



LT C Insider Chat

Volume II, Issue I

June, 2011

Inside this issue:

• Informal Dispute Resolution	1-2
• CMS Adopts New Requirements for Nursing Homes That Close	3
• Rising Temperatures – Tips for Resident Safety	4
• Changes to Nursing Home Compare	4
• Long Term Care Provider Training Presenters - 2011	5
• Update ICF/MR Survey and Certification	6
• When Do I Have To Report This?	7
• The Scope of Practice for RN/ LPN - Oklahoma	8-9
• Web Information	10

Are You Having Any Fun Yet?

Dorya Huser, Chief, Long Term Care

No, I am not being flip or sarcastic. I am asking if your place of work is an enjoyable experience. What makes you smile? We all work in a challenging industry and face some of life's most difficult situations. So do policemen, firemen, hospital workers, steel hangers, highway workers, rescue specialists, oil platform workers, coast guard, military personnel, emergency response workers, etc. You get the point. So, now that we all know we are in great company, what is your recruitment and retention plan? What are your personal satisfaction goals? What pumps up your enthusiasm? What did you do today to help residents in your home smile and feel secure you are there? What punched your personal validation ticket today?

So people say you can work at fast food and flip burgers and not have to deal with this. Hey – I'm all over that one – not! I'm betting they have not done that job. Spare me!

You have opportunities every day – both staff in the home and surveyors to make someone's day a little brighter, to ease pain, to let your people know they count, to choose to laugh and find joy and humor in life's experiences. You do important work. You can be creative in your environment and you should!

Do you know what spirited debate is? That is what I call diversity of opinion in my Long Term Care meetings. It is a place that all voices are important and should be heard. It is a place



Life is ten percent what happens to me and ninety percent how I react to it.
– Charles Swindoll

that productive discussion occurs. It is a place where the next comment may change minds or the way we do business. It is a place where problems are identified and solved. It is a place where communication is critical. I like the word "spirited." It means I don't have to agree with everything, but I do have to put something forward that is positive and listen to others and decide to come out on the other side with a better product or decision. It means I have respect for the process and get respect for my efforts. It means change can be good. It means everyone can find ownership in the common goals of the workplace. It means you and your coworkers should be diligent and deliberate in working together maybe using spirited debate to make life good. What does it mean to you?

Are you having any fun yet?

In the Spirit,
Dorya Huser

Informal Dispute Resolution For Skilled Nursing Facilities and Nursing Facilities

James Buck, Assistant Chief, Long Term Care

Federal certification regulation 42 CFR 488.331 and State Operations Manual (SOM) Section 7212, Informal Dispute Resolution, requires the State Survey Agency to offer facility representatives an informal opportunity, at their request, to

dispute survey findings subsequent to the receipt of the official Statement of Deficiencies (SoD).

The purpose of the Informal Dispute Resolution (IDR) process is to give providers an opportunity to refute cited deficiencies after any

survey that has new findings .

• A facility may request an IDR for each survey that cites deficiencies. The following indicates when an IDR may be requested based on the results of a survey, revisit or as a result

...cont'd on page 2

*Continued From Page 1.....***Informal Dispute Resolution**



“Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen.”

– Winston Churchill.”



“Life is not a matter of holding good cards, but sometimes, playing a poor hand well.”

~Jack London

of the previous IDR outcome.

- Facility staff **may** request an IDR for:
 1. Cited deficiencies above the Substantial Compliance level (“A”, “B”, or “C”).
 2. Severity and scope assessments of deficiencies that constitute Substandard Quality of Care or Immediate Jeopardy.
 3. Continuation of same deficiency at revisit.
 4. New deficiency (i.e. new or changed facts, new tags) at revisit or as a result of an IDR.
 5. New example of deficiency (i.e. new facts, same tag) at revisit or as a result of an IDR.
 6. Different tag but same facts at revisit or as a result of an IDR constituting Substandard Quality of Care.

- A facility **may not** request a review of a previous IDR decision.
- Facility staff **may not** use the IDR to:
 1. Delay the formal imposition of remedies.
 2. Challenge alleged inadequacy or inaccuracy of the Informal Dispute Resolution Process.
 3. Challenge any aspect of the survey process, including:
 - A. Severity and scope assessments of the deficiencies with the exception of Substandard Quality of Care or Immediate Jeopardy.
 - B. Alleged failure of the survey team to comply with a requirement of the survey process.
 - C. Alleged inconsistency of survey teams in citing deficiencies among facilities.

The IDR Panel is an informal administrative process and is not to be construed as a formal evidentiary hearing. If the provider chooses to have legal counsel present, counsel

may not address the panel during the presentation.

The IDR Panel lead or designee will convene and moderate the IDR process.

- a) All participants are directed to refer to residents by numeric identifier rather than name to protect privacy.
- b) Facility representatives will present information on a deficiency-by-deficiency basis.
- c) Surveyor staff or designee will be given an opportunity to present information supporting that documented in the CMS 2567L and/or respond to the issues presented by the facility representatives.
- d) Panel members may ask questions throughout the process. Questions from provider representatives or survey staff must be directed to the panel members.
- e) Panel members may request the provision of additional documents, forms, and/or information for review. The provider will be responsible for forwarding one copy to the IDR coordinator.

At the conclusion of the IDR, a report summarizing the IDR conference and documenting the IDR panel members’ recommendations will be provided. The referenced report and written notification of the decision will be sent to the facility administrator within ten business days.

Panel Members Recommendations & Final Outcomes.

1. At the conclusion, the IDR Panel members will review the information presented verbally and in writing for each disputed deficiency and recommend one or more of the following outcomes per disputed deficiency:
 - a) Uphold the deficiency as written.
 - b) Delete the deficiency.
 - c) Modify the deficiency

through one or a combination of the following:

- Delete extraneous or erroneous remarks from the text of the deficiency. No additional information will be added to deficiencies.
- Move a finding(s) to a more appropriate regulatory reference/citation existing in the relevant CMS 2567L.
- Move a finding(s) to a more appropriate regulatory reference (tag), creating a new deficiency, which may result in a determination of Substandard Quality of Care.
- Reduce or increase the severity and scope assignment. After a federal deficiency is deleted or modified by the IDR Panel decision, any associated licensure deficiencies will be reviewed and appropriate changes made.

Facility Staff Responsibilities.

Within ten days of receipt of the revised CMS-2567L, facility staff must prepare, sign, and submit a Plan of Correction (PoC). The facility will receive a new copy of the Form CMS-2567L if there are revisions or changes. This will be the releasable copy only when a new PoC is provided and signed by the facility. The original Form CMS-2567L is disclosable when a new PoC is not submitted and signed by the facility. Any Form CMS-2567L and/or PoC that is revised or changed as a result of the IDR process must be disclosed to the Ombudsman in accordance with §7904 of the SOM.

Deficiencies pending IDR should be entered in the Automated Survey Processing Environment (ASPEN) but will not be posted to the Nursing Home Compare website until the IDR process has been completed.

CMS Adopts New Requirements for Nursing Homes That Close

Jerry Taylor, Enforcement Coordinator

Effective March 23, 2011 The Centers for Medicare and Medicaid Services (CMS) adopted new regulations governing Nursing Facilities (NFs) and Skilled Nursing Facilities (SNFs) that quit business. The new regulations implement Section 6113 of the Affordable Care Act and are intended to protect facility residents, family members and visitors by requiring the facility to provide an organized plan that allows a reasonable time for families and residents to make necessary arrangements when a facility closes. Before you read further, remember this only applies to SNFs and NFs participating in Medicare and Medicaid. It does not apply to Assisted Living Centers, Residential Care Facilities, Adult Day Care Centers or ICF-MR facilities.

Since 1980, the Oklahoma Nursing Home Care Act has had a requirement that a nursing home must provide the Oklahoma State Department of Health (OSDH) notice at least 90 days in advance of closing the facility or any portion of the facility. That state law is not affected by these standards and will remain in effect. However, the new CMS regulations have several provisions that ARE NOT covered by Oklahoma Statutes, including the provision for fines to be levied against individual administrators in amounts up to \$100,000. That certainly got my attention when I read it!

Major provisions of the new regulations are:

- The administrator of the facility must provide written notification prior to impending closure to the Secretary of Health and Human Services. CMS will be designating the State Survey Agency (Oklahoma State Department of Health) to act on the Secretary's behalf. The administrator is also required to notify the State Medicaid Agency (Oklahoma Health Care Authority), the State Long Term Care Ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties regarding the transfer and adequate relocation of the residents specified in the plan for the SNF or NF closure. This is similar to current State requirements, but much more detailed and specific.
- The administrator must give notice 60 days prior to the date of closure; or in the case of a facility where the Secretary or the State Medicaid Agency terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate. Note: State Law still requires a more lengthy notice of ninety (90) days.
- NEW: The facility may not admit any new residents on or after the date on which such written notification is submitted.
- The closure plan shall provide for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.
- The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure.
- When the State Medicaid Agency or CMS terminates a facility's provider agreement, the State Survey Agency will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another facility. Details of how this new requirement will be implemented have not yet been worked out.
- Any individual who is or was the administrator of a facility and fails or failed to comply with the requirements in the rule will be subject to civil monetary penalty (CMP) as follows: A minimum of \$500 for the first offense; a minimum of \$1,500 for the second offense; and a minimum of \$3,000 for the third and subsequent offenses. Note that these are penalties that will be imposed on the individual administrator not the facility.
- An administrator could be subject to higher amounts of CMPs (not to exceed \$100,000 based on criteria that CMS will identify in interpretive guidelines). At the time of publication, these criteria had not been released.

The complete new regulations are published in the Federal Register Vol. 76 No. 34 / February 18, 2011. They are available on-line at <http://www.gpo.gov/fdsys/pkg/FR-2011-02-18/pdf/FR-2011-02-18.pdf>. This will get you into the correct issue of the Federal Register. The new regulations and explanatory background information are on pages 9503 through 9512.

As with all new requirements, the complete implementation has not been worked out and additional guidance will come at some point in the future. I certainly won't pretend to understand them completely, but the regulations are in effect now.

We at the OSDH sincerely hope that none of you ever need to know any of this; we don't like seeing a facility close any more than you do. But the reality is that sometimes things just happen. These new rules affect the procedures that must be in place when that happens and we wanted you to be aware of them.



Do not forget the hands of the aged; they have touched much of life ..."

~ Anonymous



Rising Temperatures – Tips for Resident Safety

**Patty Scott, Director
Enforcement Intake and Incidents**

Frail and/or elderly residents, clients and residents taking certain medication are particularly vulnerable to adverse effects from heat exposure. State rules require nursing and intermediate care facilities for the mentally retarded (ICF/MR) to maintain inside temperatures not to exceed 80 degrees Fahrenheit and require residential care homes to maintain inside temperatures not to exceed 85 degrees Fahrenheit.

If your air conditioning fails or is not cooling adequately, it is important to have it repaired or replaced as soon as possible. Meantime, it is important that you have a plan in place and implement that plan to keep residents comfortable and hydrated in accordance with their medical plans of care.

It is recommended that all long term care facilities monitor and record the daily temperature reading in each hall between 3:30 PM and 5:30 PM, including the resident rooms at the end of the halls. When indoor temperatures rise to above 80 degrees Fahrenheit, as a temporary short-term measure, the air conditioning should be supplemented with fans in the resident rooms and corridors of hallways to provide movement of air for the comfort of the residents. If there is any danger of fire resulting from overload of electrical circuits or to the safety of the residents through the use of room and corridor fans, it will be necessary for the facility to remove residents to other, safer facilities.

Indoor temperatures above 80 degrees Fahrenheit need to be monitored every two hours and measured four or five feet from the floor. When the temperature of any distinct portion of the facility exceeds 85 degrees Fahrenheit, residents in that portion of the facility must be removed to a complying portion of the facility or to other appropriate placement and this agency notified of the action.

If resident(s) are negatively affected by the heat and require treatment, this is reportable to the Oklahoma State Department of Health (OSDH). You will need to include a plan to protect the resident(s). If this occurs in your facility, fax an incident report within twenty (24) hours to the OSDH, at 1-866-239-7553 or (405) 271-4172.

The follow up report must be submitted within five days and will need to include measures that have been taken to correct the problem and to prevent residents from further exposure to excessive temperatures. If the incident has not been fully resolved, a final report is required at the time of resolution. The required incident reporting form can be found online at [http://www.ok.gov/health/Protective Health/Long Term Care Service/Long Term Care Forms/index.html](http://www.ok.gov/health/Protective%20Health/Long%20Term%20Care%20Service/Long%20Term%20Care%20Forms/index.html). This form can be filled out online, printed and faxed to OSDH Long Term Care using the fax numbers mentioned above.

Changes to Nursing Home Compare

James Buck, Assistant Chief, Long Term Care

Did you know that The Centers for Medicare & Medicaid Services (CMS) has made changes to the Nursing Home Compare website?

Section 6103 of the Affordable Care Act requires that a wide variety of new information be posted on Nursing Home Compare at different time intervals. On April 23, 2011, CMS made three changes to Nursing Home Compare. The first change added information to allow consumers to more directly file complaints about nursing homes with State Survey Agencies. These changes included adding links from Nursing Home Compare to State complaint websites and making State phone numbers and fax numbers more prominent on Nursing Home Compare. CMS is also adding a standardized complaint form that consumers can use in cases where they prefer to submit a complaint by fax.

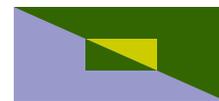
The second change added a more visible consumer rights section that clearly spells out resident and consumer rights and provides more information about courses of action that consumers can take if they feel that their rights are being violated. This section also has information on how to choose a nursing home and the Long-Term Care Ombudsman program.

In July 2011, CMS will make an additional change to Nursing Home Compare to display information for each nursing facility about the number of substantiated complaints received and about the number of enforcement actions (specifically Civil Money Penalties and Denials of Payment for New Admissions) that have been levied.

Finally, in addition to changes mandated by the Affordable Care Act, on April 23, 2011 CMS "froze" quality measure data and the five star quality measure ratings currently on the website for a period of six months. The quality measures displayed on Nursing Home Compare since January 2011 reflect MDS 2.0 data submitted during quarters one, two and three of 2010. Historically, CMS has updated quality measure data each quarter. However, new MDS 3.0- derived quality measure data are not yet available for display, so CMS will retain the current QM scores and star ratings until October 2011. We anticipate that new MDS 3.0 QM data will be available in early 2012.

If you have further questions, please refer to CMS memorandum, S&C: 11-17-NH.

“Turn the Page”
OSDH Long Term Care Provider Training Presenters - 2011
Lisa McAlister, Training Coordinator



Known as the “World’s Cleanest Comedian and Speaker,” Mr. Kent Rader is the opening key note speaker on day one of the Oklahoma State Department of Health (OSDH) Long Term Care Provider Training, “Turn the Page.” Mr. Rader’s presentation is titled “Let It Go, Just Let It Go.” His presentation focus is about teaching his audience how to appreciate and use laughter in reducing stress, which in turn facilitates the development of team building and quality organizations. Mr. Rader authored the stress reduction book also titled “Let It Go, Just Let It Go.” He performs in comedy clubs throughout the United States and was the winner of the 2007 Branson Comedy Festival.

Mr. Amigo Wade is the opening key note speaker on the second day of the OSDH Long Term Care Provider Training. As a Jurist Doctor, Mr. Wade’s presentation addresses “Just the Facts.” Participants will benefit from his presentation by being able to recognize the importance of establishing and following an internal investigation process. Mr. Wade has served as legal counsel to the Senate Committee on General Laws and Technology of the Virginia General Assembly. He also provides legal advice and counsel to members of the House of Delegates and Senate of Virginia. He is a Senior Instructor with the National Certified Investigator Training Program, sponsored by the Council on Licensure and Regulations, and has provided training with the Council since 1992.

“Get Ready” is the focus of Ms. Maria Alexander’s presentation. Ms. Alexander will provide the audience with information for

developing a personal and professional preparedness plan and identifying preparedness issues and local and regional preparedness infrastructure. For over 7 years, Ms. Alexander has served 35 counties and 3 Homeland Security Regions as the Eastern District Coordinator for the OSDH Emergency Preparedness and Response Service.

Mr. Robert Simmons will be presenting on “The Good, the Bad and the Ugly.” At the conclusion of his presentation, the audience will be able to understand and identify the ABC’s of behavior, the functions of behavior, behavioral interventions and ways to increase positive behavior. Mr. Simmons is a Psychological Technician. He assesses behavioral problems in individuals with intellectual disabilities, assists with the development of behavioral interventions and provides staff training for those providing the interventions. **Mr. Simmons provides these services through BPA, PC in Enid, OK.**

A Registered and Licensed Dietitian, Ms. Karen Meyers, who also received a certificate from the American Council on Fitness and is also a certified personal trainer says “Let’s Get Physical.” The objective of her presentation is to relay the benefits of simple exercises for residents, so they will improve or maintain their strength and agility in order to prevent a decline in their abilities. Ms. Meyers owns and has operated NutriFit of Oklahoma, LLC. In addition to her physical training expertise, Ms. Meyers has stayed current in her field by teaching nutrition classes at the university level for over ten years.

The U.S Department of Health and Human Services, Office of Inspector General (OIG) is the usual venue for Mr. Randall House. As a guest speaker and a Special Agent with the OIG, Mr. House will provide very significant and specific information pertaining to “Medicare Fraud.” Of critical importance to federal investigators are the medical and program records. Mr. House will speak to documentation “red flags” as well as address criminal, civil and federal administrative tools used by investigators. He holds a Master’s Degree in Criminal Law and has been a Special Agent for ten years. He also spent fourteen years in law enforcement and was formerly a Criminal Investigator with the State Attorney General’s Office. He is the recipient of numerous awards including HHS “Secretary’s Award for Distinguished Service.”

Mr. Nathan Johns, a Life Safety Code Specialist and Life Safety Code Supervisor with the Oklahoma State Department of Health, will provide information and specific regulatory requirements so that providers “Don’t Burn Down the House.” At the conclusion of his presentation, participants will be able to develop and implement a monitoring program to ensure compliance with Life Safety Code Regulations. Mr. Johns supervises seven LSC surveyors who survey facilities for compliance with Federal regulations. He also tracks survey timeframes to ensure compliance with Federal mandates. In addition, he performs Quality Assurance activities and workload analysis for LSC staff. Nathan recently received a Certificate from the Fire Inspector I Program at the Alabama Fire College.

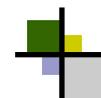


“If I could see further than others, it's because I stood on the shoulders of giants.”
Isaac Newton



Live as if you were to die tomorrow. Learn as if you were to live forever.”
Gandhi

Give me six hours to chop down a tree and I will spend four hours sharpening the ax. Abraham Lincoln (1809-1865)



Update ICF/MR Survey and Certification

Pam Hall, RN

Coordinator of Nursing and Specialized facilities

“Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective.”



“Charity is injurious unless it helps the recipient to become independent of it.”

John D. Rockefeller



Ref: S& C: 11-14-ICF/MR (dated March 18, 2011)

This is an update from The Centers for Medicare and Medicaid Services (CMS) in regard to the clarification of Self-Administration of Medications in the Intermediate Care Facilities for the Mentally Retarded (ICF/MR). This clarification is effective immediately.

Regulations:

- 483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;
- 483.440(d)(1) As soon as the interdisciplinary team has formulated a client’s individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

...Regulatory Requirement for Self Administration Programs:

There is no regulation that requires every client to have a formal, self-administration program for medications. The appropriateness of such a program for a client is determined by the interdisciplinary team in consideration of the comprehensive functional assessment data.

...Regulatory Requirement for Those Clients Not in Self-Administration Programs:

The concept of continuous active treatment at §483.440(d)(1) requires that the facility utilize the time during medication administration by staff as a teaching

opportunity for clients who have formal training programs for the development of skills that are transferrable to the drug administration process.

The regulation at §483.460(k)(4) requires the interdisciplinary team to develop and implement training objectives for individual clients, who have been determined to be appropriate for self administration of their own medications.

Self administration of medication refers to the, *“intentional, independent application or ingestion of over the counter or prescribed medications by an individual without assistance, instruction or direction.”*

The interdisciplinary team would determine, based on comprehensive assessment, whether an individual possessed, or had the potential to develop, the skills necessary to safely self administer medications. The training objectives should be individualized and address the individual clients needs to advance toward their goal of self administration.

The regulation does not require that all individuals in an ICF/MR be engaged in self administration training programs.

1. The interdisciplinary team decision that a self administration program is appropriate and/or not appropriate for a client must be based upon accurate, current, valid assessment of the individual’s skills and potential.
2. The determination as to the appropriateness of a self administration program also must never be based only on the individual’s diagnosis or current functional abilities.

For individuals assessed to be inappropriate for a self administration program, but determined by the interdisciplinary team to possess the capacity to functionally, cognitively, emotionally or developmentally benefit from participation in the drug administration process, it is expected that the facility will provide opportunities for the client to participate in the medication administration process under direct supervision. This participation can include but is not limited to identifying the medication taken, reaching/grasping a cup of water during the process and placing oral medications in the mouth, etc.

During drug passes, the surveyor will observe if clients are being offered the opportunity to participate in the self administration of medications, consistent with their functional skill level. The surveyor will verify that the programs are being carried out consistently and in accordance with the clients written objectives.

If, as a result of observations and interviews, there are any concerns as to why a client is not on a formal program, the surveyor will review the associated assessments and interdisciplinary discussions. During this review, the surveyors will look for evidence that the interdisciplinary team documented a justification as to why the client was not appropriate for a formal self-administration program. The justification provided should be based on an evaluation of the assessment results.

Deficiencies for a failure by the facility to properly assess, to develop written self administration objectives or to carry out the self-administration programs consistently will be cited at 483.460 (k) (4).

When Do I Have To Report This?

Pam Hall, RN, Coordinator of Nursing and Specialized Facilities
Michelle Raney, RN, Coordinator of Nursing and Specialized Facilities



The Centers for Medicare & Medicaid Services (CMS) issued a memorandum (policy) on March 18, 2011 for Intermediate Care Facilities for the Mentally Retarded (ICF/MR's). This policy is intended to clarify tag W 153, 42 CFR § 483.420(d) (2) the regulation pertaining to the reporting of mistreatment, neglect, abuse, and injuries of unknown source.

W153 requires that the facility ensure that all allegations of mistreatment, neglect or abuse, as well as *injuries of unknown source*, are reported *immediately* to the administrator or to other officials in accordance with State law through established procedures.

The memorandum clarifies the definitions for the terms "injury of unknown source," and "immediately". It also clarifies that CMS expects that all allegations will be reported to the administrator of the facility unless he/she is suspected to be a party to, or otherwise involved in, the occurrence.

An injury should be reported as an "injury of unknown source" when:

1. The source of the injury was not witnessed by any person and the source of the injury could not be explained by the client; and
2. The injury raises **suspicion** of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

It is important to note that members of the ICF/MR population are a mobile population and lead active lives. Therefore, they experience normal day-to-day bumps and minor abrasions as they go about their lives. These minor occurrences which are not of serious consequence to the individual and do not present as a suspicious or repetitive injury (as discussed above) should be recorded by the facility staff once they are aware of them and follow-up should be conducted as indicated. For injuries that do not rise to the level of reportable "injuries of unknown source", the facility should follow its policies and procedures for incident recording, investigation, and tracking.

W153 further requires that allegations of mistreatment, neglect or abuse and injuries of unknown source must be, "reported immediately to the administrator or to other officials in accordance with State law, through established procedures". For the purpose of this regulation "**immediately**" means there should be no delay between staff awareness of the allegation and reporting to the administrator or other officials in accordance with State law unless the situation is unstable at the time the allegation comes to the attention of the staff. In this case, reporting should occur as soon as the safety of all clients is assured and all necessary emergency measures have been taken.

This reporting must be done on a 24/7 basis. Conformity with this definition will necessitate that the facility administration have procedures in place to receive reports, even on off-duty hours (e.g., electronic mail, answering machine, voice mail, and fax). It is critical that the administrator, as designated by the Governing Body under 42 CFR § 483.410(a)(2)-(3), be notified of such occurrences as quickly as possible to ensure the safety of all residents. There must also be evidence that the information was received, in a timely manner, by that facility administrator. When the administrator is not on duty, the facility policies and procedures should detail who (either by name or title) will be acting in the administrator's absence. The person(s) acting for the administrator must have the authority to immediately take whatever corrective action is necessary to ensure client health and safety. For example, if an employee is to be removed from client contact pending an investigation, the acting administrator must have the authority to take this action without approval from another official.

CMS expects that such reporting is always made to the administrator of the facility (unless the administrator is suspected to be involved in the mistreatment, neglect or injury) and that the administrator then ensures that the appropriate State officials are notified. In any instance where a staff member is concerned that the administrator of the facility may have been involved in an incident of mistreatment, neglect, abuse or injury, the staff member should follow the facility policy for reporting to the appropriate person above the level of the administrator. The facility should have a written policy that directs the staff in these situations.

We hope this clears up any confusion, but feel free to contact Michelle Raney or Pam Hall with any questions at 405-271-6868.

"Success is not the key to happiness. Happiness is the key to success. If you love what you are doing, you will be successful."

Herman Cain



"There is creative reading as well as creative writing."

Ralph Waldo Emer-



The Scope of Practice for Registered Nurses & Licensed Practical Nurses - Oklahoma

Cindy Fansler, RN

Over the past year, we at the Oklahoma State Department of Health (OSDH) have enjoyed building a working partnership with the Assisted Living Centers, Residential Care Homes and Adult Day Care Centers in our state.

Frequently, centers and homes call or e-mail questions related to the scope of practice for Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) to include roles and responsibilities during the resident assessment process. The following are excerpts from the Oklahoma Nurse Practice Act.

The Act clearly defines the scope of practice for both the RN and the LPN. Additionally, the Act provides guidance to licensed nurses who may be delegating nursing functions to un-licensed personnel by establishing criteria for the delegation of tasks and describes nursing tasks that are inappropriate for delegation.

A complete copy of the Oklahoma Nurse Practice Act may be found on the Oklahoma Board of Nursing's official Website.

The 'Oklahoma Nursing Practice Act effective as of November 1, 2003' documented, "...3. "Registered nursing" means the practice of the full scope of nursing which includes, but is not limited to:

- A. assessing the health status of individuals, families and groups
- B. analyzing assessment data to determine nursing care needs
- C. establishing goals to meet identified health care needs
- D. planning a strategy of care
- E. establishing priorities of nursing intervention to implement the strategy of care

- F. implementing the strategy of care
- G. *delegating such tasks as may be safely performed by others, consistent with educational preparation and that do not conflict with the provisions of the Oklahoma Nursing Practice Act...*

"Licensed practical nursing" means the practice of nursing under the supervision or direction of a registered nurse, licensed physician or dentist. This directed scope of nursing practice includes, but is not limited to:

- A. contributing to the assessment of the health status of individual and groups.
- B. participating in the development and modification of the plan of care.
- C. implementing the appropriate aspects of the plan of care.
- D. *delegating such tasks as may safely be performed by others, consistent with educational preparation and that do not conflict with the Oklahoma Nursing Practice Act..*
- E. providing safe and effective nursing care rendered directly or indirectly..."

The standard of nursing practice set forth in guidelines titled, 'Oklahoma Board of Nursing...Delegation of Nursing Functions to Unlicensed Persons" Revised: 07/25/06...' documented,

I. Purpose:

"To provide guidance to licensed nurses who may be delegating nursing functions to unlicensed personnel by establishing criteria for delegation [of] tasks and for what nursing tasks are inappropriate for delegation.

II. Definitions:

- A. *Delegating means entrusting the performance of selected nursing duties to individuals qualified, competent and legally able to perform such duties.*
- B. *Supervision means providing guidance by a qualified nurse for the accomplishment of the nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing a task or activity.*
- C. *Unlicensed Person means a trained, responsible individual other than a licensed nurse, who functions in a complementary role to the licensed nurse in providing direct client care or carrying out common nursing tasks to a level of competence and safety that meets the objectives of the training.*

III. Policy:

- A. Licensed nurses (Registered Nurse/Practical Nurse) within the scope of their practice are responsible for all nursing care that a client receives under their direction. Assessment of the nursing needs of a client, the plan of nursing actions, implementation of the plan, and evaluation of the plan are essential components of nursing practice. *Unlicensed personnel may be used to complement the licensed nurse in the performance of nursing functions, but such personnel cannot be used as a substitute for the licensed nurse...*



"Unlicensed personnel may be used to complement the licensed nurse in the performance of nursing functions but such personnel cannot be used as a substitute for the licensed nurse.."



"I light my candle from their torches."

~Robert Burton

Cont. from pg. 6... **The Scope of Practice for Registered Nurses & Licensed Practical Nurses—Oklahoma**

C. **The unlicensed person shall have documented competencies necessary for the proper performance of the task on file with the employer. Written procedures shall be made available for the proper performance of each task; and**
5. The licensed nurse shall adequately supervise the performance of the delegated nursing task in accordance with the requirements of supervision as found in 59 O.S. Ss567.1, et seq...

1. Tasks which require nursing assessment, judgment, evaluation and teaching during implementation; such as...

- F. Nursing tasks that may not be delegated by way of example, and not in limitation, the following are nursing tasks that are not within the scope of sound nursing judgment to delegate:
 - a. Nursing physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up.
 - b. Formulation of the plan of nursing care and evaluation of the client's response to the care provided;
 - c. Administration of medications except as authorized by state and/or federal regulations..."

G. Transference of delegated nursing tasks. It is the responsibility of the licensed nurse to assess each client

prior to delegation of a nursing task and determine that the unlicensed person has the competency to perform the nursing task in that client's situation..."

"OKLAHOMA BOARD OF NURSING PATIENT ASSESSMENT GUIDELINES...."

Definitions:

- A. **Nursing Assessment:**
Nursing assessment is defined as "systematic collection of data to determine the patient's health status and to identify any actual or potential health problems..."
- B. **Comprehensive Nursing Assessment by the RN:**
The comprehensive nursing assessment is conducted by a Registered Nurse and is an extensive data collection (initial and ongoing) for clients, families, groups and communities. This data collection addresses anticipated and emergent changes in the client's health status, recognizes alterations from the client's previous condition, synthesizes the biological, psychological and social aspects of the client's condition, evaluates the impact of nursing care; and uses this broad and complete analysis to develop the nursing plan of care, which includes communication and consultation with other health team members...

C. **Focused Assessment by**

the LPN -
A focused assessment is conducted by a Licensed Practical Nurse and is an appraisal of the client's status and situation at hand, which includes initial and ongoing data collection, and deciding who needs to be informed of the information and when to inform...

III. The RN's role in nursing assessment
The Registered Nurse (1) conducts comprehensive data collection, assesses for any anticipated changes in condition or treatment and/or emergent change in status of the client, as an individual, family and/or community; (2) recognizes alterations in the client's condition and compares changes to previous client condition (is the condition new, harmful, life-threatening?); and (3) ***analyzes and synthesizes biological, psychological and social scientific data to determine rationale for nursing care needs of the client...***

IV. The LPN's Role in Nursing Assessment
The Licensed Practice Nurse contributes to assessment of the patient by conducting focused assessment of the client through collecting data, comparing the data collected to the client's previous condition, and determining when, to whom and where to report the data collected..."



"Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work."
 ~Florence Nightingale



***One who works with their hands is a laborer.
 One who works with their hands and mind is a craftsman.
 One who works with their hands, mind, and heart is an artist.
 One who works with their hands, mind, heart, and feet is a NURSE.***
 ~Anonymous

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Introduction to Protective Health Services

The Protective Health Services Program areas provide regulatory oversight of the state’s health care delivery service through a system of inspection, licensure, and/or certification. Several other trades/professions are also licensed.

Protective Health Services’ Mission:

To promote and assess conformance to public health standards, to protect and help ensure quality health and health care for Oklahomans.

Insider Chat: Edited by Donna Bell & Joyce Bittner

LTC Service Provider Training Opportunities

Karen Gray, Training Programs Manager

2011 Provider Training Dates

July 19th & 20th – Long Term Care – Oklahoma City

August 24th – Residential Care – Tulsa

September 14th – Intermediate Care Facilities for Persons with Intellectual Disabilities – Oklahoma City

October 18th – Assisted Living – Oklahoma City

Please note we are moving the Residential Care training to Tulsa for 2011.

Registration for these programs will not open until approximately four weeks prior to the training date. Registration forms will be mailed to each facility type announcing registration is open. Watch our website for registration information as well.

http://www.ok.gov/health/Protective_Health/Long_Term_Care_Service/Long_Term_Care_Meetings_&_Events/index.html

If you have suggestions for topics you would like to have us address at any of the trainings email your suggestions to: ltc@health.ok.gov

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