



Knowledge Update Seminar

What Providers Need to Know to Avoid Complaint Investigations

This free Knowledge Update Seminar, sponsored by the Office of Health Care Quality, is for Owners, Managers, Delegating Nurses, and Staff in Assisted Living facilities.

Registration is required as seating is limited. **Registration closes three days prior to seminar.** Care providers must be registered to attend. Registration is limited to the first 85 individuals.

Registration is limited to 3 care providers per facility. A separate registration form is required for each care provider.

Note: No confirmation will be sent; however, you will be notified if the class is full.

Seminar Information

Date: Wednesday, October 28, 2009

Location : Maryland Psych Research Center (MPRC)

**Spring Grove Hospital Center
55 Wade Avenue**

Catonsville, Maryland 21228

Time: 9:30 AM to 12:00 Noon.

No one will be admitted to the seminar after 10am.

KNOWLEDGE UPDATE SEMINAR REGISTRATION FORM

Name

Title or Position

Organization or Facility

Phone Number

E-mail address (required area) :

Date:

You may return the completed registration form by mail or fax to:

Office of Health Care Quality—Attn: Assisted Living Unit—Knowledge Update Seminar Registration
Bland Bryant Building—Spring Grove Hospital Center—55 Wade Avenue- Catonsville, Maryland 21228

Fax Number: 410-402-8212

Recipe for Success II

- A Provider's Guide to Understanding How to Avoid Complaint Investigations in Your Home
- Presented by: The Office of Health Care Quality's Assisted Living Complaint Unit
- Date: Wednesday, October 28, 2009

Complaint Investigations

- What is our purpose and goal for this presentation?
- How is the complaint unit staffed?
- What is an allegation?
- Who initiates the complaint and is it always valid?
- What happens once the complaint is made against my home?

Complaint Investigations

- What are the most common types of complaints called into our unit-FCC
- Why should you want to avoid complaints made against you home and business
 - Your reputation
 - Litigations and legal actions
 - Sanctions by the State
 - Resident care/rights violations

Abuse and Neglect

- What is abuse: COMAR 10.07.14 the regulations for assisted living defines abuse as physical, sexual, mental, or verbal abuse, or the improper use of physical or chemical restraints or involuntary seclusion.
- Example

Abuse and Neglect

- What is Neglect: COMAR defines neglect as the means of depriving a resident of adequate food, clothing, shelter, supervision, essential medical treatment, or essential rehabilitative therapy
- Example

Abuse and Neglect

- What is the facility's responsibility when the witness or suspect abuse or neglect of a resident?
- Who do you contact?
- What if you are not sure if it is abuse or neglect, what would you do?

Unlicensed Assisted Living Homes

- What is an unlicensed home- a site that has residents living there and the owner has not applied for a license with OHCQ
- How are unlicensed homes reported to OHCQ- various sources
- What happens once OHCQ gets the complaint-surveyor visits the site

Unlicensed Assisted Living Homes

- What happens once the surveor visits the site and verifies that you are running an unlicensed home- Adult Protective Services referral and possible fines from OHCQ. You will be cited.
- Who would you call if you are unsure as to whether you need to apply for a license-OHCQ

Medication Errors and Staff Training Requirements

- How should medications be administered;
 - All staff administering medications who are not health care practitioners should be trained as medication technicians and registered on the Maryland Board of Nursing (MBON) website. This training is good for two years and must be renewed.
 - Five rights must be observed(right resident, drug, dosage, route and right time of day)

Medication Errors and Staff Training Requirements

- Medications should not be administered without proper MD orders (must be reviewed every six months except in the case of antibiotics)
- All residents should have a medication administration record (MAR) and medications should be signed at the time they are administered (not the day after, etc)

Medication Errors and Staff Training Requirements cont.

- If the medication is not signed off on the MAR, it means it was not given and will result in a citation.



Medication Errors and Staff Training cont.

- **Role of the Delegating Nurse (DRN)**
 - Initial assessment on all residents admitted to the facility within 14-days of admission (accept those who are self medicated) to review the resident's medication regimen. The purpose of this review is also to educate the facility staff of medication side effects and special instructions, etc.

**Medication Errors and Staff Training
cont.**

- Pharmacy Review .29I

The assisted living manager must arrange for a licensed pharmacist to conduct on-site review of physician prescriptions and orders and resident records at least every six (6) months for any resident who is receiving nine (9) or more medications, including over the counter and PRN (as needed) medications

**Medication Errors and Staff Training
cont.**

- Ongoing 45 day assessment on all residents medications by unlicensed staff (quarterly for self medicated residents)
- To act as the facility over site/case manager (facility should call the DRN with problems before the MD accept in cases of emergency, call 911)
- To ensure that all staff administering medications are properly trained and capable of administering medications and identifying common side effects of the medications

**Medication Errors and Staff Training
cont.**

- The Assisted Living Manager (ALM) is responsible for documenting the completion of medication training in each staff person's personnel file
- The DRN who does the training is responsible for sending the information to the MBON to be entered on their data base

**Medication Errors and Staff Training
cont.**

– Common Citations in these area:

- Untrained staff administering medications
- Medications not signed off on the MAR
- Improper documentation of MD orders on the MAR
- Medications administered without a MD order
- Resident given wrong dose, wrong time, etc.



Medication Errors cont.

• Common Citations in these areas cont.

- Improper storage of medications
- MD orders not carried out. Example BP, pulse, weight, lab work (PT, PTT) for residents receiving Coumadin
- DRN orders not carried out
- DRN assessments not completed (initial and 45 day)
- Failure to secure a pharmacist to conduct on-site reviews for those residents who need them

**RESIDENT ASSESSMENT: TELL
THE WHOLE STORY; PAINT THE
FULL PICTURE**

"Assessment" means a process by which an individual's medical, cognitive, functional, and psychosocial history and status are evaluated.

–COMAR 10.07.14.02B(8)

TOOLS

- ❖ Resident Assessment Tool:
 - ❖ HCPPFA
 - ❖ ALM Assessment
 - ❖ LOC Scoring Tool

- ❖ Delegating Nurse Assessments

UTILIZING THOSE ASSESSMENTS

Can the assisted living program meet the resident's needs?

- ❖ Determine LOC
- ❖ Identifies the resident's needs

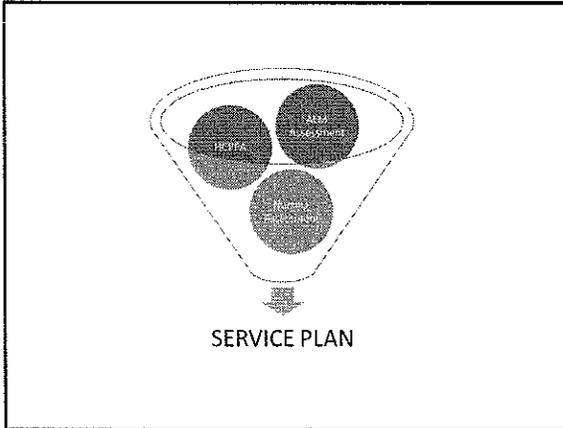
What areas might the ALP need to evaluate to ensure needs can be met?

Problems...

- ❖ Incomplete/missing information on forms
- ❖ Assessments not completed within required timeframes
- ❖ Lack of documentation
- ❖ Lack of follow through
- ❖ Resident's level of care (LOC) changes

SERVICE PLANS

Individualized written plan developed by the licensee that identifies the specific services that the program will provide which is based on the resident assessment.



EXAMPLE

Diagnoses: Diabetes, Hypertension, Dementia

Problems/Needs:

- Fall risk-recent falls, impaired balance, confusion
- Risk for under nutrition
- Risk for dehydration
- Problematic behaviors/cognitive impairment
- Monitoring diabetes
- Monitoring blood pressure
- Cuing/coaching with ADL's

Service Plans.....

- ❖ Individualized for each resident
- ❖ Service plan must be based on assessment completed as per new regulation (.26)
- ❖ Delegating Nurse should be involved in development of plan

Problems

- ❖ Service plans not based on resident assessments and not complete
- ❖ Not individualized- "One size does not fit all"
- ❖ Not reviewed/revised

INCIDENT REPORTS

- ❖ Staff must complete within 24 hours
- ❖ Reports must include:
 - ❖ Time, date, place, and individuals present
 - ❖ Complete description of the incident
 - ❖ Response of staff at the time and
 - ❖ Follow up action, including notification to resident's representatives, and licensing or law enforcement, when appropriate.

Resident Rights and Power of Attorney(POA)

- When do surveyors cite violations of resident rights-When the facility has failed to provide appropriate care and services as specified in the Resident Bill of Rights
- Where are resident rights found in the COMAR regulations-.35
- What should the manager do if they have a question about resident rights; who can they call?-Ombudsman and OHCQ

Resident Rights and Power of Attorney(POA)

- The facility manager must post the current phone numbers of OHCQ, the local Office on Aging and the local Ombudsman in the home
- What is the most common resident rights citation written by surveyors-.35(A)(B) care and services
- Example
- Clarify Advance Directives with residents and their representatives for CPR (cardiopulmonary resuscitation) to ensure wishes are followed.

Resident Rights and Power of Attorney(POA)

- If a family member tells the provider that they have power of attorney over a resident, they should provide you with a copy of the document to be kept in the resident's record
- If a family member who has power of attorney for a resident, request a copy of the resident's record, by law, the manager is obligated to make them a copy; you should not refuse

Resident Specific Waiver, Resident Funds and Resident Agreement

- When should the facility enter into an agreement with a resident-before or at the time of admission after the level of care has been determined
- What should be included in the resident agreement-review COMAR 10.07.14 .24 and 25 for financial and non-financial content

Resident Specific Waiver, Resident Funds and Resident Agreement

- What type of complaints are called into our office about resident agreement and resident funds?
- What is a resident specific waiver and when should a facility request one?
- OHCQ is the only agency who can approve a resident specific waiver

Resident Specific Waiver, Resident Funds and Resident Agreement

- What happens once OHCQ gets the request for a resident specific waiver-nurse surveyor visits
- What happens when you do not request the waiver and the resident care is beyond your level of care-deficiency
- What should the facility have in place for the waiver to be approved-detailed plan of care

Resident Specific Waiver, Resident Funds and Resident Agreement

- What must the facility have in place to manage a resident's funds?
 - A bond, letter of credit or net assets with the State, equal to the average monthly balance of all the funds managed by the manager
 - The bond, letter of credit, and list of assets shall be kept at the assisted living home for inspection by OHCQ surveyors upon request

Resident Specific Waiver, Resident Funds and Resident Agreement

- What is financial exploitation and what can happen if you, the manager is cited by the surveyor?
 - Referral to Adult Protective Services
 - Referral to Local Police Department
 - Referral to the Office of the Attorney General for investigation and possible prosecution

Plan of Correction and Five (5) Day Letter

- What is a plan of correction- a written statement (s) that explains what the provider will do to correct deficiencies written by the surveyor
- Why is it important to return it to OHCQ on time?
- When should it be returned to OHCQ and what happens when you do not return it?

Plan of Correction and Five (5) Day Letter

- How do you write your plan of correction responses?
 - The manager will explain how he/she corrected the deficient practice cited for each resident
 - Explain how they will keep the deficient practice from happening with another resident

Plan of Correction and Five (5) Day Letter

- Cont. for plan of correction
 - Explain how they will keep the deficient practice from reoccurring and who will be responsible to monitor compliance
 - Include a signature and the date each deficiencies will be corrected
 - The written plan of correction must be entered on the State form(767) or it will be returned

Plan of Correction and Five (5) Day Letter

- Unacceptable plans of correction are returned to the manager for correction and can result in a hold on the provider's license
- What is a five (5) day letter and what should you do if you get one-It is a letter that reminds you that you have not returned your plan of correction on time
- Send in your plan of correction as soon as possible

Administrative Staff

- Complaints come from all types of sources: hospital, day care centers, nursing homes, ambulance drivers, fire department, police, lawyers, Office on Aging, Adult Protective Services, but mostly family members and residents
- Once the complaint is called/sent in, it is logged into our data base and therefore must be cleared by a surveyor during an on site visit

Administrative Staff

- Method of getting complaints are
 - Phone calls
 - Letters
 - E-mail
 - Walk ins
 - Faxes
- Public request: Anyone can call our office and request information about your home

Sanctions

- What are sanctions and what happens if you are sanctioned?
 - Directed Plan
 - Decrease in level of care and census
 - Revocation/Denial of License which leads to court hearings and closure of the home
 - Civil Money Penalties or fines (up to \$10,000)
 - Referral to Attorney General which could lead to more fines and possible incarceration

Review

- Familiarize your self with the regulations for Assisted Living COMAR 10.07.14
- Learn important definitions such as abuse, neglect, exploitation and who to call when you suspect it has happened
- Treat residents and their family members with respect and in a dignified manner
- Understand the role of the delegating nurse and utilize her/him when you have questions about resident care and services

Review

- Complete all paperwork relevant to the resident record and maintain on site at the home (resident agreement, assessment, service plan, care notes, incident records)
- Update all staff training including manager and alternate manager and especially medicine technician certification
- If you get cited, return the plan of correction within the specified time frame

Review

- Initiate a resident specific waiver when needed and do not keep a resident in your home who you cannot provide the care and services to keep them safe and healthy
- Do not operate or run an unlicensed assisted living home
- Hire a consultant pharmacist to conduct on site reviews for the residents who need them
- Clarify and enforce Advance Directives for residents
- When in doubt, call us for guidance

Contact Information

- Main Number: 410-402-8217
- Toll Free Number: 1-877-402-8221
- Fax Number: 410-402-8212

- Web Site: www.dhmh.state.md.us/ohcq

Questions and Answers

- What can I do to avoid complaints in my home?



Thank You for coming!!!!
