# Division of Licensing and Certification
# Bureau of Facility Standards

## Long Term Care Facilities

### Survey Q&A

**1. Q: I see that F156 is being cited more often in Idaho lately. What are the common issues cited at this tag?**

**A:** F156 is part of the Resident Rights section of the federal regulations. It covers many areas, all related to how a facility must notify/inform each resident at admission of a variety of information. It has been cited in 2003 most often for failure to notify residents who are entitled to Medicaid benefits, in writing, at the time of admission, of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged. This would include routine personal hygiene items. F162 provides a complete list of items for which a facility may not charge a resident whose stay is covered by Medicare or Medicaid.

**2. Q: What is required for documentation of the monthly pharmacy review for residents for whom no potential problems were found? Can the pharmacist simply sign the MD order recap every month?**

**A:** No. It is not acceptable for the pharmacist to simply sign the order recap. CMS Appendix N gives specific guidance on this subject on page N-5. It states:

> A record of drug regimen reviews must be maintained in the facility to demonstrate that such reviews have been performed. This record may or may not be a part of the patient's medical record depending upon the facility's policy. Each patient must be identified, and documentation of one of the following circumstances must exist: If no potential problems were found, the pharmacist reviewer **must have included a signed and dated statement to this effect in the drug regimen review record**.
> (emphasis added)

**3. Q: Our facility staff are pushed for time in the morning to get all the residents up and ready for breakfast. Is there a problem with the night shift getting residents dressed early?**

**A:** Yes, this is a problem. The practice of awakening residents early in the morning, when it has not been appropriately care-planned (see below), is a violation. This practice violates the resident's right to choose schedules (F242) for residents who can indicate a preference. For residents who are not cognitively capable of indicating a choice for a get-up time, it is a violation of the right to dignity (F241).

Some of the practices that have been observed and cited include:

1. Night shift dresses the resident on last rounds (4-5 am) then returns the resident to bed to continue sleeping in his/her clothes.

2. Staff awaken the resident hours before breakfast, prepare him/her for the day and then place the resident in a chair where the resident sleeps until breakfast.

F242 guarantees residents the right to choose schedules. Many facilities have adopted a flexible breakfast schedule that allows residents to sleep as late as they choose and get breakfast when they awaken. This is a preferred method of avoiding the early morning rush.

Facilities are cautioned to care plan early rising for a resident only when there is supporting evidence that this is indeed the resident's preference. Further, even those who routinely want to get up very early have the option of sleeping late some days.

**4. Q: I was wondering if the survey teams will be familiar with the new Beer's list drug criteria and enforcing it during this year's survey process. Could you divulge this information to me?**

**A:** We have not received any guidance from CMS regarding a change in the Beer's list or any enforcement changes relating to drug use. If we do receive such direction, we will pass the information on to the industry.

**5. Q: What is the latest with side rails?**

**A:** CMS Region X reviewers have provided feedback to the survey agency that we have not properly enforced the federal guidelines regarding side rail use. Region X surveyors provided written clarification, which you will find below. This guidance succinctly summarizes the federal requirements for side rail use. **Facilities are encouraged to review all this information carefully as you will see a change in survey expectations for side rail use.**

**Regional Office Surveyor Consensus Related to Side Rails**

1. If side rails are in use, they are to be considered a restrain or a device.

2. If facility has done no assessment or incomplete assessment and **any** side rails are in use, cite under assessment tag appropriate to assessment time frame.

3. If there is a potential or actual negative outcome and the side rails **are** a restrain, cite under F221.

4. If there is a potential or actual negative outcome and the side rails **are not** a restraint, cite under F323 or F324.

5. Residents must be fully informed of the risks and benefits to use the side rails. No written consent is required. If facility has failed to fully inform resident of risks and benefits, cite under F154.

Further, any side rails that are used by the resident for positioning will no longer be considered automatically as "not a restraint>' The RAI manual states on page 3-201:

> "It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. **If the side rail has the effect of restraining the resident and meets the definition of a physical restraint for the individual, the facility is responsible to assess the appropriateness of that restraint."**

Any side rail use that meets the definition of restraint for the particular resident must meet all the requirements for proper restraint use, i.e., documented need for the restraint due to a medical symptom (lack of safety awareness due to dementia is not acceptable in itself), attempts at less restrictive measures tried first and found inadequate, routine attempts at reduction as appropriate. Refer to F221, Guidance to Surveyors, for more detailed information.

Also, in situations where the resident requested side rails, and the side rails constitute restraint, the facility must still ensure that all the requirements for proper restraint use are met. (See RAI Manual page 3-200)

For residents who have no voluntary movement, the facility needs to determine if there is any appropriate use of side rails. (See RAI Manual page 3-202)

**6. Q: My facility received an "A" level tag. On the state licensure survey report, there is a state licensure deficiency that refers to the federal "A" tag. I know I don't have to write a Plan of Correction for the federal "A"**

**tag, but do I have to write a Plan of Correction on the state licensure form for the same tag that refers to the "A"?**

**A:** No. You do not need to write a Plan of Correction for a state licensure deficiency that refers to a federal "A" deficiency.

**7. Q: Can my facility utilize the staff from the attached Assisted Living when the Assisted Living work is slow?**

**A:** No. Separately licensed facilities/entities cannot share staff back and forth, even if the facilities are attached. There is a specific state licensure rule indicating that staff of the SNF shall not have responsibilities that would take them away from the SNF residents. (IDAPA 16.03.02.303) The SNF must maintain its staff separate from any attached Assisted Living facility or acute care hospital. For example, the RN on duty at the attached hospital cannot be counted as the RN for the SNF for the same shift. Similarly, a CNA cannot be assigned to care for three residents of the SNF and three patients in the attached hospital on the same shift, even if the rooms are all in close proximity.

The State licensure rules specifically allow two exceptions to the "no sharing staff" rule. That is, a SNF may share administrator and director of nursing with an attached hospital, so long as the administrator is a licensed nursing home administrator in Idaho. (IDAPA 16.03.02.100.02 and 16.03.02.200.02.e)

**8. Q: Can you give us an update on side rail issues?**

**A:** 1. One problem that surveyors have identified is that many facilities show a written side rail assessment that states the side rail is not a restraint for that resident, yet the facility has coded the side rail as a restraint on the MDS, at Section P4. The RAI Manual specifically indicates on page 3-198 'to code only those devices categorized in section P4 that have the effect of restraining the resident.'

If you are coding side rails incorrectly at section P4, you will be cited F272 or F278, as appropriate.

2. Another frequent problem we are finding relates to the use of special pressure-reducing beds/mattresses. If the facility uses one of these, the facility needs to get the manufacturer's recommendations regarding side rail use. Include those recommendations in your side rail assessment. The facility must follow the manufacturer's recommendations. If side rails are used because of the bed manufacturer's recommendation, the side rails still must be assessed and a determination made as to whether the side rails are

a restraint for that resident. For residents on special air beds whose manufacturer recommends that use of full side rails which then constitute restraint for the resident;

a. The medical symptom requiring the restraint is the same medical symptom that requires the special bed.

b. Do not attempt to reduce the side rail usage as long as that bed is in use.

3. Short side rails are generally preferable to longer ones. Short side rails are less restrictive, (allow more freedom of movement), are more age-appropriate (doesn't look like a crib with bars), and provide less opportunity for accidental entrapment. Short side rails, even very short one (i.e. 4 inches long), still must have an assessment that show whether that side rail restrains that resident, weighs the risks vs. benefits, and indicates somehow that informed consent has been given for the use of the rail.

4. Points to remember when assessing side rails:

a. It is not a restraint if the resident can lower it themselves.

b. It is a restraint if it keeps the resident in bed. If the resident would have to climb over the side rail or the foot of the bed to get out, the side rail is a restraint. If the resident actually does climb over the side rail or the foot of the bed to get out, the side rails are also a hazard and must not be used for that resident. Side rails that constitute a hazard for the resident will be cited at F323.

c. It is not a restraint if the resident can go around the side rail to get up.

d. If the resident is immobile (has no voluntary movement) and could not get out of bed no matter how hard he/she tried, the side rail is not a restraint. However, side rail usage in this case is most probably inappropriate, as the resident cannot use the rail for positioning. The side rail in this case is an entrapment risk and will be cited as a hazard unless the facility can show in its assessment how that side rail is needed to assist the resident to maintain his/her highest practicable well-being.

**9. Q. Can the facility pass medications in the dining room?**

**A:** The CMS 'Dining and Food Service Investigative Protocol' tells surveyors to do the following:

6. Observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does not

> prohibit the administration of medications during meal service for medications that are necessary to be given at a meal, nor does this prohibit a medication to be given during a meal upon request of a resident who is accustomed to taking the medication with the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

Recent federal observation surveys have provided feedback that Idaho surveyors have not been citing medication pass in the dining room according to CMS directions. Therefore, we have clarified the federal expectation with Region X staff.

Medication pass timing must support a quality dining experience for the residents. The expectation is that residents may receive medication in the dining room **prior** to meal service, however, **once the first tray is delivered to any resident in the room, the medication pass must stop**. Licensed staff are expected to provide supervision of the residents' dining experience. Facilities who continue to provide medication to residents during meal service will be cited at F252.

As indicated in the dining protocol quoted above, it is acceptable for a resident to request medications be delivered during the meal. This request should be documented on the care plan. Surveyors will ask these residents to confirm that the request originated with the resident. It is not acceptable for a facility to ask residents for authorization to continue the medication pass during meals. This practice subverts the intent of the federal guidance and will be cited.

**10. Q. How do we handle medication orders and blister packs when the order changes before the end of the month?**

**A**: The expectation is that the Medication Administration Record (MAR) is updated to reflect the current order;

**And one of the following**

1.The nurse administering medication checks the chart for the correct order each time the medication is poured and administered **or**

2.The current physician order is copied and placed in the MAR notebook with updated MAR and the nurse reviews the physician order each time the medication is poured and administered to ensure the correct medication, dosage, route and frequency is followed.

The facility policy and procedure should be updated to reflect the approved practice nurses are to follow.

**11. Q**: **Should there be an Alert Sticker on the MAR when a medication order is changed and the administration directions on the bubble pack and the MAR do not match?**

**A**: It is not required but may be a best practice to prompt nurses to check the chart or the copy of the physician order in the MAR book each time the medication is given. A sticker may say "Direction changed refer to physician order". **09/05/2014**

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**13. Q: Do the requirements at F329 apply to residents at the end of life and/or who are on hospice?**

**A:** We posed the question to CMS, Central office and here is their response. Interpretive guidance language at F329, regarding the use of antipsychotics at the End of life was deleted from the "Medication Issues of Particular Relevance Table 1." The rationale for deleting the language was to assure that the physician/practitioner who prescribed the antipsychotic medication for a resident, provided the identification of distressing symptoms and clinical rationale for the use of the medication, developed interventions for assessing and monitoring the efficacy and response to the medication being used, for monitoring target symptoms, and to provide consideration for reducing and/or discontinuing the medication.

The guidance at F329 does not preclude the prescriber from using an antipsychotic medication, but recommends that other interventions should be attempted to address the medical and/or behavioral symptoms prior to the use of an antipsychotic. The prescriber must provide a specific clinical rationale for the use of the medication and identify the medical symptom(s) for which the medication has been ordered.

If the medication is ordered, the record must reflect the following:

- The prescriber must provide a specific clinical rationale for the use of the medication and identify the medical symptom(s) for which the medication has been ordered;

- The use of the medication must be monitored and the prescriber must consider discontinuing the medication or reducing the dose when the medical symptoms for which the medication was prescribed are alleviated;
- Other interventions should be identified and implemented to address the medical symptoms in an attempt to prevent, to the extent possible, the distressing symptoms and the use of an antipsychotic medication;
- The use of the medication must be documented and the record must identify and address any contributing and underlying causes of the condition and verify the need for an antipsychotic medication, and if administered, the efficacy of the medication and whether the target symptoms have resolved;
- The record should also include the plan for discontinuing or reducing the dosage of the medication;
- The use of the medication must be discussed with the resident/designated representative prior to administration and the risks and benefits discussed; and
- The care plan must include the use of the medication and identify the target symptoms and include monitoring for the symptoms and for potential adverse consequences and include other possible interventions in an attempt to reduce or discontinue the medication.

**01/13/2015**

**14. Q: Do we need to continue to check gastric residual levels for residents with a tube feeding, who are stable?**

**A:** Thank you for the inquiry you forwarded regarding whether gastric residual volume (GRV) should be checked for residents with existing PEG tubes. We appreciate the facility medical director's efforts to maintain a home-like environment for residents. While there are differing views on the value of checking GRV and how to act upon the GRV, the general standard of practice is still to check the GRV since there may be an increased risk of aspiration if gastric contents accumulate. Publicly available discharge instructions for individuals caring for a feeding tube at home generally include checking the GRV. One concern related to checking GRV is that individuals may not receive their needed caloric intake if feedings are held based on the GRV. One way to address this is to adjust the parameters for when to hold the feeding based on the GRV for each individual resident. The concern with not checking the GRV at all is that nursing home residents are often unable to report symptoms such as abdominal discomfort, bloating, and nausea to facility staff. Please note, however, that checking the GRV may not be appropriate for small bore feeding tubes or jejunostomy tubes.

The resources below may be helpful in developing policies around caring for feeding tubes:

- http://www.annalsoflongtermcare.com/article/8614; and
- https://www.ismp.org/tools/articles/ASPEN.pdf

Source of info CMS, Central Office Division of Nursing Homes **02/12/2016**