RALF
FREQUENTLY ASKED QUESTIONS

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Question	Answer
Admissions, Retention, Discharge	
A resident is perpetually late on rent and has not paid his pharmacy bill. His girlfriend is the payee. Is it okay to discharge the resident if he runs out of critical medications because the pharmacy bill is not being paid, or is the facility required to purchase them for the resident?	In this case, it would be appropriate to discharge the resident, as the resident is placing himself in danger if he is refusing to purchase medications. A referral should be made to Adult Protection if the girlfriend is misusing the resident's funds. (3/4/09)

The husband of one of our residents wants to move in, but does not need any help. Can he live here without being a resident?	No. IDAPA 16.03.22.012.14 states any adult, other than the owner, administrator, their immediate families, or employees who lives in a residential care or assisted living facility is considered a resident. (10/29/08)
Does everyone who lives in AL have to have a nurse assessment even if they do not need any services at present?	Yes. Each resident of the assisted living falls under all rules at IDAPA 16.03.22 (3/18/09)
Does the nursing assessment need to be done before the resident moves in?	If the resident takes medications, or receives any medical treatments (dressing changes, oxygen, etc.), then yes, the nurse needs to do the assessment before, or on the day of move in. The nurse must review the resident's current medication orders and/or need for treatment, and then either delegate to staff the assistance with those medications/treatments, or perform a self-administration assessment. A face to face assessment is required for each of these. If the resident does not take medications, and receives no medical treatment, the nursing assessment should be done within the first 14 days, so the nurse's recommendations can be included on the NSA. The administrator is responsible to assure before the resident moves in, that the facility can meet the resident's needs. (1/14/08)
Is a person who needs a two-person assist with transfers appropriate for admission to a RALF?	They can be, but the facility would have to have at least 2 staff on around the clock to provide the assistance. (12/8/08)
One of our residents was found with a plastic bag over her head. She had tried to kill herself. The hospital wants to send her back here. Can we re-admit?	No. IDAPA 16.03.22.152.05.e. states the facility cannot admit or retain any resident who is a danger to himself or others. Before a resident can be readmitted to the facility, they must be evaluated by a mental health professional and determined to be no longer a threat to themselves. The facility must obtain a copy of this evaluation prior to admission. (11/08/16)

How long can AL keep a resident who exceeds our level of care while awaiting a facility (skilled) opening to come available?	If the facility is unable to care for the resident or if the resident requires skilled care or care not within the legally licensed authority of the facility, then the resident should be immediately discharged to an appropriate level of care. If the resident is waiting to get into a particular facility, then they should be transferred to a different facility at an appropriate level of care, rather than stay at the assisted living facility until the preferred facility has an opening. IDAPA 16.03.22.152.05.a. states a resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care, or the resident does not require a type of service for which the facility is not licensed to provide or which the facility does not provide or arrange for, or if the facility does not have the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services; b. No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. (4/13/07)
A resident's MD emailed me that we should move her to a SNF. The resident is mobile, independent and does not have any conditions to indicate she is above level of care. There does not appear to be a medical reason she should move to a SNF. Can the resident and her POA sign a statement indicating they are aware of the MD's order but choose to have her remain in AL?	Yes. The MD orders do not have to be followed if the resident/responsible party are aware of the risks of not doing so and as long as the facility is following AL rules. (11/12/08)
Is it OK to keep a resident with a pressure ulcer that is not able to be staged?	No. The definition of an unstageable pressure ulcer according to the National Pressure Ulcer Advisory Panel: Full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar. So, by definition, an unstageable pressure ulcer is beyond a Stage II. (10/13/10)

If a resident has a Stage III or IV pressure ulcer debrided, is it okay for the facility to admit or retain the resident since it is now a surgical wound?	No. The intent of the rule, IDAPA 16.03.22.152.05.b.ix, is to ensure RALFs do not admit or retain residents who require skilled nursing care. This resident would still be at high risk and should be in skilled care until the wounds heal. (10/15/08)
A home health agency says they treat Stage III pressure ulcers in other RALFs "all the time." Is it okay to retain someone with a Stage III pressure ulcer as long as the wound in being treated by home health or hospice?	No. See IDAPA 16.03.22.152.05.b.ix, no resident can be admitted or retained with a Stage III or IV pressure ulcer. Also, the facility nurse needs to monitor the skin condition (physically assess it) to assure the outside agency is providing appropriate care and to make certain the resident is still appropriate per the RALF rules. (10/13/10)
If a resident develops a Stage III pressure ulcer, does the facility have to discharge the resident immediately?	No. As long as the facility has the capability to meet the resident's needs, they can give a 30 day discharge notice. The NSA must include the plan regarding the resident's skin care needs. There must be enough appropriately trained staff available to meet the resident's mobility/turning needs. If the facility is unable to implement measures to prevent further breakdown, the resident should be immediately discharged to a facility that has that capability. If the resident's pressure ulcer is no longer greater than a Stage II by the end of the 30 days, the facility may rescind the discharge notice. (10/13/10)
If the ulcer then heals before the notice, do they still have to move?	No, provided there is documentation the ulcer is healed and a plan is in place to prevent further skin breakdown. (9/17/08)
Would a resident with a tracheotomy be allowed in an assisted living facility?	Only if the resident could care for the tracheotomy themselves. IDAPA 16.03.22.152.05.b.vi. states, a resident who has a tracheotomy and is unable to care for it themselves, will not be accepted as a resident. (03/30/06)

We have a resident who might need a colostomy (will know next week) what are the conditions we can bring him back from the hospital and keep him?	The Nurse needs to come in and assess the resident and provide resident and facility staff education on how to properly care for the colostomy. The nurse also needs to meet with staff, face to face, prior to delegating to staff individually on how to care for the colostomy. Additionally, the UAI and NSA need to be updated to reflect the changes of cares. The nurse should come back in to follow-up and ensure care of the colostomy is appropriate. (4/13/07)
A resident has a new colostomy; can he come back to the AL?	As long as the facility nurse is versed in colostomy care and trains staff before they assist. It should be addressed in the NSA and nursing assessments. Staff training and delegation should be documented. (11/12/08)
A resident has a new G-tube and will require bolus feedings. Is this appropriate for AL?	You will have to wait 21 days to admit. Bolus feedings are allowed as long as the nurse is well versed and provides staff training before staff assist with feedings. It should be addressed in the NSA and reviewed by the nurse quarterly or more often as needed. Staff training and delegation must be completed and documented. (11/12/08)
We have a resident who wants to move in with a suprapubic catheter, but we are unable to take care of the catheter. Is it ok for the son to come in and take care of the catheter?	No. A facility should only take residents for whom they are capable of caring for all of their medical needs. Families are not always consistently available and circumstances can change. This is why facilities are not allowed to let family manage any of the cares the facility is responsible for. (10/15/08)
Is a resident with a Port-A-Catheter appropriate for admission?	There is no rule prohibiting these in AL. The nurse should be assessing, monitoring and documenting on quarterly assessments. Staff should know what it is so they can report any changes to the nurse, but should not be involved in the use or care of the Port-A-Cath. (2/4/09)
Are Jackson-Pratt drains allowed in RALFs?	JP drains would be fine in a RALF, if it was for a short-term treatment and the resident was alert and oriented. The nurse must delegate the task with clear and specific directions. Staff must know when to call the nurse, and the nurse must be very involved while the JP drain was in use. (10/10/07)

Can a man who is totally independent with peritoneal dialysis live in assisted living?	Yes. The nurse needs to monitor every 90 days the resident's continued ability to manage this, as well as the resident's response to the dialysis. IDAPA 16.03.22.305.01 states the licensed professional nurse must assess and document the resident's Response to Medications and Therapies, as well as, conduct a nursing assessment of each resident's response to medications and prescribed therapies. The facility also needs to ensure proper infection control measures are put in place to coincide with peritoneal dialysis guidelines. (4/2/07)
Is a Morphine Pump that the MD checks and fills weekly acceptable?	Yes, as long as the information on what to watch for has been obtained from the MD's office and the nurse has delegated to the staff to watch for those complications. The pump and the staff's responsibilities should be described in the NSA. The morphine pump referred to, is subcutaneous not through an IV. (3/19/08)
Is it okay for a resident to receive continuous IV therapy?	No. Continuous IV therapy is prohibited in RALFs: See IDAPA 16.03.33.152.05.b.ii (12/19/07)
Does a resident who had a positive skin test for Tuberculosis need to be immediately discharged?	No. A positive skin test does not mean the resident is contagious. Further testing is necessary. The physician can determine if the resident is currently contagious. If so, the facility must immediately report to the local public health office and follow their direction. See IDAPA 16.03.22.335.04. (10/13/10)
Are residents with NG tubes (nasogastric), allowed to reside in our facility?	Yes. There is no rule prohibiting residents with an NG tube. The facility RN must administer feedings and medications. This task cannot be delegated, as it requires specialized nursing knowledge. (11/7/14)
If a resident is being discharged for abusing other residents, is the discharging facility required to inform the admitting facility?	Yes. The admitting facility is also responsible for obtaining the resident's records from the discharging facility. This should be accomplished by having the prospective resident sign a release of information for all records from previous placements. All parties could be responsible if the resident abuses residents at the new facility because of failure to disclose and make efforts to obtain information about past behaviors. This is the administrators' responsibilities. See 510 and also see IC 54-4213 Idaho Residential Care Administrators Act section (1) (b) (5/05/15)

Billing, Charges, Admission Agreements, Required Services

IDAPA 16.03.22.430.05 reads: Basic services. The following are basic services to be provided to the resident by the facility <u>within the basic service rate</u>: a) rent, b) utilities, c) food, d) activities of daily living, e) supervision, f) first aid, g) assistance and monitoring of medications, h) laundering of linens owned by the facility, i) emergency interventions and coordination of outside services, j) routine housekeeping and maintenance of common areas and k) access to basic television in common areas. **Do we have to include charges for medication assistance in the base monthly rate, or is it okay to charge the base monthly rate, plus an additional $400 if they need assistance with meds?**	Yes, medication assistance has to be included in the base monthly rate. However, the formulas used to determine the resident's base monthly rate could include a $400 charge if they needed assistance with medication. Prior to move in, the facility must disclose to the resident what their base monthly rate will be, how the rate was calculated, and all the services it includes. The facility must also disclose to the resident their pricing methodologies and formulas, so the resident will be able to determine how much more it will cost if they need additional assistance. The base monthly rate does not change from month to month. It only increases when the resident and facility enter a new negotiated service agreement, or upon a thirty day notice that the facility is increasing its prices. (11/10/10)

How is cafeteria pricing allowed when the basic service rate must include assistance with activities of daily living?	While the facility can use service plans, points systems and other charging methodologies, the systems used must produce a static, basic rate that the resident can expect to pay each month. This rate must include all items described under the basic services rate, and may only be increased upon a re-negotiation of the Negotiated Service Agreement (NSA) or by a 30 day written notice. Items not required to be included in the basic services rate, such as transportation to community activities, can be charged on a fee for service basis. The resident's charges for these items could fluctuate each month, depending on usage, as long as the charges had been clearly described in the admission agreement and are itemized on the monthly bill: see IDAPA 16.03.22.220.02 & .03. (11/10/10)
If the increase is not agreed to by the resident/resident representative and the facility starts charging the rate after the 5 days, is the resident required to give a 30 day notice and pay for the increased needs for 25 days?	No. If the resident/resident representative decides to move out, the facility can only charge for the days the resident continues to live in the facility and receive the services; see IDAPA 16.03.22.010.29, 220.02 & 550.23. (11/10/10)
If our facility does not intend to change our current billing practice, do we need to update our current admission agreement?	No, not if the current admission agreement meets all of the rules regarding admission agreements. Review your current agreement, to ensure the facility admission agreement meets all of the requirements under IDAPA 16.03.22.220 and 221, paying particular attention to the following new sections: IDAPA 16.03.22.220.02, 220.03, 220.10, 220.13, 220.16, and 220.17. (11/10/10)
If a resident has a change in condition can the facility begin charging the increased rate after a 5 day period even if the resident has not agreed to the new rate?	Yes, as long as the admission agreement clearly explains this is what will happen; the nurse must have assessed, documented, and provided training for the resident's change of condition; the NSA must have been updated to reflect the new cares; the services must be evident, observable and documented as being provided to the resident. Refer to IDAPA 16.03.22.300.01, 305.01-08, 320.05, 320.08 & 550.23. (11/10/10)

Can we put in our admission agreement that if someone is funded by Medicaid, then they will be in a semi-private room, and, if they start as private pay, then transition to Medicaid that they will have to move to a semi-private room?	Yes. IDAPA 16.03.22.220.17. Transition to Publicly-Funded Program. The facility must disclose the conditions under which the resident can remain in the facility, if and when payment for the resident shifts to a publicly-funded program. (11/10/10)
Do we need to list in the admission agreement all services and supplies that could be charged to a resident (for example; light bulbs, batteries, briefs, chuck pads etc.), as well as each items cost?	Yes. IDAPA 16.03.22.220.02. Written Agreement (private pay). Prior to, or on the day of admission, the facility and each resident or the resident's legal guardian or conservator must enter into a written admission agreement that is transparent, understandable, and is translated into a language the resident or his representative understands. The admission agreement must provide **a complete reflection of the facility's charges**, commitments agreed to by each party, and the actual practices that will occur in the facility. The agreement must be signed by all involved parties. A complete copy must be provided to the resident and the resident's legal guardian or conservator prior to or on the day of admission. The admission agreement may be integrated within the Negotiated Service Agreement, provided that all requirements for the Negotiated Service Agreement in Section 320 of these rules and the admission agreement are met. Admission agreements must include all items described under Subsections 220.03 through 220.18 of this rule. (11/10/10)
Can we charge the resident for non-sterile exam gloves when the gloves are used to provide incontinence care for the resident?	No. According to IDAPA 16.03.22.430.06 the facility must provide, at no cost to the resident, liquid hand soap and non-sterile gloves. Gloves and liquid soap, along with paper towels, are essential to an effective infection control program. (11/10/10)
Is it true that we can no longer bill Medicaid for exam gloves?	Yes. See IDAPA 16.03.22.430.06, regarding basic supplies. The following are to be supplied by the facility at no additional cost to the resident: linens, towels, washcloths, liquid hand soap, non-sterile exam gloves, toilet paper, and first aid supplies, unless the resident chooses to provide his own. (10/13/10)

220.03.a Unless otherwise negotiated with the resident, resident's legal guardian or conservator, basic services must, at a minimum, include: iii. Food and iv. Activities of Daily living. Does this mean the facility is not required to provide these, even if the resident needs them, as long as the legal guardian says not to? **For example, the resident's legal guardian does not want the resident to be assisted with transfers in the bathroom, even though the facility has assessed they are not safe to transfer themselves independently.**	No. The facility must meet the needs of the residents and must assure that policies and procedures are in place to protect the resident from inadequate care and neglect. IDAPA 16.03.22.520 & 525. IDAPA 16.03.22.011.08 – Inadequate care. When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, or engages in violations of residents rights or takes residents who have been admitted in violation of the provisions of Section 39-3307, Idaho Code. IDAPA 16.03.22.011.24 – Neglect. Failure to provide food, clothing, shelter or medical care necessary to sustain the life and health of a resident. IDAPA 16.03.22.940.02. Reasons for Revocation or Denial of a Facility License. (b)…evidence that such conditions exist which endanger the health or safety of any resident; and 940.02.c Any act adversely affecting the welfare of residents is being permitted… Such acts may include, but are not limited to, neglect, physical abuse, mental abuse, violation of civil rights, criminal activity, or exploitation. (11/10/10)
Are there any protections or means by which the resident can dispute the increased rate?	Yes. 220.16. Contested Charges (private pay). The facility must provide the methods by which a resident may contest charges or rate increases that include, contacting the Ombudsman for the Elderly. The facility must respond as provided under Section 711.02 of these rules which states the facility must assure that the individual resident's record documents complaints and grievances, the date it was received, the investigation, outcome, and the response to the individual who made the complaint or grievance. (11/10/10)

What items and services can the facility charge or not charge a resident for?	1) The facility **cannot charge** additional fees to **private pay or Medicaid** residents for the following items or services: a) 430.01 – Common Shared Furnishings. Appropriately designed and constructed furnishings to meet the needs of each resident, including reading lamps, tables, and comfortable chairs or sofa. All items must be in good repair, clean, safe, and provided at no additional costs. b) 430.04 – Resident Telephone Privacy. The facility must have at least one (1) telephone that is accessible to all residents, and provide local calls at no additional cost. The telephone must be placed in such a manner as to provide the resident privacy while using the telephone. c) 430.06 – Basic Supplies. The following are to be supplied by the facility at no additional cost to the resident: linens, towels, wash cloths, liquid hand soap, non-sterile exam gloves, toilet paper, and first aid supplies, unless the resident chooses to provide his own. 2) The facility **can charge** additional fees to **private pay and Medicaid** residents for the following items, if the facility provides them to the resident, but not if the resident chooses to supply their own or purchase them elsewhere: a) 430.07 - Personal Supplies. Soap, shampoo, hair brush, comb, electric razor or other means of shaving, toothbrush, toothpaste, sanitary napkins, and incontinent supplies must be provided by the facility unless the resident chooses to provide his or her own. The facility may charge the resident for personal supplies the facility provides and must itemize each item being charged to the resident. 3) The facility **can charge private pay** residents for the following items or services, but the charges must be included in the monthly rate, not as an add-on charge. (**These cannot be charged to Medicaid residents**): a) 220.03.f - (located under the admission agreements). The facility may charge residents for the use of personal furnishings, equipment, and supplies provided by the facility for private-pay residents. The facility must provide a detailed itemization of furnishings, equipment, supplies, and the rate for those items the

	resident will be charged. b) 430.05.a-k - Basic Services. The following are basic services to be provide to the resident by the facility within the basic rate: rent, utilities, food, activities of daily living services, supervision, first aid, assistance and monitoring of medications, laundering of linens owned by the facility, emergency interventions and coordination of outside services, routine housekeeping and maintenance of common areas and access to basic television in common areas. Medicaid residents cannot be charged for basic services. (11/30/10)
Can the facility bill the resident for incontinent briefs?	Yes, or the resident/family can bring them in. The facility is not required to provide attends. (3/19/08)
A facility includes cable in the resident packet, but the price of cable has gone up, can the facility implement a charge for the cable, even though the admission agreement states it is included?	No. The admission agreement is signed and dated by each party and includes what services the facility has agreed to provide. The admission agreement can only be changed upon agreement by both parties, or, it can be terminated with a 30 day written notice. The facility could capture the increased costs through a rate increase, but not by changing agreements made in the admission agreement. The same situation applies if a resident agrees upon admission to pay a one-time pet fee, and later, the facility wants to implement a monthly pet fee. See IDAPA 16.03.22.220, 220.01 & 221.01. (11/30/10)
If a resident is unable to pay for medications, does the facility have to pay for the medications?	No. The facility may not be able to retain the resident if the resident is endangering his/her health by not taking the medications. The facility should document all efforts to assist the resident to obtain his/her medication, explain to the resident the risks associated with not taking the medications and document that you have explained the risk. The facility nurse should consult with the resident's physician to evaluate the level of risk, determine the most appropriate course of action and then document the results of the consult in the resident's record. See IDAPA 16.03.22.711.04. (8/1/12)

Can a facility charge a resident for choosing a pharmacy other than the facility's preferred pharmacy?	No. Residents have a right to choose their pharmacy. Facilities can charge for bubble-packing, but they can't charge for using a different pharmacy. Refer to rule sections 550.12.b, 320.07, 220.13 (8/10/15)
Can facilities require families to hire private duty aides to assist residents with eating?	No. The facility must specify in the admission agreement whether they provide assistance with eating, and the costs, including if a 1:1 assistance if needed. If the facility does not provide the level of assistance required by the resident, then the resident cannot be retained. If the facility does provide 1:1 assistance and uses private duty aides to accomplish the assistance, the facility is responsible to arrange for, contract with and supervise the private duty aides. The facility is responsible to monitor and coordinate outside services. See RALF rules 152.05.a & 430.05.d (8/10/15)
I have been asked by several families if we have "guest" rooms, can we rent the space we have to families.	No. A family can stay for a couple of days. The facility cannot provide any type of activity of daily living assistance or supervision to the family members. The family must have another home. It is a fine line between visitor and resident. Charging for rooms would not be acceptable as you can't operate a separate business within an assisted living facility. (08/10/15)
Dining, Food Safety, Special Diets	
Are pets allowed in food preparation areas?	No. Pets are not allowed in the food preparation area. They are also not allowed in common dining areas when meals are being served. See the Idaho Food Code 6-501.115. (11/09/10)
Do all staff need to show proof they have completed the Idaho Food Code course?	Our rules do not require this. However, employees who are responsible for meal preparation must demonstrate they have knowledge of the Idaho Food Code. This is necessary to protect residents from consuming potentially hazardous food. Therefore, while it is not a requirement to have certification, it is a best practice. The free online course is available at: http://healthandwelfare.idaho.gov/Health/FoodProtection/tabid/96/Default.aspx (11/09/10)

How long can we keep leftover food in the refrigerator?	The Idaho Food Code allows leftovers to be kept up to 7 days at a temperature of 41 degrees F or less. Day 1 is the day the food was prepared. The Food Code regulates food safety and not food quality. Food quality will deteriorate the longer a food is kept. The 7 days also assumes the food was properly cooled and the temperature in the refrigerator doesn't exceed 41 degrees F. This means that you should be monitoring the temperature of the refrigerator on a consistent basis. (10/13/10)
Can a farmer donate lamb to a facility?	No. IDAPA 16.03.22.004.03 states, according to Idaho Food Safety and Sanitation Standards the farmer cannot because meats must be USDA approved to be served in assisted living facilities. Home canned fruits and veggies are not allowed because they are not pasteurized and may pose a risk for food poisoning. (8/06/07)
Can we serve game meat if we raise it?	No. All game animals have to be raised, slaughtered and processed under a voluntary inspection program. See Idaho Food Code and IDAPA 16.02.19.320 & 325. (10/13/10)
Can staff use the facility's kitchen to prepare their own food?	Yes. In a RALF this is allowed. However, any food, supplies and utensils, etc. for their own use must adhere to all Idaho Food Code requirements. (5/18/09)
We have a resident who was put on the "Heart Healthy Diet" can our kitchen staff just make substitutions out of the diet manual to accommodate this new diet?	No. 451.03 requires a therapeutic diet menu planned or approved, signed and dated by a Registered Dietician. (5/18/09)

I heard it was against assisted living rules to feed a resident, is this true?	No. RALFs are allowed to admit residents who need assistance with eating. If a resident requires assistance with eating and is not receiving that assistance, it would be considered inadequate care or neglect. See RALF rule sections 520 & 525. (08/10/15)
We have run across some menus where the lunch meal is not specified – it just says either "sack lunch" or "left overs." Is this allowed?	No. According to IDAPA 16.03.22.451, menus must provide an adequate amount and variety of food to meet nutritional standards. In order to demonstrate the menu meets 100% of nutritional requirements, the foods in each meal must be specified. Sack lunches or leftovers may only be substituted for a regular meal if the substitution meets all the nutritional requirements and the foods that were substituted are documented on the menu. (08/10/15)
Incidents, Accidents, Abuse, Reportable Incidents	
Is elopement a reportable incident?	Yes, if it meets the definition of elopement in the rules. IDAPA 16.03.22.011.10.c. defines resident elopement of any duration as; when a resident who is unable to make sound decisions physically leaves the facility premises without the facility's knowledge. (4/02/07)
A resident had an incident / fall off-site. Should this be reported to us?	Yes. The rule does not say anything about on/off-site. The facility should still review and track the incident. (4/15/09)
Is staff smoking pot on duty a reportable incident? Is staff stealing medications?	These do not meet the definition of a reportable incident. However, it should be immediately report to the administrator, who is responsible to conduct an investigation to ensure resident safety during the course of the investigation. Any illegal activity should be reported to the police. (4/1/09)

If one resident is seen fondling another resident, even if we are not sure it was abusive, does it have to be reported to adult protection?	Yes. Adult Protection (AP) staff is trained to investigate allegations of abuse, neglect, self-neglect, and exploitation involving vulnerable adults and take remedial actions to protect them. Administrators who have failed to report potential abuse have been charged with a crime, lost their license and/or been banned from working in healthcare. You should always report potential and alleged abuse to AP even if you have personal doubts about the validity of the allegation. In addition to reporting to adult protection, the facility administrator is responsible to conduct an investigation, protect residents from further abuse during the investigation (usually suspending if the alleged perpetrator is staff, or providing added supervision if it is a resident), prepare a written report of the finding, and take corrective actions for substantiated allegations. See sections 215.08 & 350.02 & 350.03 of IDAPA 16.03.22. and Idaho Code 39-5303; DUTY TO REPORT CASES OF ABUSE, NEGLECT OR EXPOITATION OF VULNERABLE ADULTS. (10/13/10)
If the facility discovers two residents have had sexual contact, but are unsure of the victim, should abuse be reported?	Yes, it should be reported to the police department and to adult protection. Abuse is defined as the non-accidental act of sexual, physical, mental mistreatment, or injury of a resident through the action or inaction of another individual. TITLE 39 HEALTH AND SAFETY CHAPTER 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT 39-5303. DUTY TO REPORT CASES OF ABUSE, NEGLECT OR EXPLOITATION OF VULNERABLE ADULTS. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency. IDAPA 16.03.22.215.08 states procedures for investigations states the administrator must assure the facility procedures for investigation of incidents, accidents, and

	allegations of abuse, neglect, or exploitation are implemented to assure resident safety. (7/03/07)
Is each time a resident goes to the hospital a reportable incident?	Hospitalizations are reportable only if the hospitalization is a result of an incident. IDAPA 16.03.22.011.10.e. states an incident that results in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Definition of Incident: An event that can cause a resident injury. (4/02/07)
Is it acceptable for a facility's response to an incident to be "it's inevitable that it will happen again. Staff will just keep an eye on him."?	No. The administrator is responsible to investigate incidents and take corrective actions. See 350.01-07. There could also be core level deficiencies for admission/retention of residents who are a danger to self or others or for not protecting residents from abuse depending on the circumstances. (5/05/15)
Medications, Orders, Medical Procedures	
Can a resident's family order medications from a Canadian pharmacy?	There is nothing in our rules that prohibits this. However, Idaho Medicaid will only pay for medications from a pharmacy licensed in Idaho. There are no restrictions on private pay residents purchasing their medications from Canada. (10/13/10)
Are Caregivers allowed to take telephone orders from a physician?	No. Only an RN or LPN may take telephone orders from a physician. The RN does not need to delegate this task to a LPN for it is within the LPNs scope of practice. However, the facility must ensure a copy of the actual written, signed, and dated orders, by a physician are obtained and placed in the record within 72 hours (7/19/06). Additionally, the order can be taken by the facility nurse, or the resident's hospice or home health nurse. IDAPA 16.03.22.711.09 09. Current List of Medications, Diet and Treatments. A current list of medications, diet, treatments prescribed for the resident which is signed and dated by a physician or authorized provider giving the order. (4/2/08)

Are physician discharge orders necessary when a resident is discharged from a RALF?	No. There are no requirements in the rules for this. The facility does, however, need to obtain a copy of all current medication and other physician orders before admission. (10/13/10)
Are standing orders allowed in RALF?	Yes, but if you have the order, you must have the medication and vice versa. See IDAPA 16.03.22.305.02 & 310.02. (1/16/08)
Is it ok for a facility to consider a medication discontinued if it disappears from a re-cap order?	No. If a facility uses re-cap orders and a medication disappears from one order to the next, it should **NOT** be considered discontinued. The facility should verify the discrepancy with the physician and get a discontinue order in writing. (8/06/07)
Is it required to have written, signed, and dated orders for prescriptions? The doctor is calling in directly to the Pharmacy and is reluctant to provide us with an additional copy of prescription orders. Can we just get a printout from the pharmacy that lists all the meds?	If the pharmacy's list is signed and dated by the physician, that would be acceptable. The facility does have to have orders that are signed and dated by the physician, so a list from the pharmacy without signature or date would not be acceptable. IDAPA 16.03.22.711.09 states a current list of medications, diet, treatments prescribed for the resident which is signed and dated by a physician or authorized provider giving the order. (7/03/07)
When medications are ordered to be given daily, twice daily, etc. at specific times, can the facility adjust the medication times to fit the resident's schedule? For example: A resident wants to sleep until 10:00 AM but the physician ordered the med to be given at 8:00 AM.	If a physician orders a specific time, the medication must be given at that time. However, the facility nurse can ask the physician if they would consider a "Generic Medication Pass." Which means the physician can give a range of acceptable times. For example: AM medications will be offered between 5:00 AM and 10:00 AM, noon medications will be offered between 11:00 AM and 2:00 PM, etc. (11/09/10)

I have heard that the time allotted for scheduled medications has changed from one hour before or an hour after, to 30 minutes before or 30 after. Is this true?	Our rules do not specify such time-frames. It is up to the resident's individual physician to determine what time the medication should be given and how long before or after the scheduled time a medication can/should be given. (08/01/12)
Anti-coagulant clinics: May the facility accept an order for a Coumadin dose that is signed by the clinic, rather than the physician or authorized provider?	Yes, if the following is met: 1) The facility nurse closely monitors all changes to the Coumadin and is in communication with the staff each time a changed order is obtained. The nurse will need to delegate to staff to implement each new change. 2) The facility has copies of the following in the resident's chart: a) The Coumadin protocol orders signed by the physician or authorized provider and b) The facility physician or authorized provider's order for the resident to attend the anti-coagulant clinic for management of the Coumadin and c) The agreement between the physician and the anti-coagulant clinic and d) The resident's lab orders (so the facility RN can compare the change orders from the clinic to the Coumadin protocol signed by the physician). (4/16/08)
If a resident goes to a specialist and receives an order that is contra-indicated with their other medication orders, is the facility responsible for addressing this?	Yes. The facility nurse is responsible for reviewing all medication orders for side effects, interactions, abuse or a combination of these adverse effects, and notifying the resident's physician of any identified concerns. See IDAPA 16.03.22.305.07. Consider faxing a list of all the resident's medications to the primary physician to ask for clarification. Also refer to IDAPA 16.03.22.305.02, as it relates to the facility nurse verifying the residents' medications are current and match current medication orders. (8/1/12)
When a PSR worker is taking a resident to the physician every month and it is obvious changes have been made to the resident's psychotropic medications, do psychotropic medication reviews still need	Yes. The facility still needs to send a list of psychotropic medications or behavior modifying medications to the physician for review every 6 months along with behavioral updates so the physician can make an informed decision on the continued use of the medications. Refer to IDAPA 16.03.22.225.03, 310.04.e, and 711.09. Additionally, we would expect the PSR worker to give a copy of the physician notes to the facility. (8/1/12)

to be conducted every 6 months?	
What is a PYXIS medication system, and can it be used in assisted living facilities?	These dispensing systems are **not** allowed in Assisted Living Facilities. Similar to a med cart that has a supply of medications for which there is not an order yet. When an order comes in, the nurse punches it in and the cart dispenses the meds needed. Per the Board of Pharmacy, these dispensing systems are **not** allowed in Assisted Living Facilities because RALFs do not have a DEA # license from the Board of Pharmacy that would allow them to have medications in the facility that they do not have a current medication order for. (8/6/07)
Is a house supply of OTC medications allowed in RALF?	No. Each medication does have to be filled by a pharmacists or nurse and labeled according to pharmacy standards and physician instructions: IDAPA 16.03.22.310.01. This precludes the use of house supply medications. There is also a safety concern when using a house supply, in that OTC medications could be contraindicated for a particular resident, but staff may be in the habit of giving them for a given condition and fail to always check for the appropriate physician's order. There is nothing preventing a facility from buying OTC medications in bulk, and then having the nurse bubble pack them for each individual who has a prescription for the OTC. (4/1/09)
Do OTCs have to be purchased from the pharmacy?	There is not a requirement that the OTC medications are purchased from a pharmacy. However, there must be a physician's order, and the bottle must be appropriately labeled for each resident. The Board of Pharmacy rules describe what medication labels must include. Some of this information may already be on the bottle or may not apply. The nurse labels the bubble pack or bulk container with the rest. The nurse who fills and labels should initial the label. 27.01.01.255.04 – i) Name, address and telephone number of the institutional pharmacy. ii) Date and identifying serial number. iii) Full name of patient. iv) Name of drug, strength, and number of units. v) Directions for use to the patient. vi) Name of physician prescribing. vii) Initials of pharmacist dispensing. viii) Required precautionary information regarding controlled substances. (4/1/09)

Does rule 310.02 mean that PRN medications that are not used for more than 30 days must be thrown out?	No. PRN medication orders are valid for 15 months unless otherwise changed or discontinued. Regarding the accumulation rule, this only applies if the medication is expired or the med order has been discontinued. If there is a current PRN order, and the medications are not expired, then it does not matter when the last time the resident took the medication. IDAPA 16.03.22.310.02 states "unused, discontinued, or outdated medications cannot accumulate at the facility for longer than thirty (30) days." The unused medication must be disposed of in a manner that assures it cannot be retrieved. The facility may enter into agreement with a pharmacy to return unused, unopened medications to the pharmacy for proper disposition and credit. See IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 664 and 665, and IDAPA 27.01.01, "Rules of the Idaho Board of Pharmacy." A written record of all drug disposals must be maintained in the facility. (3/19/07)
If a resident is admitted with a supply of prescription bulk meds, can they be used?	If a resident is not a self-medicator and is admitted with a one month or less supply of his/her prescription medications in bulk, it is okay for them to use them up without obtaining a variance. However, after the medications are used up, the resident's medications should be bubble-packed or placed in a medi-set. This is only for prescription medications, not OTCs. Likewise, there should not be any reason a resident in AL is not allowed to have OTCs. The facility should assist them to obtain physician orders for the OTCs they need. In addition, a variance is not needed for those things that will not fit in a bubble pack. 16.30.22.310.01 states each facility must use medi-sets or blister packs. The facility may use multi-dose medication distribution systems that are provided for resident's receiving medications from the Veteran's Administration or the Railroad benefits. The medication system must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards and physician or authorized provider instructions. A licensed nurse may fill medi-sets, blister packs, or other approved systems as provided in Section 39-3326, Idaho Code and Section 157. IDAPA 16.30.22.310.01.e. states each medication must be given to the resident directly from the medi-set, blister pack or medication container and part f. states residents must be observed taking the medication. (5/21/07)

Can a home health or hospice RN fill medi-sets or bubble pack medications for residents?	No. Only the facility nurse employed by the RALF is allowed to do this task in the RALF. IDAPA 16.03.22.220.03.a.vii. refers to the facility's responsibility to assist with and monitor medications. Also IDAPA 16.03.22.310.01 relates to the facility nurse filling medi-sets or blister packs. This rule does not extend to an RN not employed by the facility. (8/1/12)
When we provide day care, residents bring bulk medications with them. Do we need a variance?	No. A variance is not needed but the medications must be properly labeled and safe-guarded. IDAPA 16.03.22.345.02.a & b. (10/13/10)
Do you need to re-label over the counter medications for self-medicators?	No. If they have a bottle of Tylenol in their room, that is fine, as long as the original label is on it and the facility/resident includes Tylenol on the resident's physician orders. (5/21/07)
Do the narcotics of self-medicating residents need to be tracked?	Yes. All narcotics in the facility must be tracked and counted. IDAPA 16.03.22.735.04. (2/4/09)
Do controlled medications need to be double-locked?	No. Our rules do not require double-locking of controlled medications, however, this is a recommended best practice. (10/13/10)
What is the proper way to dispose of medications?	Medications should be taken out of the original container and placed in coffee grounds or kitty litter with a small amount of water. This mixture should be placed in a nondescript container and then buried in the trash. (9/5/09)
Do two nurses have to dispose the narcotics or can your witness be a lay person?	Our rules do not require the witness to be a nurse. IDAPA 16.03.22.735.03 states "a written record of all drug disposals must be maintained in the facility and include: **a.** A description of the drug, including the amount; **b.** Name of resident for prescription medication; **c.** The reason for disposal; d**.** The method of disposal; **e.** The date of disposal; and **f.** Signatures of responsible facility personnel and witness." (6/20/07)
Do you need a witness when narcotic meds are being disposed?	Yes. Our rules **do** require a witness for the destruction of **<u>all</u>** medications. Facility policy should describe how narcotic medications will be disposed of. (7/03/07)

Do you need a witness when <u>non</u>-narcotic meds are being disposed?	Yes. Our rules **do** require a witness for the destruction of **<u>all</u>** medications. Facility policy should describe how non-narcotic meds will be disposed of. (6/20/07)
When a resident leaves the facility, do the prescription medications have to be destroyed or can they go with the resident?	The medications belong to the resident and therefore should go with the resident. If the resident passes away, the prescription medications must be destroyed or returned to the pharmacy. They should not be given to the family or anyone else. (11/30/10)
Can a physician delegate directly to the facility LPN?	Yes. (3/19/07)
Can the RN delegate assessments to the LPN?	An LPN can work under the direction of an RN within the LPN's scope of practice. The LPN can gather the data, but the RN is responsible for the assessment. The RN must visit the facility every 90 days and when there is a change in the resident's condition. The RN must also assess and document, including date and signature, for each resident as described in IDAPA 16.03.22.05.305. 16.03.22.305.LICENSED PROFESSIONAL NURSE RESPONSIBILITIES The licensed professional nurse must assess and document, including date and signature, for each resident **03. Resident Health Status**. Conduct a nursing assessment of the health status of each resident by identifying symptoms of illness, or any changes in mental or physical health status. IDAPA 23.01.01.460.LICENSED PRACTICAL NURSE (LPN). **02. Functions**. A partial listing of some of the functions that are included within the legal definition of licensed practical nurse, Section 54-1402(3), Idaho Code, (Nursing Practice Act) follows. This list is for example only, it is not complete. The licensed practical nurse: **a.** <u>Contributes</u> to the assessment of health status by <u>collecting</u>, <u>reporting</u> and <u>recording</u> objective and subjective <u>data</u>; and …. (4/2/08)
Can the LPN delegate UAP to assist with PRNs?	Yes, the LPN can determine if the PRN should be given as long as the RN approves this practice. (2/8/08)

Can UAPs be delegated to inject a set dose of insulin or other medications that require being given by injection?	Yes. The facility RN may decide to delegate injections of medications if the following criteria are met: 1) The RN physically assesses the resident and determines they are medically stable. 2) The RN determines the UAPs are competent to be delegated to. 3) The RN provides written and oral training and has the UAP demonstrate competency of the task. 4) The RN determines the level of supervision required to ensure the delegated task is preformed appropriately. 5) The RN must actively monitor and evaluate the effectiveness of the delegated task. (11/7/14)
Are UAPs allowed to assist residents with their sliding scale insulin dose when the resident is not capable to manage the sliding scale insulin independently?	Yes. Before deciding to delegate, the facility RN must determine the stability of the resident. The RN must also ensure physician orders for sliding scale insulin are current and accurate, with clearly written parameters of how many units of insulin are to be given according to set blood glucose levels. Once the decision to delegate has been made, the RN must provide written and oral training. Then the RN must have the UAP demonstrate their competency of the task to the delegating RN. Consistent monitoring is required by the RN to ensure UAPs are appropriately assisting with medication as ordered. The RN also needs to ensure the UAPs are documenting the units given were appropriate for the resident's blood glucose level. (11/7/14)
Are UAPs able to determine a dose of a medication when the physician's order is not a set dose?	No. In situations when residents are not cognitively able to request a preferred dose of a medications, such as "1-2 tablets" or "every 2-4 hours" the order must be clarified to a set dose or the nurse must be called by the UAP to determine what dose should be given, as UAPs cannot make assessments. When a resident is fully cognizant they may request their preferred dose and time medications are given. (11/7/14)
Are PICC lines allowed in RALFs?	Yes. The RN must initially and continually assess the PICC line site to rule out any adverse complications, i.e. infections; hematomas and the functionality of the PICC line. The nurse must witness the entire IV infusion (the nurse cannot start the IV and let UAP disconnect). In addition, the nurse must complete all of the cap changes and maintenance flushes in-between IV administrations. The nurse must also provide training for staff on what to do in an emergency and what to watch for with regard to the PICC line when IV infusion is not in progress and the nurse is not present. Continuous IV therapy is prohibited in RALFs (IDAPA 16.03.22.152.05.b.ii). (11/7/14)

Can a UAP (unlicensed assistive personnel) be delegated to catheterize a resident?	Yes. If the resident's straight-catheter is not new, but has been an on-going treatment, then the facility RN may decide to delegate. If delegation is considered, the facility RN would need to provide appropriate written, oral instructions and parameters when the UAPs should notify the RN. In addition, the RN should train UAPs by practicing the skills on a mannequin before attempting to straight-catheterize a resident. Once the UAP performs the skill and exhibits competency, delegation can occur. The nurse must actively monitor and evaluate the effectiveness of the delegated task. (11/7/14)
Irrigating Catheters: Are UAP allowed to irrigate either Foley or supra-pubic catheters?	Yes. The facility RN must ensure the following steps are implemented and the resident is stable, prior to delegating: 1) The physician's order documents the procedure is clean and includes the type of irrigation solution to be used and the proper amount. 2) Determine the ability of UAPs to perform the task. 3) Provide written and oral instructions and follow up by testing the UAPs competency. 4) Monitor to ensure the procedure is done correctly and there are no adverse outcomes. (11/7/14)
Can a UAP set O2 to the level specified in the physician's order as long as the nurse has delegated this task?	Yes. If the order for the oxygen is a set liter flow rate, then the nurse can delegate UAPs to set the oxygen flow rate to the prescribed dose. However, UAPs cannot be delegated to assess and determine the flow rate. For example, UAPs cannot determine whether to adjust the flow rate, when an order documents: 2 or 3 liters per minute, PRN or to maintain oxygen levels above 90%. (11/7/14)
Can a UAP be delegated to assist unconscious residents with suppositories?	Yes. Assistance with suppositories to an unconscious resident can only be delegated when the physician's order is for a scheduled dose. If the order for the suppository is as needed (PRN), the UAP would not be able to be delegated, as an assessment would be required. (11/7/14)
Can a UAP give liquid morphine to an unconscious resident?	Assistance with sublingual medications to an unconscious resident can only be delegated when the physician's order is for a set scheduled dose. If the order for the sublingual medication is titrated or a PRN, the UAPs would not be able to be delegated, as an assessment would be required. (08/10/15)
Who is responsible for administering medications when a hospice resident becomes unresponsive at the end of life?	If the physician's medication order is not for a set dose, a licensed nurse must administer the medications. It could be a nurse from the facility or from the hospice agency. The contract between the hospice agency and the facility must specify how it will be handled if a resident becomes unresponsive and thus requires medication administration for titrated or PRN doses. The NSA and the hospice care plan also

	must specify who is responsible to ensure the residents receive their medications appropriately. UAPs can only assist with set doses. IDAPA 16.03.22.730.03 refers to having copies of contracts with outside service providers. (11/7/2014)
Can the family give sublingual meds in a RALF?	Families may be allowed to give sublingual medications to a hospice patient in RALF on a case by case basis with the following considerations: 1) A variance to rule 16.03.22.011.08 and 16.03.22.430.05 (medication assistance is required as basic service in RALF) must be obtained from Licensing and Certification. The licensing agency will talk with both AL and Hospice teams, and may talk with the family before making final decision on granting the variance. 2) The resident's death is imminent. 3) Hospice assumes responsibility for all meds and for training the family, including responsibility for reviewing med orders, ordering, implementing, making certain they are obtained, etc. Both the RALF and the hospice agency are responsible if the family fails to administer the medications: Hospice is acting as an outside service, so even though they are responsible for the medication regimen as described above, the facility is still responsible to coordinate and monitor outside services. In practice, we would expect to see the RALF nurse monitoring the situation (reviewing the meds, etc. to ensure the services the resident is supposed to be getting are being provided, reviewing hospice notes, care plan, etc.). We expect the RALF to know what the condition of the resident is and what services are being provided by who at all times, regardless of who is actually providing the service. In this scenario, we would be giving a variance for the part of the basic service rule that requires the RALF to provide assistance with medications but not to the part that requires the RALF to monitor the meds. Both the RALF NSA and the hospice care plan should clearly identify that the family is administering the medications and describe how this is being done, when, and by which family member(s). The RALF must monitor that family is appropriately giving the medications as ordered, so the resident's pain is well controlled. (11/7/14)

If a resident refuses to take their medications, is it okay to hide it in food or liquid?	No. Hiding medications or tricking a resident into taking them is prohibited by IDAPA 16.03.22.550.12.d. The only time putting crushed meds into food would be allowed is if the resident knows what they are taking and crushing of the medications has been directed by the nurse or physician. (08/10/15)
If the resident is taking an anxiety medication, do we have to monitor for the symptoms of anxiety or have a behavior management program?	If the resident is not displaying maladaptive behaviors as a result of the anxiety, then it would be acceptable to just monitor for the symptoms the anxiety medication is prescribed to alleviate. The reason for the anxiety medication must be described in the resident's record along with the symptoms the resident was placed on the medication for and any potential side-effects. The nurse is responsible to provide education to staff and resident regarding the purpose of the medication, symptoms the medication is prescribed to alleviate, any side-effects the staff should watch for, where to document, and when to call the nurse. Both the staff and the nurse must be able to describe how symptoms and side-effects are being tracked and where they are to be documented. The nurse must monitor for side-effects and effectiveness of the anxiety medication by reviewing documentation and interviewing staff/resident during the quarterly and as needed nursing assessment and reporting any concerns to the physician. See 711.08.c and e, 305.01, 04. 07 and 08. Whether a BMP is warranted depends on what the resident does when he/she is anxious. For example, if the resident throws things at other residents when he/she is anxious, then the act of throwing things would require a behavior program. (08/10/15)

What does nurse delegation entail?	Delegation must involve both verbal and written instructions. See BON rules IDAPA 23.01.400.02.g**.** Determine that the person to whom the act is being delegated has documented education or training to perform the activity and is currently competent to perform the act; and h. Provide appropriate instruction for performance of the act. IDAPA 23.01.400.03. Monitoring Delegation. Subsequent to delegation, the licensed nurse shall: a. Evaluate the patient's response and the outcome of the delegated act, and take such further action as necessary; and b. Determine the degree of supervision required and evaluate whether the activity is completed in a manner that meets acceptable outcomes. The degree of supervision shall be based upon the health status and stability of the patient, the complexity of the care and the knowledge and competence of the individual to whom the activity is delegated. (11/09/10)
Does the BON require re-delegation each year?	No. The BON rules do not address re-delegation. However, the rules do address monitoring that delegation to ensure staff competency. A licensed nurse must evaluate whether a particular act is within the legal scope of that nurse's practice and determine whether to delegate. Therefore, if the facility changes nurses, the new nurse must delegate each of the tasks to each staff member. See IDAPA 23.01.01.400. (10/13/10)
Can MA's (medical assistants) assist with meds?	The same nurse delegation required for a medication assistant is required for an MA. The board of nursing determines if a course or training is appropriate to prepare someone to assist with medications. The MA would either need a medication assistant certification or documentation from the board of nursing that their MA training was sufficient to allow them to assist with medications. IDAPA 16.03.22.645 Before staff can begin assisting residents with medications; the staff must have successfully completed a Board of Nursing approved medication assistance course. The training is not included as part of the minimum of sixteen hours of orientation training or a minimum of (8) hours of continuing training requirements per year. IDAPA 16.03.22.157.02 MEDICATION POLICIES. Nurse Delegation. The process the nurse will use to delegate assistance with medication and how it will be documented. (11/12/08)
After a medication aid has completed a medication course approved by the Board of Nursing, can the	No. The facility nurse must delegate and provide written and oral instructions to the medication aide. The nurse should observe that the medication aide is competent before he or she assists residents with their medications. The nurse must document the delegation is complete and include his or her signature and the

aide begin helping residents with their medications?	date of completion. The proof of delegation must be retained at the facility. See IDAPA 16.03.22.300.01 & 730.01.h. (8/1/12)
Does the nurse have to delegate baths, hair combing, toenails, etc.?	No. These tasks do not need to be delegated. However, UAP cannot cut the toenails of a person with diabetes. (5/21/07)
Can enemas be delegated by the RN?	Yes. We would expect to see documented training and delegation to staff. (1/22/09)
Can UAP assist with G-tube meds?	Yes, as long as they have completed the expanded med assist course and the RN has provided training and delegation. (10/12/06)
When does the nurse need to be contacted before giving or withholding medications?	If withholding medications, the nurse should be contacted at all times. For a medication that says hold if BP is less than (#), if the nurse has delegated blood pressures to staff, then staff can follow a direct order, i.e. "withhold medication" and then inform the nurse the medication has been withheld. (9/25/06)
Do you have to document the results of PRNs?	It is best practice to document the results of PRNs, on the back of the MAR, or elsewhere, although our rules do not specify results must be documented or where they must be documented. However, in order for the facility to comply with 16.03.22.305.01 and 16.03.22.305.7, documenting the results of PRNs enables the facility RN to evaluate the effectiveness of prescribed medications. (2/8/08)
Our residents sometimes get embarrassed when the med aides bring all their medication cards to the dining table. Do they need to pop out the medications in front of each resident?	The medications do not have to be popped in front of the resident in this situation, but be certain staff punch out only one resident's medications at a time, lock the med cart when they leave it, and sign off each of the resident's medications before moving to the next resident. IDAPA 16.03.22.310.01.d states assistance with medication must comply with the Board of Nursing requirements. (6/11/07)

Can staff give everyone's meds and then go back and sign for them all at once?	No. Staff must sign after each medication is punched or after each resident consumes the pills. The facility policy should address how exactly this is to be done. (10/2/08)
Can a med aide (staff with medication assistance certification) go back and initial the MAR if they did not sign it?	If the med aide recalls giving the medication, they could go back and sign the MAR. This should not be done more than 24 hours after the medication was given. The facility policy must describe this process. IDAPA 16.03.02.157.01 states that each facility must develop written medication policies and procedures that detail receiving of medications and documentation requirements. (8/6/07)
If a resident is safe to administer a dose of medication at a time, is it acceptable for the facility med tech to punch meds out and give to the resident to take to day treatment?	The nurse should assess the resident as safe to do this prior to practice being used. Only the nurse can pack meds in to a medi-set or other container. If the resident is not safe to take the daily dose with them and take it independently at the appropriated time, the facility should make arrangements with the day treatment to assist the resident with medications while they are there. The pharmacy can pack two bubble packs for one medication (One pack has weekdays and is taken to the day treatment. The other has only weekend doses and stays at the house). (3/18/09)
What if the resident is conscious? Can the UAP assist with Liquid morphine then?	The Medication Assistance Course is taught with the assumption that the resident would otherwise be able to take their own medications except for unusual circumstances such as a physical disability, mental illness, etc. The BON Rules layout a process and every situation is unique. So it is left up to the licensed nurse to determine if the UAP is capable of doing it and if he or she wants to delegate the task. (4/2/07)
May staff draw liquid oral medications into a syringe?	Yes. This is allowed when the syringe is used as a measuring device. Before this occurs, the nurse must train, delegate, and document the delegation. (10/13/10)
Does a resident have to have his or her dosage of insulin memorized to be considered self-administering?	If a set daily dosage of insulin is drawn up in advance by the nurse, and the resident can physically inject the medication without prompting or direction and the resident can stated this is my insulin and it is for……, then is would be sufficient for the resident to be considered self-administering. They do not have to have the dosage memorized. (12/8/08)

PRN Meds with a Dementia resident: May a resident who has dementia, make a self-assessment to determine if a prn is needed?	If a resident with dementia can ask for the prn, and the facility RN has delegated to staff the resident's prn medications, then UAPs can assist the resident with those medications. Ultimately, the facility RN must determine the cognition of the resident to decide the extent that PRNs can be delegated to UAPs to assist with. For example, a resident with dementia may be able to communicate pain, but may not be able to state whether 1 or 2 Tylenol are needed. Therefore, the prn order would need to be specific or the RN would need to be called to make that assessment and direct staff. (4/30/08)
Can medical assistants inject insulin for residents who reside at an AL?	No, an MA needs to be delegated by a MD before assisting with medical tasks. Therefore, it would be out of scope in an assisted living facility because there is no physician's oversight. (2/8/08)
Can family come in and administer insulin?	No. The facility is required to provide monitoring and assistance with medication as part of basic services. Since family members are not employed by the facility and licensed to administer insulin, the facility would not be providing the appropriate monitoring of the insulin administration. See IDAPA 16.03.22.05. (1/16/08)
Can a friend of the family who is a nurse come in and give the resident's shots?	Not unless the facility hires the person, and ensures proper licensing and training, background check, etc., and payment is made through the facility. The facility is responsible to provide assistance and monitoring of medications as part of basic services. IDAPA 16.03.430.05. (11/25/08)
Self Medicator: A resident is unable to give an injection herself and the facility does not have a nurse present to give the injection; may a family member, who is a nurse, give the injection?	Only if the facility hires the family member as a contracted nurse. IDAPA 16.03.22430.05 requires the facility to provide assistance with medications. Oversight of the medication administration and the resident's response to the medication is a responsibility of the facility's licensed nurse: IDAPA 16.03.22.300 & 305. Additionally, nursing services must be performed in accordance with Board of Nursing rules. The facility must ensure the qualifications and the license standing of the nurse who is a family member. (6/18/08)
Can the wife of a couple who lives in our facility put eye drops in her husband's eyes? The wife is a self-medicator, the husband is not.	Yes, if nurse assesses that she is able to do so safely. The nurse should check every 90 days, when she does the wife's self-medication assessment, to see the wife is doing the drops correctly. (3/19/07)

Do self-medicators need a variance to keep their medications in bulk form?	No, self-medicators do not need a variance to keep their medications in bulk, because these medications are not part of the facility's distribution system. If a resident is not a self-medicator and is admitted with a supply of his/her prescription medications in bulk, but is switching over to blister as soon as they are used up, it is okay for them to use them up without obtaining a variance. This is only for prescription medications. Likewise, there should not be any reason a resident in AL is not allowed to have OTCs. The facility should assist them to obtain physician orders for the OTCs they need. In addition, a variance is not needed for OTC or for those things that will not fit in a bubble pack. (8/21/15)
Can a self-medicating resident have family or friend fill their medi-set for them?	Medi-sets can only be filled by a pharmacist or a nurse. In situations where the resident is fully cognizant, and would be able to fill the medi-set themselves, except for a physical disability, it would be acceptable for their family member to assist them as long as the resident was present the entire time the person is filling their medi-set. This should only be done when the resident could do it themselves except for a physical impairment. If resident cannot perform this cognitively, then they probably are not appropriate for self-medicating. The resident must be able to pass the self-medication assessment, including knowing what the pills are, what they are for, and any significant side effects they should be watching for. (4/30/07)
Is it okay to start a psychotropic med when a resident initially shows behavior?	No. A physical assessment should be completed first to rule out medical causes, and then other non-drug interventions should be tried before beginning medications. See IDAPA 16.03.22.310.04.a. (1/02/07
If a hospice resident has blackout episodes that are a part of their disease process does 911 have to be called?	Not if the facility has written parameters from the physician describing when 911 should not be called. (4/2/07)

Families have sometimes become angry when 911 was called. What should we do about this?	The facility should disclose to families during the admission process what level of nursing the facility has in the building and that when there is not a nurse in the building, then 911 will be called, as facility staff cannot assess residents. Ultimately, the facility is responsible for ensuring the residents are provided the necessary medical care. (7/15/09)
When a resident falls we were recently told that the nurse first had to assess them before they were helped up from the floor. Is it possible for it to be a phone assessment by the nurse or do they need to come in? Our nurse has instructed the staff to ask the resident to do various ROM tasks to determine if an unobvious fracture is present. She would be happy to do this over the phone but was unaware that she needed to come in for every fall. Please advise.	Unlicensed Caregivers can be trained to take vitals and direct the resident in ROM tasks. The nurse would need to provide face to face training for staff and document the delegation. When called, the nurse could determine, based on the resident and the information reported by staff, if 911 needed to be called. If 911 was not called, the nurse should come in and do an assessment to ensure the resident is ok. (6/11/07)

Outside Services	
Should the facility call 911, not the hospice nurse first if there is an emergency not related to the terminal condition?	Yes, 911 must be called first in this situation. The hospice nurse cannot substitute for the facility nurse. (9/15/06)
Do hospice agencies or other outside service providers need to provide the facility with copies of their employees' criminal history and background checks?	Yes. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. IDAPA 16.03.22.009.03. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks" is disclosed, the individual cannot have access to any resident. (11/9/10)
Can the hospice/home health nurse delegate to the facility staff?	Yes, as long as the delegation is face to face and documented the same as it would be from the facility nurse. The hospice nurse can delegate to facility staff, however, staff cannot then train each other. For each staff, training/delegation must come directly from either the facility nurse or the hospice/home health nurse. Further, the hospice or home health nurse should communicate to the facility RN about what was delegated to staff. (7/15/09)
Resident Rights, Behavior Management, Privacy, Confidentiality	
If the facility wants to switch pharmacy providers, does the resident have the right to refuse to switch to that pharmacy?	Yes – See IDAPA 16.03.22.550.12. (11/09/10)
Can you discharge a resident who refuses to allow staff to clean his room?	The facility must address through contract with the resident, behavior program, family or caseworker involvement, etc. See if the resident will allow a cleaning service to come in. If those efforts fail, and the resident's room in unsanitary, the facility should give a 30-day notice. (10/2/08)

Can Power of Attorney (POA) sign for resident?	It depends on the specifics of the POA. A power of attorney can be very broad or narrow. For instance, if it's a general and unlimited power of attorney for health care, the holder of the POA probably has the authority to sign the agreement. However, a POA can also be very limited in terms of both time and power. There's no fixed form for a POA, but a properly written one should show the duration of the power and the circumstances for which the power is given. It may be very limited, such as the power to make veterinary decisions for pets, or sweep very broadly, such as making all decisions the person himself could make. But, a holder of a POA, if properly authorized, should be able to sign an admission agreement. However, the POA might be personally on the hook for decisions made, unlike a guardian. W. Abbott (11/6/06)
Is it against the rules for a resident who takes a medication that is contra-indicated with alcohol to consume alcohol?	No. The nurse should be monitoring and notify the physician if the resident uses alcohol and it is contra-indicated with their medications or other health conditions. The physician can determine if the medication needs to be stopped or orders otherwise changed. Facility policy should address how this will be handled. (8/4/06)
Is residents having sex prohibited by rule?	No. The facility can have a house rule prohibiting this. If there is a house rule, it should be in the admission agreement too. The facility is responsible to protect residents who are unable to give informed consent. (8/18/06)
If a resident wants the bed taken out of their room, must the facility provide one?	No, but the facility should request a variance to the rule 16.03.22.03. (1/16/08)
We have a resident who has MD orders/driving restrictions, but continues to drive.	The facility should develop a written agreement regarding driving restrictions that is included in the NSA. Then, if resident fails to comply with agreement, there are grounds for discharge. The facility is responsible to protect resident/others from harm when they know a potentially harmful situation exists. The facility has a responsibility to let the physician and the DMV know if the resident is breaking the law. (7/15/09)
What do we do with a diabetic resident who refuses to follow their ADA diet?	The resident or responsible party should be informed of the consequences of not following the diet and this information should be documented in the record. The physician should also be notified. This refusal and how staff is to respond, needs to be identified in the NSA. The nurse should re-visit this issue and document

	status and any changes in the 90 day assessment. (10/15/08)
Where is it okay/not okay to use video cameras in a facility? Consents?	It is permissible for a facility to place video cameras in common areas, not bathroom/dressing room. Residents should be informed in the resident admission agreement. A family placing a camera in a resident's room is a guardianship/POA issue; the facility needs to assure placement of the camera will not violate the privacy of other residents. (11/20/06)
Is it okay to do random room checks for medications?	This is acceptable only if this practice is described in the facility policy and the resident is notified and agrees to this prior to moving in. (3/19/07)
Are locks required on Resident rooms?	There are not rules specific to whether resident rooms should or should not have locks on them. Considerations must be made for resident rights to access their own room without delay or permission, for keeping medications stored in resident rooms locked, and for the need for staff to access to assist with evacuation or other medical emergencies. The resident must be informed who has access to keys if the room is locked. (4/1/09)
Can a facility require that they handle the resident's personal funds (the amount they have for spending after Board and Care are paid)?	No. See IDAPA 16.03.22.550.05. a. which states a facility must not require a resident to deposit his personal funds with the facility. (3/19/07)
Is a resident inventory required?	No. However, the facility must have a policy to protect resident's belongings. See IDAPA 16.03.22.153.05. (1/02/07)

Can RALFs exclude sexual offenders from their communities?	Yes. There is nothing in the RALF rules to prohibit facilities from excluding sex offenders. (3/5/08)
What do we do when friends or family pose problems while visiting a resident?	Residents have the right to visitors of their choice with reasonable restrictions (i.e. 3:30 am) 550.07.b & c. The facility must attempt to work with the resident and visitors to minimize disruption or other problems. Banning a person from the facility that the resident wants to have visit would not be a reasonable restriction. (4/1/09)
Does the facility have to have a behavior management program for every resident who is on an anti-depressant?	Not necessarily. If the resident is not displaying symptoms or maladaptive behaviors as a result of the depression, then it would be acceptable to just monitor for the symptoms the antidepressant is prescribed to ameliorate. (3/5/08)
Is a behavior program still needed if a resident is taking behavior modifying medication and not exhibiting any behaviors?	Yes. The former behaviors need to be documented so staff are aware and can respond appropriately if behaviors occur. Further, the facility is responsible for providing behavior updates for the 6 month psychotropic medication review. If the facility does not maintain a record of what behaviors the psychotropic medication was prescribed to address, then it may not be possible to justify the continued use of the psychotropic medication. Refer to IDAPA 16.03.22.225.01 – 03. (8/1/12)
I suspect a resident is doing drugs, but I do not have proof. I called the police, but they stated they cannot force the resident to take a UA. Can I still give the resident notice to move out?	Yes, you can give the resident a 30 day notice to move out if you have a valid reason to believe they are doing drugs. Document the behavior and your observations that lead you to suspect drug use. (10/2/08)
Smoking: If a resident smokes, but requires constant supervision while smoking, do we have to take the resident out to smoke whenever he wants?	No. The facility needs to establish a policy to address how often it will provide supervision for smoking. Additionally, it needs to be addressed in the resident's Negotiated Service Agreement. The facility and resident should establish a reasonable schedule and negotiate the price for this service. (10/2/08)
While residents are being	Yes. Often the MARs are left on top of the medication carts and contain private

assisted with their medications, is it necessary to keep the MARs secured to protect the residents' privacy?	information about residents. IDAPA 16.03.22.330.03 states the facility must safeguard resident information against loss, destruction, and unauthorized use. Also see IDAPA 16.03.22.550.12.c the right to confidentiality and privacy concerning medical or dental treatment. (8/1/12)
What is a behavior?	Within the context of the RALF rules, "a behavior" refers to any actions of the resident that are distressing to the resident (this includes actions that place their safety at risk) or infringe on the rights of others. (5/05/15)
Who all needs a Behavior Management Program?	Any resident that is doing something that is distressing to the resident, places the resident's or other's safety at risk, or infringes on the rights of others (see 225), and any resident that is on a psychotropic medication for behaviors that they have displayed in the past. (5/05/15)
How often does the behavior management program need to be reviewed?	1. Within 72 hours of implementation. 2. When the behaviors are continuing. 3. Each time a behavior is displayed that places the resident or others in danger. 4. For residents taking psychotropic medication to control the behavior, the behavior data needs to be provided to the prescribing physician every six months and anytime the facility is requesting a change in the medications used to address the behavior. (5/05/15)
Is the facility required to have a behavior management program for every resident who is on an antidepressant?	No. If the resident is not displaying maladaptive behaviors as a result of the depression, then it would be acceptable to just monitor for the symptoms the antidepressant is prescribed to alleviate. The reason for the anti-depressant must be described in the resident's record along with the symptoms the resident was placed on the medication for and any potential side-effects. The nurse is responsible to provide education to staff and resident regarding the purpose of the medication, symptoms the medication is prescribed to alleviate, any side-effects the staff should watch for, where to document, and when to call the nurse. Both the staff and the nurse must be able to describe how symptoms and side-effects are being tracked and where they are to be documented. The nurse must monitor for side-effects and effectiveness of the antidepressant by reviewing documentation and interviewing staff/resident during the quarterly and as needed nursing assessment and report any concerns to the physician. See 711.08.c and e, 305.01, 305.04, 305.07 and 305.08. (5/05/15)
Is the facility required to	No. If the medication is being used only for sleep, and the resident displays no

have a behavior management program for a resident who is on a psychotropic medication prescribed for sleep?	behavioral symptoms, then it would be acceptable to just monitor for the effectiveness of the medication – i.e. the resident's sleep. The reason for the medication must be described in the resident's record along with the symptoms the resident was placed on the medication to address and any potential side-effects. The nurse is responsible to provide education to staff and resident regarding the purpose of the medication, symptoms the medication is prescribed to alleviate, any side-effects the staff should watch for, where to document, and when to call the nurse. Both the staff and the nurse must be able to describe how symptoms and side-effects are being tracked and where they are to document them. The nurse must monitor for side-effects and effectiveness of the medication by reviewing documentation and interviewing staff/resident during the quarterly and as needed nursing assessment and report any concerns to the physician. See 711.08.c and e, 305.01, 305.04, 305.07 and 305.08. (5/05/15)
We have a resident who does not display any outward symptoms of anxiety, but has a PRN for anxiety and requests it when she is feeling anxious. Do we need a behavior program for this?	No. As long as the resident is not displaying any maladaptive behaviors and the medication is being used only upon request of the resident, then a behavior management program is not needed. See 711.08.c and e, 305.01, 305.04, 305.07 and 305.08 for documentation, training and education requirements. (5/05/15)
How long after a resident has stopped displaying a behavior does it need to continue to be monitored?	All behaviors that are distressing to the resident or infringe on the rights of other residents must be documented. The facility policy should describe where unusual behaviors are to be documented. The facility must continue to monitor the resident to determine continued need for the medication based on the resident's demonstrated behaviors and monitor for any side effects and provide behavior updates every 6 months to the physician or authorized provider. see 711.01.a-c, 310.04.c 310.04.d and 310.04.e (5/05/15)
Must every behavior plan have an accompanying data (tracking) sheet?	No. However, the behavior plan must specify where and how staff is to document the behavior should it occur. Each behavior must be documented, including the date, time, specific behavior that was observed, the interventions that were used and the effectiveness of the interventions. All staff must be able to describe where and how they would document the behavior. See 153.07, 711.01.a-c (5/05/15)
Do we have to use a	No. There are some templates available on our website

particular format for our behavior plans?	www.assistedliving.dhw.idaho.gov, but you can use whatever template you like as long as you include each of the required elements. See rules 225.01 a-g and 225.02.a-c. (8/10/15)
Can the BMP be part of the NSA rather than a separate document?	Yes, as long as the NSA includes all of the required elements. The staff, nurse and administration must know where the information is and where to document behaviors, and the plan must be reviewed as needed. (8/10/15)
Safety, Environment, Restraints	
Our facility has the locks on the bedroom doors turned around (so they lock from the outside) is this okay?	No. Seclusions and restraints are both prohibited in RALFS. A resident being in a room they cannot get out of would be considered both. (5/18/09)
Are gloves a restraint?	They could be if the resident is unable or not allowed to take them off herself. They may also be considered a dignity issue if the resident is wearing them indoors. (11/12/08)
Can we use a baby gate?	While these are not specifically mentioned in our regulations, they would be considered a dignity issue. They would also be looked at very closely to see if they were being used as a restraint and could be an indication there is not appropriate supervision of the residents. Baby gates and other obstructions also create a potential impediment for safe evacuation in an emergency. (6/11/07)
Are lap buddy's allowed in RALFs?	No. A lap buddy is considered a restraint and therefore prohibited in RALFs by IDAPA 16.03.22.152.05.b.iii, unless the resident was fully cognizant and was consistently able to disengage the lap buddy without assistance. (4/1/09)
Are Transfer Poles considered a restraint?	No. They are not considered a potential restraint or bed rail, but it does need to be monitored for safety. A qualified professional should assess the device and the resident and train the resident and staff how to properly use it. Include the pole on the NSA. (2/4/09)
Are bed canes considered a restraint?	Bed canes pose the potential for injury. They need to be assessed by a qualified professional that it is safe and that it is for transfer, not to keep the resident from falling out of bed. The bed cane needs to be included on NSA. (11/30/10)

Can we request a variance to have bed rails for a resident who wants them?	No. Variances for the use of bedrails will not be granted, as all physical restraints, including bedrails are prohibited in RALFs. One exception is a short term variance for hospice residents with air beds that have rails attached. Serious injuries and deaths in Idaho have been attributed to the use of bedrails. If a resident would otherwise be able to get out of bed unassisted, then the rail is not acceptable. A resident who requires the use of a bed rail to keep them in bed is not acceptable for assisted living. A full bed rail is never acceptable in a RALF. When a device is needed for positioning, the least invasive, safest device available that still meets the resident's needs should be used. When the survey team encounters a ½ bedrail, a ¼ bedrail, a bed cane, or similar device, a review will be done to ensure that per the RN assessment, the NSA, and resident, staff and family interviews, the resident needs the device for positioning and not restraint. If a ½ or ¼ rail is used, the assessment should specify why a smaller, safer devise would not be effective. The facility should have a policy on the use of these devices. The use of the device must also be addressed in the resident's NSA. IDAPA 16.03.22.152.05. Policies of Acceptable Admissions. Written descriptions of the conditions for admitting residents to the facility must include: **b.** No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include: **iii.** A resident who requires physical restraints, including bed rails, an exception is a chair with locking wheels or chair in which the resident cannot get out of.... (6/11/07)
A resident has difficulty staying upright in his w/c, and has a tendency to lean to the left. The resident needs a safety belt to help him not fall over in his w/c. Question: Is this a restraint? I read rule # 152.05.iii, and said as long as the resident is able to remove the safety strap by	"Chair a resident cannot get out of" is referring to a recliner or sofa. The chair with locking wheels is a wheelchair. As long as the resident can remove the belt themselves, it would not be considered a restraint. A resident in a recliner or couch that they were unable to get up from independently needs to be checked frequently. The staff needs to make sure the resident is assisted up when the resident no longer wants to sit. Staff also needs to assure the resident is assisted to the restroom, and offered snacks/fluids, change position, etc. as needed. (2/22/07)

himself and whenever he wants it's not a restraint. What does this mean: "…an exception is a chair with locking wheels or chair in which in which the resident cannot get out of;"	
Bed Rails: Can beds with air mattresses have a side rail?	If the manufacturer recommends the use of side rails with the product, then a variance to the rule IDAPA 16.03.22.152.05.b.iii. would need to be requested. A variance must be requested for each resident, as a facility wide variance would not be appropriate. (4/2/08)
What is needed for approval of an interior or exterior secure environment?	Plans with dimensions, and the specification sheets for the proposed locking devices must be submitted to Division of Licensing and Certification – Fire/Life Safety & Construction Program for approval prior to installation. (11/9/10)
Can we put locks on the gates in our yard? I found an automatic lock with a key pad at Radio Shack. Can I put these on our doors to create a secure environment?	No. The Division of Licensing and Certification – Fire/Life Safety & Construction Program must be contacted prior to any modification of exit doors, delayed egress locks on doors, including automatic locks and delayed egress locks. Unapproved locks on doors requiring special knowledge or tools would be cited as a core issue, and may be considered immediate danger. (11/9/10)
Is there a state law that there must be one exterior door that remains unlocked at all times?	No. ALFs should take precautions to prevent break-ins. Locking all doors at night would be prudent. The doors cannot be locked from the inside though unless it is a secure environment in which case, the doors must automatically unlock in the event the fire alarm goes off. (3/18/09)

Would you define secure environment?	Facilities that have one or more residents who are at risk for wandering must provide a secure **interior environment** to ensure residents do not leave the premises unsupervised. The uniform assessment should identify if the resident is considered a risk for wandering; if they have attempted to exit the facility, have a history of attempting to elope before moving to the facility (from home or another setting), or express an intent to leave the facility. Because measures used to secure the environment may be effective for one resident, but not another, the type of security provided should be evaluated for the effectiveness in protecting each of the residents based on their individual needs and abilities, and should be adjusted (increased or decreased) as necessary. Examples of measures that could be used to secure an environment include keypads, buzzers, alarms, delayed egress, etc. These measures should be individualized to each resident and must be included in the Negotiated Service Agreement. Should a resident get in a situation of potential danger (getting outside the facility or the secure exterior yard without staff knowledge) the measures in place must be re-evaluated and adjusted to prevent recurrence. In the event a resident is outside without staff knowledge or in the event of an elopement, a facility would be cited if they knew or should have known of the resident's behavior and did not implement adequate measures (7/30/07). A secure **exterior yard** provides an area where residents can spend time outside and be safe from wandering away from the premises. A secure exterior yard may be a fenced area, or a courtyard surrounded by the building. The height and construction of the fence should be sufficient to assure residents are not able to climb over or slip through the fence, or exit a gate undetected. If the secure exterior yard is a part of a means of egress (fire exit) the facility will need to assure the yard does not trap or create a hazard in the event of a fire. Using a delayed egress (push to exit, alarm will sound) or controlled egress (magnetic and key pad) system that are tied to the fire alarm system and automatically fail-safe would enable individuals to escape the yard in the event of fire. The facility should consult with the local fire and building officials, and the licensing authority for approval of such a system prior to installing delayed or controlled egress devices (1/10/08).

	Applicable rules: IDAPA 16.03.22.010.11—Definition of Assessment 16.03.22.010.15—Definition of Behavior Management 16.03.22.011.02—Definition of Functional Abilities Assessment 16.03.22.011.25—Definition of Negotiated Services Agreement 16.03.22.012.02.c.d—Definition of Personal Assistance 16.03.22.012.25-- Definition of Supervision 16.03.22.152.05.a—Policies of Acceptable admissions 16.03.22.152.01.a states that the admission policies to identify the purpose quantity and characteristics of available services 16.03.22.220.02 requires that the facility include in the admission agreement staffing patterns and qualifications of staff on duty during a normal day. 16.03.22.225.01 &.02 require the facility to evaluate behavioral symptoms and develop interventions for the behavioral symptoms. 16.03.22.250.14. Secure Environment. If the facility accepts and retains residents who have cognitive impairment, the facility must provide an interior environment and exterior yard which is secure and safe. 16.03.22.405.07 states that any locks on exit doors must be single action and easily operable from the inside without the use of keys or any special knowledge. The locking arrangements must meet the referenced NFPA code. 16.03.22.550.03.iii requires facilities to ensure that the living environment is safe and sanitary. (7/30/07)
May a mentally ill resident live in a secure environment?	If the person is their own guardian and state they do not want to live in a secure environment, having them do so could be a violation of their rights. A secure facility should not house residents who do not require a secure environment or who have not consented. (3/18/09)
Are portable heaters allowed?	No. See IDAPA 16.03.22.405.05.f. (10/13/10)

How far away from the building does the outside smoking area need to be?	There isn't a set distance requirement. Residents and staff should smoke in a designated smoking area that is not close to weeds, or where there are combustibles (wood piles, garbage cans, beauty bark, or wooden decks), that could catch on fire. Designated smoking areas should provide noncombustible ashtrays and a noncombustible self-closing garbage can. If the designated smoking area is in the garage, the area would need to be protected by fire sprinkler head(s) as this becomes an occupied space. (11/30/10)
How do I make my designated smoking area safer?	Smoking rules need to be adopted, posted and enforced. Assess residents to ensure they can safely smoke on their own or provide assistance/supervision which may include 1:1 oversight. Cigarette butts need to be extinguished in a noncombustible ashtray. Ashtrays need to be emptied in a metal butt can that has a self-closing automatic lid. Never discard smoking materials into a plastic garbage can, or one that is stored in the garage because that could start a garage fire. Do not allow residents who require oxygen gas to smoke near their oxygen supply or tubes. Smoking by residents who are assessed as not responsible shall be prohibited. (11/30/10)
What steps must be taken for a resident on oxygen who smokes?	The facility policy can prohibit smoking by residents on oxygen. Residents who are smokers need to have the oxygen turned off and the oxygen tubing removed from their bodies prior to having their cigarette lit. It would be ideal if there was at least a two minute time lapse between the removal of the tubing and the lighting of the cigarette. Having residents sign a document that states they accept the responsibility if they catch on fire does not absolve the facility of its responsibility to provide supervision and a safe living environment. (9/25/06)

How do I inspect my fire extinguishers every month?	Fire extinguishers should be inspected when installed and after the annual visit by the fire extinguisher service company – this is for quality assurance. Then they need to be checked monthly for: 1) Are they located where they are supposed to be and can anybody get to the extinguisher? 2) Is there a sticker to show how the extinguisher is used and are the tamper seals unbroken? 3) Take the extinguisher off the hanger and check the gauge, hose and nozzle to see if there is physical damage, corrosion, leakage, or a clogged nozzle. 4) Date and initial the tag indicating the inspection has occurred. Immediate corrective action should be taken if any fire extinguisher is found to have a condition where it wouldn't correctly operate. (11/9/10)
Do the fire drills have to include the actual alarm, or can we just let everyone know we are conducting the drill?	Fire drills shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Silent drills may be practiced for the night shift when residents are asleep. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms, according to NFPA code. From a practical standpoint, some night time drills should include actual fire alarm and evacuation, otherwise how does a facility know if residents will hear the alarm and respond properly. When a drill is conducted during sleeping hours it is permissible to announce the drill in advance. (11/30/10)
Does a Hoyer lift have to be "delegated?"	No, but staff must be trained on the proper use and the training must be documented. See IDAPA 16.03.22.153.11, 620, 625.03.d, 730.01.e. Also see BON rules for list of items that <u>do</u> need delegation from the nurse. (11/9/10)
Hoyer lifts: Do Hoyer lifts require two staff to operate?	It depends. The facility needs to have a copy of the manufacturer's specifications and follow them. If using a lift and only one person is available, be sure to get a lift designed to be operated by one person. Also, make certain all the staff has been trained and the training is documented. (3/19/08)

Do staff and residents have to actually evacuate in a fire drill?	It depends on the number of licensed beds; small facilities (16 beds or less) – yes, large facilities (17 beds or more) - no. Small facilities need to practice complete evacuation during drills. Drills involve the actual evacuation of all residents to a place outside and provide residents with experience in using all exits and means of escape (as an example, residents need to know windows are a means of escape). During inclement weather evacuation can be movement to the exit or the means of escape. Actual exiting from windows is not required, opening the window and signaling for help is an acceptable alternative. Those residents who cannot assist in their own evacuation or who have special health problems are not required to be moved but should participate in the drill to the level that they are capable of. Staff must plan and practice moving residents who cannot self-evacuate using dummies and wheelchairs or other staff members, if needed. For large facilities the following applies: a plan is written for protecting all persons in the event of fire, for keeping persons in place inside (which is allowed by more rigid construction), for evacuating persons to areas of refuge (behind smoke barrier doors to another wing for example), and for evacuating persons from the building when absolutely necessary. "Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building." Normally a complete evacuation is not required, only relocation to an area of safety. For all facilities, a drill is a measure of response of the staff and residents, problems encountered and recommendations for improvement. Staff needs to thoroughly discuss and document issues, know what proper actions are to be taken and seek to change any plan if any resident's condition changes. For large or small facilities all residents must participate in the drills. Why do only the small facilities need to evacuate? Because smaller facilities are constructed differently and have less fire protection capabilities so immediately getting out the building in case of fire is the number one priority. (11/12/10)
Are Hoyer Lifts allowed in RALFs?	Yes, with documented training for all staff who use the lift and safe practices observed during survey. (3/19/07)
May a facility keep a tank of	No. If a resident is requiring oxygen, and normally does not require oxygen, then

oxygen on hand for emergencies?	EMS is a more appropriate response. Further, UAP cannot make the assessment to determine whether a resident requires oxygen in an emergency and cannot titrate the oxygen. Further, oxygen is a medication, requiring a physician's order. (7/15/09)
Closed toe shoes- Is there a requirement for closed toe shoes?	It is not specifically required in our rules, but is up to the facility's policy and procedures and could be considered a best practice. The facility must ensure that infection control measures are being taken in light of the decision to require or not require closed toe shoes. (6/04/08)
Do soiled briefs or clothing have to go into bio-hazard containers?	No. However, if the item is soiled with blood, it may need to. The facility should have policies regarding infection control, including standard precautions. Staff should be familiar with and follow these policies. See IDAPA 16.03.22.335. & 335.03. Linens must be handled and processed in a manner that prevents cross-contamination. Resident's personal laundry cannot be washed with the facility's general linens (sheets & towels). IDAPA 16.03.22.260.05.c and h. (10/13/10)
Are common use bars of soap and towels allowed?	No. To promote good infection control, each resident should have their own bar of soap and a towel. Bar soap and shared towels should never be used in public bathrooms. If staff need to wash their hands while in residents rooms, liquid soap and paper towels should be available to them. See IDAPA 16.03.22.335, 335.03 & 430.06. (11/30/10)
If two residents share a room, do they have to have separate, labeled towel racks?	The rules do not address towel racks. The key though is infection control. We would be looking for a system to ensure the towels are kept from contaminating each other and the residents are not using each other's towels. (10/15/08)
Staffing, Staff Roles, Employee and Contractor Records	
Is it better to use an administrator designee or use an administrator from another facility?	Using an administrator from another facility is not considered good practice. The administrator designee is someone who acts on behalf of the administrator when the administrator is away from the facility. The designee must know the facility policies and procedures, be familiar with the residents, and know how to respond in an emergency situation. The administrator designee does not need to possess an administrator's license. The administrator designee may not assume the

	administrator's responsibility for daily oversight and supervision of personnel on an ongoing basis. According to IDAPA 16.03.22.215 "Each facility must be organized and administered under one (1) licensed administrator assigned as the person responsible for the operation of the facility. Multiple facilities under one (1) administrator may be allowed by the department based on an approved plan of operation." (6/04/08)
Are assisted living facilities required to have a nurse on call 24-7?	Yes, the nurse needs to be available to address changes in the resident's medication orders, or mental and physical condition to include behaviors. IDAPA 16.03.22.300.02. Licensed Nurse. The facility must assure that a licensed nurse is available to address changes in the resident's health or mental status and to review and implement new orders prescribed by the resident's health care provider. (7/19/06)
Is there a minimum resident to staff ratio?	No. According to the rules the administrator is responsible to schedule sufficient staff to meet the needs of each resident. See IDAPA 16.03.22.600.06.a and 152.05.a. (10/13/10)
Does there need to be a med tech (staff with medication assistance certification) on the night shift?	If any residents take PRN medications on the night shift, there would need to be a med tech there to give them if needed. If the facility uses an on call person to come in if PRN is needed, then the policy plus evidence that someone is available at all times would be needed. IDAPA 16.03.22.600.06 states that there must be sufficient staffing to provide care for all residents. (8/6/07)
Can a facility hire employees under 18 to do non-resident care jobs? And would they require a background check?	Yes. The facility may hire someone under 18 years of age to do non-resident care jobs. If they have direct patient access (housekeeping, etc.), they must have a criminal history and background check completed. The administrator must ensure that no personnel, who provide hands on care or supervision services, will be under 18 years of age unless they have completed a certified nursing assistant certification course. See IDAPA 16.03.22.009.03 & 215.12. (10/13/10)
What is considered "direct patient access" when referring to criminal history checks?	Direct access means just that; a bookkeeper who works at the corporate office and never sees the resident would not have direct patient access. A person who works in the facility and comes in contact with the residents, regardless of their position, would be considered to have direct access. Maintenance and housekeeping persons routinely have access, as do many kitchen staff. (4/1/09)
When a change of ownership occurs, does the facility need	If the Department of Health and Welfare background checks are within three years, then a State police Background check would be required. Otherwise, new

to do new background checks on the current employees?	checks would need to be completed. (1/22/09)
Are cooks required to have specialized training in Alzheimer's/Dementia also?	Yes. The rules state the facility must train "staff." They do not differentiate between direct care and other staff. All staff is likely to interact with residents occasionally and should be trained in the special needs of the population being served. 16.03.22.630. (11/25/08)
How often does staff need a background check?	There is not a requirement for facilities to re-check a staff member who has been continuously employed by them since their initial background check. IDAPA 16.03.22.009.05 New Criminal History and Background Check. An individual must have a criminal history and background check when: a. Accepting employment with a new employer; and b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. IDAPA 16.03.22.009.06.c. An employer may use a previous criminal history check that is within three years, provided the employer completes a state-only background check. (8/7/07)
Does a staff that has completed the H&W course for PCS qualify as medication certified?	No. They have to pass the assistance with medications certification course that is approved by the BON. (12/8/08)
Will surveyors be checking for criminal background checks on administrators and facility nurses?	Yes. See IDAPA 16.03.22.009.03 which states any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to work only under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. (10/13/10)
Is "horseplay" allowed between caregivers and residents?	No. While it is important for staff to develop rapport with residents, professional boundaries must be maintained. Horseplay can easily be viewed as abuse. It is the administrator's responsibility to supervise and monitor staff/resident relationships. See IDAPA 16.03.22.600.05. (10/13/10)
Survey and Licensing	
How does a facility get on the	There is not an abbreviated schedule. Facilities that have had no core issue

abbreviated survey schedule?	deficiencies for two consecutive licensure surveys are to be surveyed at least every 36 months, while those without two consecutive licensure surveys without a core issue are to be surveyed once every 12 months. IDAPA 16.03.22.130.01 states the Licensing and Survey Agency will assure that surveys are conducted at specified intervals in order to determine compliance with this chapter and applicable rules and statutes. The intervals of surveys will be: a. Within ninety (90) days from initial licensure followed by a survey within fifteen (15) months. Facilities receiving no core issue deficiencies during both the initial and the subsequent survey will then enter the three (3) year survey cycle. b. Once every twelve (12) months, or more frequently at the discretion of the Licensing and Survey Agency for those facilities receiving core issue deficiencies during any survey. Surveys will be conducted until the facility attains two (2) consecutive surveys, excluding follow-up surveys, without a core issue deficiency. c. <u>At least</u> every thirty-six (36) months, for those facilities having attained no core issue deficiencies for two (2) or more consecutive surveys, regardless of survey type. (4/03/07)
Are there 2 types of infractions a facility can be cited for?	Yes. A core and a punch. A core issue could be one very serious instance of non-compliance. It could also be a collection of non-core situations that taken together indicate there is a system failure. A core issue is any one (1) of the following: abuse; neglect; exploitation; inadequate care; a situation in which the facility has operated for more than thirty (30) days without a licensed administrator designated the responsibility for the day to day operations of the facility; inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or surveyors denied access to records, residents or facilities. Core Issues are used to identify incidents of non-compliance that: o Result in harm o Have a potential for harm o Indicate a breakdown in facility systems that could lead to harm. Non-core issues would be things such as a past due inspection of the furnace, fire extinguishers", smoke alarm inspections, etc. Non-core issues are those that do not rise to the level of core or do not meet the definition of core as described above. The facility does need to fix non-core issues and send evidence that it has been fixed within 30 days of the exit. (2/26/07)

Miscellaneous	
Sexual Offender Notifications: When we notify residents that there is a resident on the SO registry, do we need to tell them which resident it is and how does it need to be documented?	You are not required to state who is on the list, but your policy should describe how notification is to be done. Each resident should be informed upon admission if the facility accepts sex offenders. Document the date each resident is notified. Refer to IDAPA 16.03.22.152 ADMISSION POLICIES 01. Admissions. Each Facility must develop written admission policies and procedures. The written admission policy must include; 02. d. Notification of any residents who are on the sexual offender registry and who live in the facility. The registry may be accessed at http://www/isp.state/id.us/identification/sex_offender/public-access/html (10/2/08)
If a resident passes away unexpectedly, who do we call?	This depends on your facility policy and the expectations of your local coroner. Each county is different. Local coroners have the authority to determine under what circumstances they want to be notified. If you are unsure, contact your local coroner for direction in writing your facility policy. Hospice cases are typically handled by the hospice agency. (10/15/08)
POST: Does the state require all residents to have a POST?	No. Our rules do not require that residents have a POST. However, it is a good idea as the POST becomes more and more common to ensure the Resident's wishes are carried out. (10/2/08)
Are electronic signatures acceptable on all orders, H&P's etc.?	The rules do allow for facilities to develop and use e-records and signatures. They must have systems in place to ensure confidentiality and security of data that no one may alter another's entry. There must be systems in place to provide alternate methods of record keeping in the event of a system disruption. Rule references: IDAPA 16.03..22.010.27--Definition of Electronic Signature, E-Signature 16.03.22.159.02--Deals with the policies re: electronic records 16.03.22.700—Records. (4/13/07)
Electronic records storage: Can a facility scan their historical records onto a computer so they don't have to store all the hard copies?	Yes, as long as they are accessible (printable) to surveyors immediately and to residents within one day of request. There must be an off-site back-up to the electronic records in case of disaster or computer failure. Copies of all resident records must be kept for three years. (3/19/08)

NSA: What if a resident will not sign the NSA, but does agree to the care?	Note on the NSA the date and time the NSA was reviewed with the resident and the resident's response. (10/2/08)
Can a physician rather than an RN sign the care plan?	Yes. (3/19/07)
What are the rules regarding pets?	The only rule specific to animals is: no live animals in the kitchen. The facility does need to assure residents' right to a safe and sanitary living environment. (5/21/07)
Does the facility have to carry liability insurance?	No, but if they don't, they must notify the residents in writing per IDAPA 16.03.22.220.05 and the staff per IDAPA 16.03.22.730.01.c. (11/30/10)
Are there any rules prohibiting residents from hitting staff?	No, but there are a number of rules that address the facility's response to such an incident. The facility would need to make sure staff is appropriately trained to respond to physical aggression. There should be enough staff to keep the resident and others safe. The behavior must be assessed and an appropriate BMP developed. See IDAPA 16.03.22.152.05.3, 153.06, 225.1-3 and 320.02.i. (10/13/10)
A family member of the administrator lives in the basement, is he considered a resident?	If the facility is billing Medicaid for his care, then yes, he must be treated as a resident and meet all rules. If Medicaid is not paying for care, then he does not need to be counted as a resident. (10/2/08)

Can we have slot machines in our assisted living?	Our rules do not prohibit slot machines. However, the Idaho state slot machines and gambling are regulated by the state. You would want to talk with your local police or sheriff before purchasing any. **18-3810. SLOT MACHINES -- POSSESSION UNLAWFUL -- EXCEPTION.** (1) Except as otherwise provided in this section, it shall be a misdemeanor for any person to use, possess, operate, keep, sell, or maintain for use or operation or otherwise, anywhere within the state of Idaho, any slot machine of any sort or kind whatsoever. (2) The provisions of section 18-3804, Idaho Code, shall not apply to antique slot machines. For the purpose of this section, an antique slot machine is a slot machine manufactured prior to 1950, the operation of which is exclusively mechanical in nature and is not aided in whole or in part by any electronic means. (3) Antique slot machines may be sold, possessed or located for purposes of display only and not for operation. (4) An antique slot machine may not be operated for any purpose. (10/15/08)