Revised 7/2004

Frequently Asked Questions in Long Term Care or FAQs on LTC

- **Question:** Isn't incontinence just a normal consequence of the aging process?

  Answer: NO - It is true that incontinence increases with age. However, it is not a normal consequence of aging. In addition, control of bladder and bowel functions is a sensitive subject for residents struggling to maintain control. Therefore, facilities are expected to be proactive in caring for resident's experiencing incontinence. Proactive care includes regular and routine monitoring and changing of soiled clothing and bed linen. Failure to assist an incontinent resident with appropriate adult hygiene products violates a resident's human dignity and can lead to urinary tract infections, skin irritations and the associated risk of skin breakdown including pressure ulcers, not to mention a violation of numerous regulations. Facilities are expected to implement appropriate toileting programs for each resident experiencing incontinence, including adequately and timely assistance to the bathroom, and to assure that each resident has sufficient hygiene products to meet their *individual* needs.

- **Question:** If a resident's physician has recorded "do not resuscitate" in the resident's medical record, is it necessary to complete the standardized Durable Do Not Resuscitate (DDNR) form as required by the Office of Emergency Medical Services of the Department of Health?

  Answer: YES - Without a signed DDNR form instructing otherwise, a resident *will be resuscitated* by emergency medical technicians (EMTs) should that resident require medical transport *for any reason.* The purpose of the DDNR is to instruct EMTs, who otherwise would not know, a resident's wishes. For state policies on "Do Not Resuscitate" orders, refer to the Office of Emergency Medical services web site at: www.vdh.state.va.us/oems/ddnr/ddnr.asp

- **Question:** Can a facility require, as part of their admissions criteria, that residents use only the facility's pharmacy provider?

  Answer: NO - Facilities may not restrict access to "out of system" medications. Refer to the guideline: "Receiving Out of System Medications."

- **Question:** Is pronouncement of death a delegated nursing task?

  Answer: NO - State law and Board of Nursing regulation (12 VAC 90-20-420 thru 450) does not permit pronouncement of death as a nursing task. State law does permit *registered* nurses to pronounce death when: (i) the nurse is employed by a home care organization, hospice, hospital or

nursing facility and is directly involved in the care of the patient, (ii) the death is anticipated and the patient is under a physician's care when it occurs, and (iii) the patient has a valid Durable Do Not Resuscitate order (DDNR). The nurse is required to inform the patient's physician and any consulting physicians of the death as soon as practicable. (§ 54.1-2972.B of the Code of Virginia)

- **Question:** Can a physician delegate tasks to physician's assistants, nurse practitioners or clinical nurse specialists?

  Answer: Yes - but with limitations. A physician *may not* delegate a task when: (i) the regulation specifies that the physician must perform the duty personally, or (ii) the delegation is prohibited under state law or the facility's own policies. Physicians assistants, nurse practitioners, and clinical nurse specialists may provide medically necessary care to long-term care residents, except in those situations where the regulations require that the task be personally performed by a physician or when prohibited by state law or facility policy. (S&C-03-18)

- **Question:** Does HIPAA prohibit the release of confidential health information for the purposes of assisting with crime scene investigations by law enforcement personnel?

  Answer: NO - Federal HIPAA privacy regulations do not prohibit police or law enforcement personnel from conducting investigations of a crime on the premises of a health care provider. HIPAA law expressly permits disclosure to law enforcement officials of protected health information of a crime committed on the premises of the provider. Facilities are expected to facilitate any law enforcement investigation of crime occurring on the premises, including cases of abuse, as required by Virginia law.

- **Question:** What is the policy in Virginia regarding families placing cameras in nursing facilities?

  Answer: State and federal long-term care regulations do not prohibit the placing of cameras in resident rooms for the purposes of monitoring at risk residents. Therefore, facilities must have procedures in place to obtain the *documented consent* of *the resident* to be filmed, *including* any resident sharing a room with the resident to be filmed. Residents have a right to refuse consent to be filmed. Family members cannot insist on camera use over the objections of the resident. Facilities cannot use cameras in violation of the law based solely on a family member's request or approval. Documentation should be kept in the resident's medical record. It is not necessary to obtain consent of employees or for using cameras in community areas such as hallways, elevators, and dining rooms. Refer to the guideline: "Electric Monitoring of Resident's Rooms" for more information.

- **Question:** If a staff member is certified in CPR, are they also required to attend in-service training on the basic principles of CPR in compliance with 12 VAC 5-371-260.B.10? What "basic principles of CPR" in-service training include?

  Answer: NO - By maintaining current CPR certification, the staff member meets the requirements of 12 VAC 5-371-20.B.10 since CPR certification training is more intensive than basic principles of CPR in-service training. At a minimum, basic principles training should cover: (i) recognition of sign of cardiac arrest and choking, (ii) names of staff with CPR certification, and (iii) location and use of portable defibrillators. The facility's Medical Director should be able to assist with designing appropriate in-service training.

- **Question:** When is it necessary for facilities to notify residents, families, and physicians of noncompliance to certification standards after the first revisit?

  Answer: Federal law does not require facilities to notify residents, families, or physicians of noncompliance to certification standards. However, the Center for Quality Health Care Services and Consumer Protection will request that a facility notify residents, families, and physicians when the facility receives a scope and severity rating of "G" or higher on a revisit survey to determine facility compliance.

Question: If a person has been convicted of a felony, how long after the conviction can the person be hired? Are there certain types of offenses that are treated differently?

Answer: Under § 32.1-126.01 of the *Code of Virginia*, convictions for offenses unrelated to abuse, neglect, or moral turpitude would not disqualify an applicant for employment. Criminal convictions for such offenses as traffic violations, burglary, check fraud, and larceny, for example, may not disqualify an applicant. However, such other convictions may disqualify an applicant on the basis of the facility's hiring, personnel, or other regulations or policies. Facilities are referred to the "Criminal Records - Employment Barrier Crimes in Nursing Facilities" guideline for further clarification.

Question: Is the use of over the counter (OTC) topical medication intended to prevent skin breakdown prohibited?

Answer: The Drug Control Act, Chapter 34 (54.1-3400 et seq.) of Title 54.1 of the *Code of Virginia*, does not address the administration of OTC medication. The Virginia Board of Nursing does not oppose the administration of OTC topical medications intended to prevent skin breakdown to

patients by properly trained licensed or certified individuals.

Question: Can I use a resident room for something other than its intended use as a bedroom? Must I inform the Center of this special use?

Answer: Yes, a resident room may be used for other purposes for up to 12 months provided: (i) the room is currently unoccupied, (ii) no residents will be displaced, (iii) no new resident will be denied admission; (iv) the room can be returned to its intended use as a resident room within 24 consecutive hours if a request for admission is received that would necessitate the room's use as a resident room, (v) written notification of the temporary use of the room is sent to the Center prior to conversion of the room. Written notification of the return to resident use status should be filed with the Center within 5 days of resident occupation of the room. If the room is not returned to its original use as a resident room within the 12-month period, the room's beds are removed from the facility's licensed bed inventory. Therefore, it is incumbent on the facility to notify the Division of Long Term Care of the Center of the return of the room to resident use status. Beds not retained in a facility's bed inventory will be included in the bed inventory for the applicable planning district and may be eligible for redistribution in the next COPN Request for Applications or RFA.

Question: Are side rails considered assistive devices or restraints?

Answer: All side rails are devices but only some devices are restraints. To determine whether a side rail is a restraint, the facility must conduct an assessment and, by using the care planning process, identify the safety issue and/or medical symptoms supporting its use as the least restrictive way to address the issue. Half rails are NOT restraints *if:*

1. They do not prevent the resident from moving in ways the resident would otherwise be able to move;
2. They are used by a resident for bed mobility, repositioning, transferring, etc;
3. They support or facilitate the resident's highest practicable level of physical functioning and may contribute to the resident's psychosocial well-being by enhancing independence and mobility.

CMS considers 3/4 side rails to be full bedrails. All side rails, whether restraints or enablers, should be assessed as *accident hazards*. Some residents (e.g., those who are frail, very thin, or have agitated behavior or uncontrolled movements) are at risk for injury using side rails. Facilities must take affirmative actions to eliminate the hazard or minimize the risk as much as possible. It is important to remember that each resident must be assessed individually to identify *all* safety problems and the *least* restrictive methods to solve them.

Question: Is the use of side rails to be documented in the resident's record?

Answer: The decision to use side rails must be clearly recorded in the resident's clinical record. The information provided to the resident (family member, or legally responsible person) that permitted the individual to make an informed choice about the use of side rails, including risks and benefits, should be documented in the resident's record. As in all good documentation, the record should also include a statement about the resident's response to the side rail. The record should be reviewed periodically to ensure the documentation supports the continued use of the side rails and to assess the need for change in the plan of care, if needed.

Example: If the side rails are used as enablers to support independent mobility, *all* documentation, e.g., nurses' notes, physician progress notes and orders, the MDS, care planning, and therapy notes should support the rationale.

Question: How should the use of side rails be recorded?

Answer: The use of side rails should be recorded in the appropriate section of the MDS assessment. When used as devices, side rails are counted in section P of the MDS 2.0 as devices. Since they also act as *enablers*, they must also be listed on section G6b. To calculate the number of restraints (devices minus enablers) for reporting on the CMS 672, subtract the enablers (G6b) from the total number of devices and restraints listed in section P. See CMS MDS 2.0 Q&As 57 and 120-129 for clarification on counting restraints and the use of side rails as restraints. Though CMS has not fully resolved restraint issues internally, CMS's "Side Rails Guidance" (Feb. 4, 1997) remains the operative statement of policy in addition to the statute, regulations under §483.13, and the interpretive guidelines.

Question: If a resident becomes mentally incapacitated or is deceased, who can request copies of the medical record?

Answer: Under Virginia law, patient records are the property of the provider maintaining them. The provider is prohibited, however, from disclosing a person's medical record except in compliance with state law. If a person is mentally incapacitated, or is deceased, medical records may be released to: (i) a personal representative or executor of the deceased person, or (ii) the legal guardian or committee of the incompetent or incapacitated person. If no such person has been appointed, then the following persons, in order of priority may request the records:

1. A spouse
2. An adult son or daughter
3. Either parent
4. An adult brother or sister
5. Any other relation of the deceased in order of blood relation.

Revised 7/2004

Additional information regarding medical records can be located in § 32.1-127.1:03 of the Code of Virginia

Question: What information is required in a discharge notice to residents?

Answer: State law requires a facility provide "advance written notice" to residents who are transferring or being discharged from a facility. Federal regulation stipulates the information certified facilities are to include in a discharge notice:

1. The reason for the discharge or transfer;
2. The effective date of the transfer or discharge;
3. The location to which the resident is transferred or discharged;
4. A statement that residents, *whether Medicaid/Medicare, commercial insurance or private pay,* in federally certified facilities have the right to appeal the transfer or discharge to the Department of Medical Assistance Services and the address for filing appeals:

Director
Division of Client Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23213

5. The name, address, and telephone number of the state long-term care ombudsman:

Ombudsman
State Long-Term Care Ombudsman Program
Virginia Association of Area Agencies on Aging
530 E. Main Street, Suite 428
Richmond, VS 23219

Phone: (804) 644-2804 or toll free: 1-800-552-3402

For residents with developmental disabilities, the notice shall include the mailing address and telephone number for the:

The Office of Protection and Advocacy
202 N. 9th Street, 9th Floor
Richmond, VA 23219

Phone: (804) 225-2042 or toll free: 1-800-552-3962

For residents who are mentally ill, the notice shall include the address and telephone number of the local community services board.

Question: What are the services available for addressing the mental health needs of a resident?

Answer: There are 3 options available to facilities for addressing the mental health needs of residents:

1. Specialized in-service training for facility staff in behavior management for individuals with aggressive behavior. There are several specialized training programs available to nursing facilities.
2. The local CSB or private provider may conduct a consultation, recommend services, and help develop a plan of care for a resident.
3. Specialized services for active treatment ordered by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) after an evaluation of the services needed. The facility should contact the Office of Mental Health Services and ask for a Nursing Home Pre-Admission Screening Assessment.

Question: What is the process for having an individual committed to a mental health facility for evaluation?

Answer: If the steps above have been tried and supporting appropriate documentation in the resident's record indicates commitment to a mental health facility may be necessary, there is a legal process for the involuntary commitment to a mental health facility. A physician, facility administrator, family member, or any responsible person may swear out a petition for a Temporary Detention Order (TDO). A TDO evaluation is conducted by the local Community Service Board (CSB) pre-admission screening evaluator. If the resident meets the TDO criteria, the case is taken to a magistrate. The magistrate makes a decision to grant the TDO based on the testimony provided.

If the evaluator finds the resident does not meet the commitment criteria and the person responsible for filing the petition disagrees, they may take the petition to the magistrate. The magistrate must hear the petition and make a decision based on all the evidence provided. If a TDO is granted, the resident is assigned to a state facility or a private hospital while an extensive psychiatric evaluation is conducted.

NOTE: Detention is for 48 to 72 hours. However, if the TDO period falls over a holiday weekend, detention can be longer.

Once the psychiatric evaluation is concluded, a special justice hears the case and makes a decision

on commitment. For this hearing, the resident is assigned an attorney. If commitment is ordered, the resident is admitted to the mental health facility. If the resident does not meet the TDO criteria, the individual is released with a recommendation for services needed, if necessary.

Occasionally, it may be necessary to contact the police or sheriff if a resident becomes violent. In that case, an Emergency Custody Order (ECO) may be issued on the resident. The primary purpose of the ECO, which is of four hours duration, is the resident's safety while a TDO evaluation is conducted by a Community Service Board (CSB) pre-admission screening evaluator. If the resident meets the TDO criteria, the case is taken to a magistrate and the commitment process as described above begins.

Question: Can a facility submit computer generated forms in lieu of the CMS 802 and 672?

Answer: Yes, if the computer generated form is an exact duplicate of the corresponding CMS 802 and 672. That means columns; lines, blocks and headers must match the columns, lines, blocks and headers of the CMS forms. If the computer generated forms do not duplicate the CMS forms, they cannot be used for their intended purpose, data entry.

Question: A facility chooses to go "smoke free." What are the facility's obligations toward its residents that choose to smoke?

Answer: A facility that permitted smoking may choose to go smoke free, however, it must still accept and accommodate those residents who were smoking in the facility prior to its going smoke free. Residents who were smoking in the facility prior to its going smoke free cannot be required to give up smoking because the facility is changing its smoking policy. The facility does have the option of restricting smoking to designated areas and may limit a resident's access, i.e., staff available to accompany a resident for the duration of a smoking break.

Careful consideration must be utilized in designating smoking areas so that nonsmoking residents will not be exposed to second hand smoke. For example, a television lounge used by both smokers and non-smokers is not an acceptable designated smoking area. However, the designated smoking area should maintain the quality of life for residents who smoke. Requiring residents who smoke to go outside is not an appropriate accommodation. Once the facility has adopted a "smoke free" environment, new applicants should be informed of the no smoking policy prior to and at time of admission. The facility can prohibit visitors, volunteers, and employees from smoking in the facility regardless of when the facility changed its policy.

Question: Why are deficiencies that are corrected during a survey still reported on the 2567?

Answer: The deficiencies are reported on the 2567 because they existed prior to, or during, the survey, making the deficiency subject to disclosure. Facility action to correct the deficiency during

the survey is also reported as part of the 2567. However, the correction of the deficiency during the survey does not preclude it from recurring. Therefore, the facility is expected to address how they will prevent further recurrences of the problem according to established criteria in their Plan of Correction.

Question: Should resident beds be moveable? Or should they be stationary?

Answer: It is important that resident beds be equipped with wheels or castors in case a bedfast resident must be evacuated. However, the wheels or castors must be equipped with locks or brakes to secure the bed from moving unexpectedly during normal use by an ambulatory resident.