

# Nutrition and Hydration Care

## What Nursing Assistants Can Do

### Unintended Weight Loss

#### Watch for Warning Signs

The following are some signs that a resident may be at risk for or suffer from unintended weight loss:

- Needs help to eat or drink
- Eats less than half of meals/snacks served
- Has mouth pain
- Has dentures that don't fit
- Has a hard time chewing or swallowing
- Has coughing or choking while eating
- Has sadness, crying spells, or withdrawal from others
- Is confused, wanders, or paces
- Has diabetes, chronic obstructive pulmonary disease (COPD), cancer, HIV or other chronic diseases

#### Report and Take Action

**Below are some** action steps to increase food intake, create a **positive dining environment**, and help residents get enough calories:

- Report observations and warning signs to nurse and dietitian!
- Encourage resident to eat
- Honor food likes & dislikes
- Offer many kinds of foods and beverages
- Help residents who have trouble feeding themselves
- Allow enough time to finish eating
- Notify nursing staff if resident has trouble using utensils
- Record meals/snacks intake
- Provide oral care before meals
- Position resident correctly for feeding
- If resident has had a loss of appetite and/or seems sad, ask what's wrong

### Dehydration

#### Watch for Warning Signs

The following are some signs that a resident may be at risk for or suffer from dehydration:

- Drinks less than 6 cups of liquids per day
- Has one or more of the following:
  - dry mouth
  - cracked lips
  - sunken eyes
  - dark urine
- Needs help drinking from a cup or glass
- Has trouble swallowing liquids
- Frequent vomiting, diarrhea, or fever
- Is easily confused/tired

#### Report and Take Action

**Most residents** need at least 6 cups of liquids to stay hydrated. **Below are some** action steps to help residents get enough to drink:

- Report observations and warning signs to nurse and dietitian!
- Encourage resident to drink every time you see the resident
- Offer 2-4 ounces of water or liquids frequently
- Be sure to record fluid intake and output
- Offer ice chips frequently (unless the resident has a swallowing problem)
- Check swallowing precautions, then if appropriate, offer sips of liquid between bites of food at meals and snacks
- Drink fluids with the resident, if allowed
- Make sure pitcher and cup are near enough and light enough for the resident to lift
- Offer the appropriate assistance as needed if resident cannot drink without help

### Pressure Ulcers

#### Watch for Warning Signs

The following are some signs that a resident may be at risk for or suffer from pressure ulcers:

- Patient subject to incontinence
- Needs help moving arms, legs, or body; turning in bed; or changing position when sitting
- Weight loss
- Eats less than half of meals/snacks served
- Dehydration
- Has discolored, torn, or swollen skin over bony areas

#### Report and Take Action

**Below are some** action steps to help residents who are at risk for or suffer from pressure ulcers:

- Report observations and warning signs to nurse and dietitian!
- Check and change linens as appropriate
- Handle/move the resident with care to avoid skin tears and scrapes
- Reposition frequently and properly
- Use "unintended weight loss action steps" so resident gets more calories and protein
- Use "dehydration action steps" so resident gets more to drink
- Record meals/snacks intake

This guide was adapted from the Nutrition Care Alerts developed by the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging, and sponsored by Ross Products Division of Abbott Laboratories.

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**§483.25(i) Nutrition**

**Based on a resident's comprehensive assessment, the facility must ensure that a resident—**

**(See F326 for intent, guidelines, procedures and probes for §483.25(i))**

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**F325**

**(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and**

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**F326**

**§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem**

|            |                                       |
|------------|---------------------------------------|
| Hematocrit | Females: 12-15 g/dl<br>Males: 41 - 53 |
| Potassium  | Females: 36 - 46<br>3.5 - 5.0 mEq/L   |
| Magnesium  | 1.3 - 2.0 mEq/L                       |

Some laboratories may have different “normals.” Determine range for the specific laboratory.

Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident’s clinical condition and baseline normal values.

**NOTE:** There is no requirement that facilities order the tests referenced above.

### **Clinical Observations**

Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.

Risk factors for malnutrition are:

1. Drug therapy that may contribute to nutritional deficiencies such as:
  - a. Cardiac glycosides;
  - b. Diuretics;
  - c. Anti-inflammatory drugs;
  - d. Antacids (antacid overuse);
  - e. Laxatives (laxative overuse);
  - f. Psychotropic drug overuse;
  - g. Anticonvulsants;
  - h. Antineoplastic drugs;
  - i. Phenothiazines;
  - j. Oral hypoglycemics;

**Probes: §483.25(i)**

For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable:

- Did the facility identify factors that put the resident at risk for malnutrition?
  - Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement.
  - What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)?
  - Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes?
  - Was this care provided consistently?
  - Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?
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- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident should know of, or be able to provide information about the causes of a resident's condition or problem.
  - Determine if the care plan was developed utilizing the clinical conditions and risk factors identified in the assessment for unintended weight loss. Were the care plan interventions, such as oral supplements, enteral feeding, alternative eating schedule, liberalized diet, nutrient supplements, adaptive utensils, assistance and/or increased time to eat developed to provide an aggressive program of consistent intervention by all appropriate staff?
  - Determine if the care plan was evaluated and revised based on the response, outcomes, and needs of the resident.

**Note:** If a resident is at an end of life stage and has an advance directive according to State law, (or a decision has been made by the resident's surrogate or representative in accordance with State law) or the resident has reached an end-of-life stage in which minimal amounts of nutrients are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then the weight loss may be an expected outcome and may not constitute noncompliance with the requirement for maintaining nutritional parameters. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with 42 CFR 483.25, F309, Quality of Care.

- Observe the delivery of care as described in the care plan, e.g., staff providing assistance and/or encouragement during dining; serving food as planned with attention to portion sizes, preferences, nutritional supplements, and/or between-meal snacks, to determine if the interventions identified in the care plan have been implemented. Use the Dining and Food Service Investigative Protocol to make this determination.

**Task 6: Determination of Compliance:**

- Compliance with 42 CFR 483.25(I), F325, Nutrition:
    - For this resident, the unintended weight loss is unavoidable if the facility properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, the weight loss is avoidable; cite at F325.
  - Compliance with 42 CFR 483.25, F309, Quality of Care:
    - For the resident who is in an end-of-life stage and palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life, then for this resident, in the area of palliative care, the facility is compliant with this requirement. If not, cite F309.
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## **Etiologies of Unplanned Weight Loss**

- 1) Decreased nutritional intakes.
    - a) Decreased appetite.
      - i) Dementia.
      - ii) Medication (see handout “Medications Associated with Weight Loss”).
      - iii) Depression.
      - iv) Poor food quality.
      - v) Food preferences not honored.
      - vi) Not allowed to eat at preferred times of day.
      - vii) Nausea, emesis, diarrhea, constipation, reflux (other GI discomfort).
      - viii) Unpleasant eating environment (socially or physically).
      - ix) Pacing behaviors (Often residents with pacing behaviors have a decreased interest in meals. Pacing can be related to dementia or mental illness).
      - x) Pain.
    - b) Physical limitations.
      - i) Paralysis.
      - ii) Need for adaptive equipment (plate guard, “built-up” spoon, swivel spoon, etc.).
      - iii) Dysphagia (difficulty swallowing).
      - iv) Oral pain (infection, sore gums, ill-fitting dentures, edentulous).
      - v) Blindness.
  - 2) Increased nutritional needs.
    - a) Infections (some common).
      - i) Pneumonia.
      - ii) Flu.
      - iii) Urinary tract.
    - b) Fractures (especially long bone).
    - c) Wound healing.
      - i) Pressure sores.
      - ii) Stasis ulcer.
      - iii) Healing surgical sites.
      - iv) Other.
    - d) Hypermetabolic disease states.
      - i) Chronic obstructive pulmonary disease.
      - ii) Cancer.
      - iii) Cardiac cachexia.
      - iv) HIV/AIDS.
      - v) Hyperthyroidism.
      - vi) End-stage-dementia-related illnesses (e.g., Alzheimer’s disease, organic brain syndrome, Parkinson’s disease) may also increase nutritional needs, and simultaneously decrease one’s interest in or ability to consume food by mouth. (Refer to section of this lesson regarding enteral support and end-of-life considerations.)
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-14

**DATE:** January 13, 2005

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Electronic Signature Guidance - Clarification

**Letter Summary**

- Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) may implement the use of electronic signatures for clinical record documentation whether or not the clinical record is entirely electronic. Included in this policy clarification is the Minimum Data Set (MDS), provided that state and local laws and the long-term care facility's policy permits.
- A long-term care facility that implements the use of electronic signatures must have policies in place that identify those who are authorized to sign electronically and security safeguards to prevent unauthorized use of electronic signatures.

**This memorandum replaces S&C-04-46 dated September 9, 2004 that provided guidance to Regional Office (RO) and State Agency (SA) personnel regarding the use of electronic signatures.**

The intent of this clarification is to inform certified long-term care providers who have the capability to implement electronic signatures for their MDS documentation that they may do so whether or not the clinical record is entirely electronic.

**Background**

The Centers for Medicare & Medicaid Services (CMS) has received requests for authorization to use electronic signatures on the MDS and the clinical record. Demand for the use of electronic signatures and current CMS requirements to retain hard copies of the MDS and clinical record has raised operational issues and concerns by both facility staff and authorized reviewers.

CMS has adopted the current hospital guidelines for electronic medical records and electronic signatures for other providers that do not have specific regulations governing the use of electronic signatures, such as Rural Health Clinics and Federally Qualified Health Centers. In addition, some states have specific requirements for the use of electronic signatures. A few states do not address electronic signatures in their statutes or regulations, but may permit the use of electronic signatures with approval from fiscal intermediaries or state authorities.

### **Discussion**

Based on a review of the State Operations Manual (SOM), conflicting messages exist in current CMS policy. Some of our existing guidance requires the need for a hard copy of all MDS forms whether or not the facility is able to document signatures electronically, while another reference in the guidance allows the use of electronic signatures rather than a hard copy. Specifically:

- Appendix PP (Guidance to Surveyors – Long-Term Care Facilities) guidance regarding 42 CFR 483.20(d) states, “Whether or not the facility’s clinical record system is entirely electronic, a hard copy of all MDS forms, including the signatures of the facility staff attesting to the accuracy and completion of the records must be maintained in the resident’s clinical record.”
- Appendix PP guidance regarding 42 CFR 483.20(i) states, “Whether the MDS forms are manually completed or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses on the forms relative to the resident’s condition and discharge status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the MDS record. When MDS forms are completed directly on the facility’s computer (e.g., no paper form has been manually completed), then each individual assessor signs and dates a computer generated hard copy, after they review it for accuracy of the portion(s) they completed. Back dating completion dates is not acceptable.”
- Appendix R, (Revised Long-Term Care Resident Assessment Instrument User’s Manual, version 2.0, December 2002) with updates through June 2004 states, “Until such time as CMS adopts an electronic signature standard that is compatible with pending HIPAA requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS.” Another policy found in the RAI Manual states, “There is no requirement to maintain two copies of the form in the resident’s record (the hand written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable.”
- However, Appendix PP guidance regarding 42 CFR 483.75(1)(1) states, “In cases in which facilities have created the option for an individual’s record to be maintained by computer, rather than a hard copy, electronic signatures are acceptable.” Further guidance provides an example of how the facility may set up a system with safeguards to prevent unauthorized access to an individual’s record maintained by computer.

**Decision**

Nursing homes may use electronic signatures on the MDS when permitted to do so by state and local law and when this is authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure that they have proper security measures to protect use of an electronic signature by anyone other than to which the electronic signature belongs. The policy must also ensure that access to a hard copy of clinical records is made available to surveyors and others who are authorized access to clinical records by law.

Long-term care facilities that are not capable of maintaining the MDS signatures electronically must adhere to the current requirements addressing the need for either a hand-written copy or a computer-generated form. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard.

For questions regarding this memo, please contact Rosemary Dunn at (410) 786-1372 or e-mail at [Rdunn@cms.hhs.gov](mailto:Rdunn@cms.hhs.gov).

**Effective Date:** The information contained in this memorandum clarifies current policy and must be implemented no later than 30 days after issuance of this memorandum.

**Training:** The information contained in this announcement should be shared with all survey and certification staff, their managers, the RO/state training coordinators, and all long-term care providers.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-46

**DATE:** September 9, 2004

**TO:** Associate Regional Administrators  
State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Electronic Signature Guidance

**Letter Summary**

- Long-term care providers, that is Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs), may implement/accept the use of electronic signatures for their clinical record documentation including the Minimum Data Set (MDS) if this is permitted by state and local law and authorized by the long term care facility's policy.
- A long-term care facility that implements/accepts the use of electronic signatures must have policies in place that identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures.

The purpose of this memorandum is to provide guidance to Regional Office (RO) and State Agency (SA) personnel regarding the use of electronic signatures by certified long-term care providers who have the capability to implement electronic signatures for their clinical records.

**Background**

The use of electronic medical records appears to be increasing in nursing homes. The Centers for Medicare & Medicaid Services (CMS) has received requests for authorization to use electronic signatures on the MDS and the individual health record. Demand for the use of electronic signatures and current CMS requirements to retain hard copies of the MDS and clinical record has raised operational issues and concerns by both facility staff and authorized reviewers.

CMS has adopted the hospital guidelines for electronic medical records and electronic signatures for other providers that do not have specific regulations governing the use of electronic signatures, such as Rural Health Clinics and Federally Qualified Health Centers. Some States have specific requirements that include requirements for the use of electronic signatures. A few States do not address electronic signatures in their statutes or regulations, but may permit the use of electronic signatures with approval from fiscal intermediaries or State authorities.

### **Discussion**

Based on the review of the State Operations Manual (SOM), conflicting messages exist in current CMS policy, as guidance requires the need for a hard copy of all MDS forms whether or not the facility's clinical record is entirely electronic. Another reference in the guidance allows the use of electronic signatures rather than a hard copy; the contradiction is noted in the following:

- Appendix PP, Guidance to Surveyors – Long-Term Care Facilities on page PP-76, [42 CFR 483.20(d)] tag F286 states “Whether or not the facility’s clinical record system is entirely electronic, a hard copy of all MDS forms, including the signatures of the facility staff attesting to the accuracy and completion of the records must be maintained in the resident’s clinical record.” Similar language is also found in the guidance for tag F278 on PP-81 [42 CFR 483.20(i)].
- In addition, Appendix R, the Revised Long-Term Care Resident Assessment Instrument User’s Manual, version 2.0, December 2002 with updates through June 2004 on page 1-27, Section 1.18 Reproduction and Maintenance of the Assessments, states “Until such time as CMS adopts an electronic signature standard that is compatible with pending HIPAA requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS.” Current policy found in the RAI Manual states “There is no requirement to maintain two copies of the form in the resident’s record (the hand written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable.”
- However, guidance found in Appendix PP, [42 CFR 483.75(1)(1)], tag F515, Clinical records, references the facility’s “option for an individual’s record to be maintained by computer, rather than a hard copy, electronic signatures are acceptable.” Further guidance provides an example of how the facility may set up a system with safeguards to prevent unauthorized access to an individual’s record maintained by computer.

### **Decision**

Nursing homes may use electronic signatures in a clinical record including the MDS when permitted to do so by state and local law and when this is authorized by the long-term care facility’s policy. As noted above, the guidance language found in Appendix PP, tag 515, Clinical records currently reflects the use of electronic signatures in the clinical record. Facilities must have written policies in place to ensure that they have proper security measures to protect from the use of an electronic signature by anyone other than to which the electronic signature belongs. The policy must also ensure that access to clinical records is made available to surveyors and others who are authorized by law.

Long-term care facilities that are not capable of maintaining an individual's record electronically must adhere to the current requirements that address the need for either a hand written copy or a computer-generated form. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard. In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

For questions regarding this memo, please contact Rosemary Dunn at (410) 786-1372 or e-mail at Rdunn@cms.hhs.gov.

**Effective Date:** October 15, 2004

**Training:** The information contained in this announcement should be shared with all survey and certification staff, their managers, the RO/state training coordinators, and all long-term care providers.

cc: Survey and Certification Regional Office Management (G-5)

/s/

Thomas E. Hamilton

## **INVESTIGATIVE PROTOCOL**

### **MEDICAL DIRECTOR**

#### **Objective**

- *To determine whether the facility has designated a licensed physician to serve as medical director; and*
- *To determine whether the medical director, in collaboration with the facility, coordinates medical care and the implementation of resident care policies.*

#### **Use**

*Use this protocol for all initial and extended surveys or, as indicated, during any other type of survey. Use this protocol if the survey team has identified:*

- *That the facility does not have a licensed physician serving as medical director; and/or*
- *That the facility has designated a licensed physician to serve as medical director; however, concerns or noncompliance identified indicate that:*
  - *The facility has failed to involve the medical director in his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies; and/or*
  - *The medical director may not have performed his/her roles and functions related to coordination of medical care and/or the implementation of resident care policies.*

#### **Procedures**

*The investigation involves interviews, review of pertinent policies and procedures, and may involve additional review of resident care.*

#### **Provision of a Medical Director**

*Determine whether the medical director is available during the survey to respond to surveyor questions about resident care policies, medical care, and physician issues.*

*Interview the facility leadership (e.g., Administrator, Director of Nursing [DON], others as appropriate) about how it has identified and reviewed with the medical director his/her roles and functions as a medical director, including those related to coordination of medical care and the facility's clinical practices and care.*

*prevention and treatment and management of incontinence, pain, fall risk, restraint reduction, and hydration risks) and quality of life.*

### ***Coordination of Medical Care/Physician Leadership***

*If the survey team has identified issues or concerns related to the provision of medical care:*

- *Interview appropriate facility staff and management as well as the medical director to determine what happens when a physician (or other healthcare practitioner) has a pattern of inadequate or inappropriate performance or acts contrary to established rules and procedures of the facility; for example, repeatedly late in making visits, fails to take time to discuss resident problems with staff, does not adequately address or document key medical issues when making resident visits, etc;*
- *If concerns are identified for any of the following physician services, determine how the facility obtained the medical director's input in evaluating and coordinating the provision of medical care:*
  - *Assuring that provisions are in place for physician services 24 hours a day and in case of emergency (§483.40(b));*
  - *Assuring that physicians visit residents, provide medical orders, and review a resident's medical condition as required (§483.40(b)&(c));*
  - *Assuring that other practitioners who may perform physician delegated tasks, act within the regulatory requirements and within their scope of practice as defined by State law (§483.40(e)&(f));*
  - *Clarifying that staff know when to contact the medical director; for example, if an attending or covering physician fails to respond to a facility's request to evaluate or discuss a resident with an acute change of condition;*
  - *Clarifying how the medical director is expected to respond when informed that the staff is having difficulty obtaining needed consultations or other medical services; or*
  - *Addressing other concerns between the attending physician and the facility, such as issues identified on medication regimen review, or the problematic use of restraints.*

*In addition, determine how the facility and medical director assure that physicians are informed of expectations and facility policies, and how the medical director reviews the*

*and a failure of medical direction. Noncompliance for F501 may include (but is not limited to) the facility's failure to:*

- *Designate a licensed physician to serve as medical director; or*
- *Obtain the medical director's input for timely and ongoing development, review and approval of resident care policies;*

*Noncompliance for F501 may also include (but is not limited to) the facility and medical director failure to:*

- *Coordinate and evaluate the medical care within the facility, including the review and evaluation of aspects of physician care and practitioner services;*
- *Identify, evaluate, and address health care issues related to the quality of care and quality of life of residents;*
- *Assure that residents have primary attending and backup physician coverage;*
- *Assure that physician and health care practitioner services reflect current standards of care and are consistent with regulatory requirements;*
- *Address and resolve concerns and issues between the physicians, health care practitioners and facility staff;*
- *Resolve issues related to continuity of care and transfer of medical information between the facility and other care settings;*
- *Review individual resident cases, as warranted, to evaluate quality of care or quality of life concerns or other problematic situations and take appropriate steps to resolve the situation as necessary and as requested;*
- *Review, consider and/or act upon consultant recommendations that affect the facility's resident care policies and procedures or the care of an individual resident, when appropriate;*
- *Discuss and intervene (as appropriate) with the health care practitioner about medical care that is inconsistent with applicable current standards of care; or*
- *Assure that a system exists to monitor the performance and practices of the health care practitioners.*

*This does not presume that a facility's noncompliance with the requirements for the delivery of care necessarily reflects on the performance of the medical director.*

The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.

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**Intent**

- (1) The facility has a licensed physician who serves as medical director to coordinate medical care in the facility and provide clinical guidance and oversight regarding implementation of resident care policies;
- (2) The medical director collaborates with facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice; and

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**Intent, cont.**

- (3) The medical director helps facility identify, evaluate, and address/resolve medical and clinical concerns and issues that affect resident care, medical care, quality of life, and/or are related to provision of services by physicians and other licensed health care practitioners.

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**Investigative Protocol**  
Provision of Medical Director

- Does facility have a medical director?
- Is the medical director available?
- Interview leadership
- Interview medical director

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**Investigative Protocol**  
Provision of Medical Director

If the facility **lacks** a medical director:

- Determine duration and possible reasons
- Identify facility efforts to try to obtain a medical director

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**Investigative Protocol**  
Resident Care Policies

Concerns about the implementation of **resident care policies:**

- Review related policies and procedures
- Interview leadership to determine level of involvement of medical director in developing policies and procedures
- Interview the medical director

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## Determination of Compliance

The facility is in compliance if:

- They have a designated medical director who is a licensed physician; and
- The physician is performing the functions of the position; and
- The medical director provides input and assists the facility to develop, review, and implement care policies; and
- The medical director assists the facility in the coordination of medical care and services.

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## Determination of Compliance Clarification Point

Cite noncompliance for F501 when noncompliance is identified at another tag

- Survey team must demonstrate an association between identified deficiency and failure of medical direction

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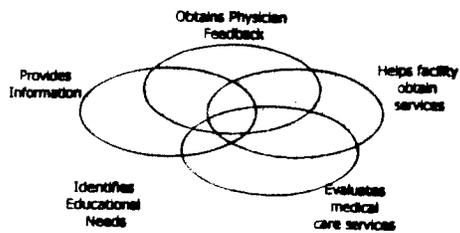
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## Coordination of Medical Care

Areas for medical director input



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# **Oklahoma State Department of Health**

## **Nurse Aide Registry**

# **Statistics**

**Prepared for**

**Long Term Care Advisory Board**

**Wednesday, November 14, 2007**

**Lisa McAlister, BSN, RN  
Director, Nurse Aide Registry**

**For questions regarding:**  
Nurse Aide Registry, call (405) 271-4085

**Oklahoma State Department of Health - Nurse Aide Registry**

**Number of Individuals on the Nurse Aide Registry as of October 30, 2007**  
82,859

**Total Nurse Aide Certifications on the Registry as of October 30, 2007**

| Adult Day Care | Certified Medication Aide | Home Health Aide | Developmental Disability Aide | Long Term Care Aide | Residential Care Aide | CMA GM | CMA IA | CMA RG | Feeding Assistant |
|----------------|---------------------------|------------------|-------------------------------|---------------------|-----------------------|--------|--------|--------|-------------------|
| 193            | 14,431                    | 29,920           | 7,964                         | 73,050              | 963                   | 221    | 203    | 1,164  | 409               |

**Total Certification 128,518\***

**Initial Nurse Aide Certifications by Quarter FY 2008**

| Quarter         | Adult Day Care | Certified Medication Aide | Home Health Aide | Developmental Disability Aide | Long Term Care Aide | Residential Care Aide | CMA GM | CMA IA | CMA RG | Feeding Assistant | Total Certs |
|-----------------|----------------|---------------------------|------------------|-------------------------------|---------------------|-----------------------|--------|--------|--------|-------------------|-------------|
| 1 <sup>st</sup> | 7              | 226                       | 621              | 110                           | 1,587               | 7                     | 32     | 30     | 239    | 61                | 2,920*      |
|                 |                |                           |                  |                               |                     |                       |        |        |        |                   |             |
|                 |                |                           |                  |                               |                     |                       |        |        |        |                   |             |
|                 |                |                           |                  |                               |                     |                       |        |        |        |                   |             |

**Initial Nurse Aide Certifications for FY 2007**

| FY   | Adult Day Care | Certified Medication Aide | Home Health Aide | Developmental Disability Aide | Long Term Care Aide | Residential Care Aide | CMA GM | CMA IA | CMA RG | Feeding Assistant | Total Certs |
|------|----------------|---------------------------|------------------|-------------------------------|---------------------|-----------------------|--------|--------|--------|-------------------|-------------|
| 2007 | 12             | 973                       | 2,865            | 470                           | 6,819               | 51                    | 181    | 166    | 742    | 294               | 12,573*     |

**Initial Nurse Aide Certifications for FY 2006**

| FY   | Adult Day Care | Certified Medication Aide | Home Health Aide | Developmental Disability Aide | Long Term Care Aide | Residential Care Aide | CMA RG | CMA IA | CMA RG | Feeding Assistant | Total Certifications |
|------|----------------|---------------------------|------------------|-------------------------------|---------------------|-----------------------|--------|--------|--------|-------------------|----------------------|
| 2006 | 35             | 1,330                     | 2,995            | 549                           | 6,641               | 70                    | 111    | 19     | 111    | 19                | 11,750*              |

**Initial Nurse Aide Certifications for FY 2005**

| FY      | Adult Day Care | Certified Medication Aide | Home Health Aide | Developmental Disability Aide | Long Term Care Aide | Residential Care Aide | CMA RG | CMA IA | CMA RG | Feeding Assistant | Total Certifications |
|---------|----------------|---------------------------|------------------|-------------------------------|---------------------|-----------------------|--------|--------|--------|-------------------|----------------------|
| FY 2005 | 13             | 1,446                     | 3,272            | 614                           | 6,748               | 38                    | 38     | 38     | 38     | 38                | 12,131*              |

\*Total Nurse Aides certified and added to the registry by the following:

- Trained and tested or tested
- Reciprocity from another state
- Added to registry by waiver
- Deemed to test without training