of early rising, maybe the resident would be happier if she/he was up and in a common area near staff activity in the early hours of the morning. The same might be true for the 'night owls.' Maybe they would be happier with a snack and watching TV after most of the other residents have gone to bed. The purpose for submitting incident reports, as required by federal and state regulations, is to give OSDH the opportunity to see how the facility addresses critical incidents. Your submitted reports allow OSDH to see how you identify the incidents that require reporting; how you conduct investigations; how you determine causes; and how you implement individualized corrective/protective measures.

Incidents will happen. It is your response to the incidents that shows if you understand your responsibilities not only in reporting but also in providing residents with the care and services they need.

If your submitted incident reports are complete, including the required forms, the name of the resident(s), perpetrator(s), date of incident, narrative of the incident, extent of injuries, notifications, summary of the investigation and corrective/protective measures you can "*Quote the raven, 'nevermore*'" to faxes and calls from OSDH requesting the required submissions.

"Incident reports provide the facility with working documents of unusual occurrences for tracking and trending. "

To pill plan or not to pill plan...That is the question

Cindy Fansler RN

Many assisted living and residential care home residents are prescribed medications for preventative and curative reasons. Assisted living centers and residential care homes are required to adopt and implement policies and procedures for safe medication administration for the residents, including the residents who self administer their own medications.

Some residents can manage a medication routine just fine independently, while others may require varying degrees of assistance. The assisted living centers and residential care homes each have regulations that they shall be familiar with and follow to ensure residents take what they are supposed to take, when they are supposed to take them. Without assistance, some residents may take more than required, less than required or hopefully, just the right amount. Over the last few years pill planner or medication minders have made their way into these licensed homes.

The following rules and requirements will help explain why pill planners and pill minders are not acceptable for use in the licensed homes and centers.

In Chapter 310:663, the Continuum of Care and Assisted Living Rules & Act,

C1922(2) documents, "The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication"

C1931(1) documents, "The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident.

C1933(3) documents, "Only a licensed nurse, physician, pharmacist, certified medication aide or medication aide technician may dispense for administration these medications and only upon a physician's written order for as needed or nonscheduled dosage regimens…"

In Chapter 310:680 Residential Care Home Regulations and Residential Care Act

R 0630 (2) (b) documents, "(2) Administration of Medications.
(B) The person responsible for medication administration must personally prepare the dosage, observe the resident swallowing the medication, and chart the medication."

R 0634 (2) (f) documents, "(2) Administration of Medications.
(F) A resident who has been determined by his physician as capable of self-administering medication may retain the medications in a safe location in the resident's room. The facility shall develop and follow policies for accountability. Scheduled medications shall not be authorized for self-administration. A resident who has been declared legally incompetent is not eligible for self-administration of medications."

R0636 (3) (b) documents,"(3) Monitoring of medications.
(B) An accurate written record of medication monitoring shall be made by the individual monitoring the medication. This record must identify the individual responsible for the drug monitoring."

Per The State of Oklahoma Board of Pharmacy Rules and Regulations

Title 59, Section 355.1 (A) Except as provided for in Section 353.1 et. seq. of this title, only a licensed practitioner may dispense dangerous drugs to such practitioner's patients and only for the expressed purpose of serving the best interests and promoting the welfare of such patients."

Title 59, Section 353.13 (A) It shall be unlawful for any person, other than a licensed pharmacist, to certify the finished prescription, as defined by the Board, before delivery to the patient or the patient's agent or care giver.

535:20-7-2. "Repackage" means changing the container, quantity, or labeling of a drug to further the distribution of the drug and requires a packager license. Repackaging does not include the filling of a prescription by a pharmacy.

535:20-5-3. (a) Applicants shall be registered with the federal Food and Drug Administration (FDA) and meet the federal requirements to repackage.

OSDH
1000 N.E. 10TH STREET
Oklahoma City, OK
73117-1299

LTC is on the web! Visit us at: www.health.ok.gov

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

ltc@health.ok.gov

Managing Resident Funds In Residential Care

Debbie Zamarripa, R.N.
Coordinator, A.L., R.C., and A.D.C.

Do you ever have problems balancing your own checkbook? How about balancing resident funds and records?

During your survey, we review resident financial records to ensure compliance with the rules and regulations that are listed in:

Chapter 680 Residential Care Homes
Subchapter 19 310:680-19-2:
Residential Care Homes-Resident Rights and Resident Funds
There have been some questions asked about resident funds and exactly what is required in residential care.
Some of the citations that have been written in the past include:

- Failure to provide written statements explaining the resident's rights regarding personal funds.
- Failure to maintain resident funds in a separate account.
- Failure to obtain written authorization for safekeeping and managing of resident funds.
- Failure to have quarterly accountings of personal funds for residents.
- Failure to refund money after a resident went to the hospital and did not return to the facility.
- Failure to refund prorated charges for payments made in advance for discharged resident.
- Failure to include deposit amount in resident contract.
- Failure to accurately reflect all transactions involving resident funds and inaccurately recording deposits or balances.
- Failure to ensure written authorization to manage resident funds was witnessed by person not connected to the home.
- 10.Failure to reserve a portion of each resident funds in an amount not less than $25.00 as a personal needs allowance.
- 11.Failure to ensure an accurate and complete accounting of resident funds.

During your survey, resident funds will be reviewed to ensure compliance with the regulations.
I will be happy to help you understand the requirements so together we can ensure your home does not receive a deficiency related to resident funds. If you have questions related to a specific case or area of concern at your home, please contact: Debbie Zamarripa RN, Licensure Coordinator, OSDH debrash@ok.health.gov or 405-271-6868.

Insider Chat: Edited by Donna Bell and Barbara Reed

PLEASE POST AND SHARE THIS NEWSLETTER WITH STAFF.

This publication was issued by the Oklahoma State Department of Health (OSDH) as authorized by Terry L. Cline, Ph.D., Commissioner of Health. 1000 copies were printed by OSDH at a cost of $1,740.00. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.