

**Round Table Questions and Answers: ISDH and Provider Meeting
March 14, 2008**

1. Is the recently released CPR policy applicable to licensed Residential facilities?

ANSWER: The CPR policy is based on an appropriate facility policy which, in turn, would require appropriate assessment of the resident. That would be a physician or nursing assessment of whether the criteria were met. Residential care facilities are not necessarily required to have nursing staff on site at all times [410 IAC 16.2-5-1.4(b)]. If the facility does not have nursing staff on site, there will not be a qualified individual to assess the resident pursuant to this policy. In that case, the facility is obligated to initiate CPR unless there is a "do not resuscitate" order. If there is a nurse on site who can make the necessary assessments (as per facility policy), the policy would be applicable to licensed residential care facilities.

2. Can a CNA apply a barrier cream (e.g., zinc oxide, A & D ointment) to the intact skin of a resident as a preventative measure?

ANSWER: Please review Standard 14 of the NA curriculum which states the following:

STANDARD 14: NURSE AIDE SCOPE OF PRACTICE:

The nurse aide will perform only the tasks in the course standards and *Resident Care Procedures* manual, unless trained appropriately by licensed staff of the facility with policies and procedures and a system for ongoing monitoring to assure compliance with the task, i.e., (see supplements for examples).

This additional training would only apply for tasks, which are not prohibited by paragraphs 2 and 3 of this section and by current rule, which prohibits the giving of injections.

The nurse aide will not perform any invasive procedures, including enemas and rectal temperatures, checking for and/or removing fecal impactions, instillation of any fluids, through any tubing, administering vaginal or rectal installations.

The nurse aide will not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin, such as moisture barrier cream.

Note: The specific question was posed as to whether zinc oxide would be included in the category of moisture barrier creams acceptable to be applied by a CNA and the response provided was "yes."

3. Are refrigerators, microwaves and other such small appliances allowed in resident rooms?

ANSWER: Resident refrigerators and other such small appliances are allowed in long term care facilities in Indiana in accordance with facility policy. The facility policy should address at a minimum: Appliance safety prior to use and ongoing preventive maintenance, cleaning and monitoring of the refrigerator, add monitoring of the resident's ability to safely operate the device and use and storage of the device without risk of injury to confused residents. The facility must maintain a balance of "homelike environment" and safety.

Providers are advised to encourage the use of thermos/carafe coffeemakers in lieu of hotplate-type models and to monitor the use of any microwave (in the resident room or otherwise) due to opening bags of popcorn (which can be extremely hot), etc..

The appliances may be plugged into any outlet. If a power strip is used, the appliance must not be high voltage and/or have a three prong plug. The power strip may not be located near the head of the bed.

4. ISDH advisory to facilities regarding side rails: There recently was a tragic death of a resident in an Indiana nursing home involving bed rail entrapment. Facilities need to be checking the bed rails being used for residents. Please be especially observant of the rails on any of the beds in the facility that have more than 4 ¾ inches between the bars. Please review the guidance provided from CMS on F323 and from the FDA web site for information about entrapment in hospital bed rails. While the entrapment zones are listed as "recommendations" for appropriate measurements, they are considered by the FDA as somewhat of best practices, hence facilities should be aware of these recommendations when determining facility practice and assessing facility compliance.

Round Table Questions and Answers: ISDH and Provider Meeting May 16, 2008

1. Reportable Unusual Occurrence Guidance/Significant Injuries: Facilities have reported being cited for not having reported a fracture incurred by a resident who is "not" totally dependent as per MDS coding. When questioned, the rationale given by the surveyor included that the facility must proceed in the guidance and include the reporting of the fracture as meeting the description stating "serious unusual and/or life-threatening injury."

Clarifications have been provided multiple times in the past as to reporting a fracture incurred by a "totally dependent" resident. Please advise if there has been a revision in practice.

ANSWER: There has been no revision to prior clarifications which stated that a fracture should be reported if incurred by a totally dependent resident (as per MDS coding). Providers are reminded however to evaluate whether the circumstances of the fracture would meet the reporting guidelines of "significant injuries" because of the event causing the fracture being viewed as "serious/unusual and/or life threatening injury."

Each situation must be reviewed individually. If a provider has reviewed the reportable unusual occurrence guidance and determined that the circumstance which resulted in a fracture incurred by an individual who is not totally dependent (per MDS coding) does not meet the guidance, it would behoove the provider to denote on the facility record/report rationale as to why the facility determined the event did not meet the reportable criteria. This will assist in later review to clarify the thought pattern of the provider in making the determination "to report" or "not to report" should the same be questioned.

Lastly, the provider can always contact the area supervisor and discuss the issue in question. In this manner, the supervisor can assist to provide direction as to whether it would be anticipated that the issue/event be reported.

2. Follow-up to Question and Response #1 from Q & A dated 2/15/08 regarding reporting disciplinary action for failure to perform assigned duties: ISDH was originally requested to "consider clarification as to anticipated facility reporting should employees warrant discipline and/or termination on the basis of care provided (or lack thereof)." The original response provided was, "Facilities are required to report allegations of abuse, neglect, or misappropriation of resident property. If the facility disciplines an employee, up to and including terminates, for failing to 'provide goods and services necessary to avoid physical harm, mental anguish or mental illness to a resident, then it should be reported to the ISDH." Providers have still yet voiced a desire for clarification to the aforementioned response.

ANSWER: The reportable unusual occurrence guidance regarding neglect states that "failure to provide goods and services which has resulted in resident negative outcome" is required to be reported. If a staff

member is disciplined for failure to perform a service, lacking a negative outcome, it is not reportable. The provider must consider however whether the circumstance meets the definition of abuse (e.g., one might question if the omission of service or deprivation meets the definition of "willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, or pain, or mental anguish"). Abuse is a negative outcome and therefore always reportable.

Each situation must be reviewed individually. If a provider has reviewed the reportable unusual occurrence guidance and determined that the circumstance does not meet the guidance, it would behoove the provider to denote on the facility record/report rationale as to why the facility determined the event did not meet the reportable criteria. This will assist in later review to clarify the thought pattern of the provider in making the determination "to report" or "not to report" should the same be questioned.

Lastly, the provider can always contact the area supervisor and discuss the issue in question. In this manner, the supervisor can assist to provide direction as to whether it would be anticipated that the issue/event be reported.

Round Table Questions and Answers: ISDH and Provider Meeting June 27, 2008

1. Does a PPD have to be done if a resident, with an up-to-date PPD, is transferred from the facility to the hospital, admitted to the hospital and then readmitted/admitted to the facility after the hospital stay?

ANSWER: The PPD does not have to be redone because this is a 'readmission" not an "admission" and the rule requires the PPD be done within 3 month prior to "admission" or upon admission.

2. Is a PPD required when a resident is transferred from one nursing facility to another (with no time elapsed between leaving one facility and entering another)?

ANSWER: When a resident is admitted to a long term care facility regardless of the location prior to the admission a PPD is required within three months prior to admission or upon admission to the new facility.

3. Does this apply for the chest x-ray as well? Would this be accurate if the resident went home between facilities; however, if transferring immediately to another facility would not apply?

ANSWER: When a resident is admitted to a long term care facility regardless of the location prior to the admission a chest x-ray is required no more than six months prior to admission to the new facility.

Regulatory references: Comprehensive Care: 410 IAC 16.2-3.1-18 (c) & (e), Residential Care: 410 IAC 16.2-5-12 (c) & (e)

Please contact Debbie Beers, ISDH Division of Long Term Care, 317/233-7067, if you have additional questions.