

Office of Health Care Quality
New Regulation Questions & Answers*
COMAR 10.07.14
April 5, 2011

QUESTION	COMMENT/ANSWER
<p>.02 B DEFINITIONS Resident Assessment Tool-Is the Health Care Practitioner required to include his/her license number on the HCPPAF (Health Care Practitioner’s Physical Assessment form) and Level of Care Scoring Tool?</p>	<p>No. (5/26/09)</p>
<p>.03 INCORPORATED BY REFERENCE Sprinklers- I was unable to locate the regulation referring to sprinkler systems. Could you point out to me the regulation in the new manual?</p>	<p>The requirements for sprinkler systems are incorporated by reference into the AL regulations. Contact your local fire department concerning sprinklers in order to comply with NFPA101. (Refer to .03) (9/17/09)</p>
<p>.05 LEVELS OF CARE G (1) - Is it permissible to offer dementia care if we have enough staffing to meet the residents needs?</p>	<p>Yes, the ALP must have staff with the experience and training to meet the specific conditions of the residents the ALF intends to serve. (Refer .05G and .19A) *Note: If you choose to have an Alzheimer’s special care unit as defined by Regulation .02B (7), you must then comply with the requirement of Regulation .30 Alzheimer’s Special Care Unit. (9/17/09)</p>
<p>.06 RESTRICTIONS D- Can a facility provide care for residents for one day?</p>	<p>Facilities cannot provide day, partial, or hourly adult day care (ADC) services without appropriate Adult Medical Daycare licensure. If a resident has applied for admission or been admitted to the ALP, the resident may transition into the ALF in increments of partial days, not to exceed a 30 day timeframe prior to becoming a resident. (Refer to .06D) Short-term residential care, as defined in .02B, allows a facility to provide short term stays as long as the ALF meets all regulatory requirements. (Refer .21E) (9/17/09)</p>
<p>.08 CHANGES THAT AFFECT OPERATING LICENSE A (2) - If our program is only moving from one location to another but taking the same residents and staff do we need to have a survey?</p>	<p>Yes. Regulation .08A (1) requires the licensee to submit a new application and written request for a new license when there is a change in location. All address changes prompts an on-site survey unless it is relocation due to an emergency event and is of a temporary nature. (5/26/09)</p>

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<p>A (1) - If we wanted to increase the number of our licensed A.L. beds would we be required to go through the C.O.N. (certificate of need) process?</p>	<p>No. If an ALP wants to increase the number of beds they will need to apply to the Department for a bed increase. (Refer .08) (If the Assisted Living Program is located in a Nursing Home then it may have to contact the Health Care Commission for approval.) (9/17/09)</p>
<p>.10 UNIFORM DISCLOSURE STATEMENT (UDS) With the modifications being made to it, will all AL facilities have to redo their forms now? If they do need to redo them, can it be within a specific timeframe - like 6 months or by the end of the year?</p>	<p>Facilities are not required to re-do the UDS form unless the program has changes to the services reported on the UDS form. With changes, the ALP should complete the new UDS form and submit the amended form to OHCQ within 30 days of the change in services. (2/18/09)</p>
<p>.11 INVESTIGATION BY THE DEPARTMENT Does this include staff bedrooms?</p>	<p>Staff bedrooms should only be inspected if the residents have access to them (left unlocked etc.) (1/13/09)</p>
<p>.13 ADMINISTRATION A-Quality Assurance (QA) - Are there going to be sample tools for Quality Assurance (QA) programs available?</p> <p>It is required that the ALM and the delegating nurse meet every 6 months as part of the quality assurance plan. What if the ALM and the delegating nurse is the same person?</p> <p>If the weekly nursing notes, the 45 day review, pharmacy reviews, and the service plan reflect no changes or issues in a resident, does a Quality Assurance (QA) review of that resident need to be done?</p>	<p>Facilities are responsible for developing and implementing their QA programs. Various resources are available that provide information on developing and implementing QA programs which may include: a consultant, the internet, public libraries, and provider organizations. (3/19/09)</p> <p>The regulation sets the minimum standard. If the ALM/delegating nurse is the same individual then that individual is responsible for reviewing the required areas every 6 months and documenting the review as required. The ALM/DN may want to include other involved personnel (i.e. alternate ALM, consultant pharmacist) to participate in the required quality assurance.(5/26/09)</p> <p>The QA process is required for all ALP's every 6 months. Individual resident issues may be included in the QA process if the ALF so chooses however the QA program is based on process analysis. (5/26/09)</p>
<p>.14 STAFFING PLAN C- Awake Overnight Staff- Our ALF already has 24 hour awake overnight staff. Do we still need to do the</p>	<p>Yes, regulations require resident reassessment using the Resident Assessment Tool be completed whenever required; triggers for awake/overnight staffing requirements are</p>

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<p>assessments on each resident?</p> <p>The new evaluation requires that the healthcare professional sign off on the last page of the assessment in order to waive the overnight, awake requirement. However, our two units have overnight, awake staff seven days per week. Is the signature still required if we insert a statement that we have overnight awake staff (i.e. we do not need a waiver)?</p> <p>A- Staff levels-Why are there not regulations that govern patient to caregiver ratios? For example, I have been in facilities where the ratio is 17:1.</p>	<p>only a part of the assessment and if your facility already has awake overnight staff that should be indicated in the appropriate area of the Resident Assessment Tool. (3/19/09)</p> <p>If the ALP has awake, overnight staff seven days per week the health care professional does not have to sign the box. The healthcare professional is only required to document a clinical reason and sign the box if, in the practitioner’s clinical judgment, awake overnight staff is not required even though triggers were identified. (5/26/09)</p> <p>The diversity of ALP’s and AL residents requires each program to develop an individualized staffing plan that meets the needs of its residents. Regulation .14 requires ALP’s to provide sufficient numbers of qualified on-site staff to meet the 24 hour scheduled and unscheduled needs of their residents. Each ALP is required to analyze the number of residents and the individual needs of each resident and based on that analysis develop a staffing plan required to provide the services required.(3/19/09)</p>
<p>.15 ASSISTED LIVING MANAGER (ALM)</p> <p>How many facilities and/or beds can an ALM manage?</p> <p>A1(c)-Qualifications- What is the definition of “health care related field”?</p> <p>Does it matter if experience is full-time or part-time?</p> <p>How is experience verified?</p>	<p>The regulations do not stipulate the number of licensed programs and/or beds an ALM may manage. However, ALM’s will be held responsible for fulfilling all ALM requirements for each facility. (3/19/09)</p> <p>See Transmittal dated 1/14/09 located on the AL website under Transmittals.(1/13/09)</p> <p>Yes. Experience should be full-time. If experience is part-time, the individual should have 4 years of experience. (1/13/09)</p> <p>Resume and/or complete statement on application. The individual needs to affirm that information regarding experience is true and correct. (1/13/09)</p>

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<p>Does a CNA/GNA certification qualify as a health care related field?</p>	<p>Yes. (1/13/09)</p>
<p>A1 (h)-What is acceptable documentation to verify knowledge?</p>	<p>Documentation of successful completion of training or appropriate licensure/certification. Documentation, such as a certificate, needs to indicate the individual successfully completed the course, not just attended the course. (1/13/09)</p>
<p>Can the ALM do assessments since they must have verifiable knowledge in the resident assessment process, and only the registered nurse can assess?</p>	<p>Regulation .21C allows the ALM or designee to collect the information required on the Functional Assessment (ALM Assessment) component of the Resident Assessment Tool. This information is required, along with the Healthcare Practitioner’s Physical Assessment (HCPPA) to determine the resident’s Level of Care and the need for awake, overnight staff. The HCPPA form, part of the Resident Assessment Tool, can only be completed by the healthcare professionals identified on the HCPPA form; one of which can be a registered nurse. Unless the ALM is a licensed professional identified on the HCPPA form then they cannot complete the HCPPA component of the resident assessment. The ALM must have knowledge of the assessment process but unless they are an RN they cannot do a nursing assessment. (9/17/09)</p>
<p>A1 (i)-Initial/Annual Training-When will the current ALM have to complete the updated training required in .15A (1)(i)? (Provided they have not been getting the annual training because the previous regulations only read “have adequate knowledge in..”)</p>	<p>Regulation .15A (1)(i) now requires the ALM to receive initial and annual training in fire and life safety; infection control, including standard precautions; emergency disaster plans; and basic food safety. Documentation to support verifiable knowledge or completion of required training will be required by no later than December 2009. This is separate from the implementation dates for the 20 hour ALM continuing education required under regulation .16. ***Please note, per Regulation .15A(2), an ALM who has Completed the training and passed the examination set forth in .16 shall be presumed to have met the knowledge requirements of Section A (1)(g) & (h). (9/17/09)</p>
<p>If an ALM is approved through OHCQ to teach the initial and annual trainings must the ALM get annual training from an outside source?</p>	<p>Yes. (6/3/10)</p>

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<p>If the ALM meets the criteria on the training grid is the ALM exempt from annual training requirements?</p>	<p>No. (6/3/10)</p>
<p>A1 (h)(iv) Cuing/Coaching- Do AL facilities have to purchase the cuing/coaching tape?</p>	<p>Yes, the ALM is required to have verifiable knowledge in cuing, coaching, and monitoring residents who self-administer medications, with or without assistance. The cuing and coaching training material is approved by the Department and available through the Office of Health Care Quality. (3/19/09)</p>
<p>A1 (j)-CPR/First Aid-When is certification required? Is CPR and Basic First Aid recertification required for all ALM's? If not, when would it be required –if the ALM delivers hands on care?</p>	<p>All ALM's are required to have initial certification in Basic CPR and First Aid. Recertification is required when the ALM is involved in hands on care. (1/13/09)</p>
<p>If the ALM is a nurse will first aid training still be required?</p>	<p>Yes. (5/26/09)</p>
<p>C (2)(a)-Duties-Is there any age limit on obtaining criminal background checks?</p>	<p>Under COMAR 10.07.14.07A (5)(d), a criminal background check or criminal history records check is required of any household/staff member. For persons under the age of 18, there may be instances where some information is confidential. The ALP is required to request whatever information may be made available to it under law. (5/12/09)</p>
<p>C (2)(k)-Notifying OHCQ- Is there a time in which the provider must notify OHCQ of the termination of the delegating nurse contract? What form of notification should be expected? (Phone, fax, mail?)</p>	<p>No, but the time frame should be reasonable. (1/13/09) All forms are acceptable: Phone: 410-402-8217 Fax: 410-402-8212 Mail: Office of Health Care Quality Assisted Living Unit Spring Grove Ctr.-Bland Bryant Bldg. 55 Wade Avenue Catonsville, MD 21228</p>

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<p>C(2)(I)-Report Significant Changes- A.) Do ALM's have to be nurses since the ALM is required to report any significant change in the resident's condition?</p> <p>B.) How can the unlicensed ALM determine what is a significant change in the resident's condition?</p>	<p>A.) Regulations do not require that the ALM be a nurse.</p> <p>B.) .02B(74)(a)(b) defines "Significant change of condition" as a "shift in a resident's health, functional, or psychosocial conditions that either causes an improvement or deterioration in a resident's condition as described in Appendix A of the Resident Assessment Tool". A significant change of condition "does not include any ordinary, day-to-day fluctuations in health status, function, of behavior, or an acute short-term illness, such as a cold, unless these fluctuations continue to recur." The ALM should review the "Understanding and Using the Assisted Living Assessment Tool and Level of Care Scoring Guide" located on the AL website under <u>Forms</u> with particular attention to Appendix A. It is recommended the ALM notify the DRN/CM with any questions regarding a change in resident condition for guidance. (9/17/09)</p>
<p>.16 ALM TRAINING A- Will just the individual named as the assisted living manager have to take the 80 hour course?</p> <p>Is the term "certified AL manager" only going to be given to those that take the course or would someone who is exempt also be able to use the term?</p> <p>B (1) - When people take the 80 hour AL Manager program are they required to take the "staff training?"</p> <ul style="list-style-type: none"> • Fire and Life Safety - use of a fire extinguisher • Basic Food Safety • Infection Control (Standard Precautions) • Emergency Disaster Plans 	<p>The Assisted Living Manager for the ALP is the only individual required to complete the 80 hour ALM course. (9/17/09)</p> <p>There is no designation as "certified AL Manager". AL regulations do not use the word "certified" in relation to the Assisted Living Manager. (5/26/09)</p> <p>When the ALM completes the 80 hour ALM course they will have met the requirements for the above trainings for that year. Annual updates will still be required as per .15A1 (i). The ALM is still expected to complete the required Emergency Preparedness training in addition to the 80 hour course. The only credit the 80 hour course will fulfill is .46E (3). (9/17/09)</p>

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<p>C-Can NHA CEU's satisfy the AL CEU requirement?</p> <p>I am a licensed Nursing Home Administrator and have recently completed 40 hours of CEUs for renewal. Can those CEUs be transferred and fulfill the requirement for the ALF Manager according to the new regulations? If so, do I need to submit those certificates of completion to the office (or to whom)?</p> <p>If the ALM fails to complete the 20 hours continuing Education required within 2 years, does the ALM have to repeat the entire 80 hour ALM course?</p> <p>If the ALM fails to obtain the 20 hours of continuing education within the 2 years, how long does the Department give the ALM to be in compliance with the regulations?</p> <p>E- The exemption for the course states that you have to be employed as a manager in Maryland for one year prior to January 1, 2008. Does this mean the year leading up to January 1, 2008 or any year before January 1, 2008? For example, if I worked as a manager between 2005-2006 but now work in a different capacity for the AL, would I be exempt or would I need to take the course if I wanted to again "be the manager."</p> <p>E- With the AL manager, if the ALM is a nurse, do they</p>	<p>We would encourage a vendor or trainer providing CEU's for NHA's to seek approval with OHCQ for credits to be extended to the AL requirement. The decision would rest in large part upon the subject matter of the training, consistent with .17. (2/5/09)</p> <p>Yes, active MD nursing home administrators (NHA) may utilize their CEU requirement to fulfill the ALM requirement. This is only for Maryland NHA's with an active license. No you do not have to send them. If an ALM has an active NHA license in MD the assumption is that the ALM has completed the 40 hours. Please have verification that you are an active NHA in MD available for the surveyors. NHA with INACTIVE licenses are NOT exempt from the 20 hours for ALM. (9/17/09)</p> <p>No. (12/13/10)</p> <p>The Department recommends ALM's complete the required continuing education in a timely manner. If the education is not obtained, the ALF may be cited as non-compliant with the regulation and the ALF will be required to submit a Plan of Correction (PoC) to correct the deficient practice which is then approved by the Department. (12/13/10)</p> <p>Employment as an Assisted Living Manager (ALM) is not required to be concurrent. (5/26/09)</p> <p>The ALM is required to complete the 80 hour course for all ALF's licensed for 5 or more</p>
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<p>still have to complete the 80 hour trainings? Or if the alternate ALM is a nurse, is this sufficient to satisfy the 80 hour training requirement? Or is this not necessary for the alternate ALM? Does nursing training qualify as training for any of these courses if not all of them?</p>	<p>beds unless exempt regardless of whether they are a licensed nurse. The Alternate ALM is not required to have the 80 hour course. (5/26/09)</p>
<p>E(1)- Does a new ALM have 6 months to meet the 80 hour ALM course based on COMAR .16E(1)?</p>	<p>If the ALP employs an individual to assume the ALM position who does not have the required training, the ALP should be prepared to present documentation the individual hired is enrolled and will complete the ALM Training Course within six (6) months of hire. The ALP should make every effort to have the ALM candidate enrolled in a training course before the candidate assumes the position; otherwise the ALP will have 45 days from the date of hire to enroll the new ALM into a training course.</p> <p>The above is intended for ALP's hiring a candidate after August, 2009 to assume the ALM position that may not have the required training. Current ALM's, whose hire date was after January 1, 2006 should have documentation of successful completion of the ALM training course by August, 2009. (9/17/09)</p>
<p>E-Regulation .16E states the 80 hour training is not required if an individual is licensed as a nursing home administrator in Maryland. Are these individuals still required to show documentation of having CPR, basic first aid, fire/life safety, basic food safety, dementia/Alzheimer's training, etc?</p>	<p>YES. Also, please refer to the additional ALM training information contained on the grid. (6/3/10)</p>
<p>E-If an ALM has been employed in an out-of-state ALP for at least one year prior to January 1, 2008, do they meet the one year of experience to be exempt from the ALM course?</p>	<p>No, the experience must be in Maryland. (6/3/10)</p>
<p>G- If an ALM leaves an AL program, how long does the facility have to get another qualified manager?</p>	<p>For facilities with five (5) or more beds, a person may function temporarily as the ALM for no longer than 45 days. The program may request an extension from the Department if over 45 days. (3/19/09)</p>

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<p>Can an ALP promote someone from within who has the qualifications to be an ALM at a Level of Care Three program if they have not completed the 80 hour course but are signing up to take it? Who can assume the role of ALM in the meantime because the alternate ALM does not have the 80 hour training either and neither employee would be able to obtain the 80 hour course within the 45 days the regulation allows.</p>	<p>COMAR .16E allows an individual to temporarily serve as an ALM for 45 days or less. Whoever assumes the role permanently should have documentation that they are enrolled and will complete the ALM Training Course within six (6) months of assuming the position of ALM. (9/17/09)</p>
<p>.17 ALM TRAINING-BASIC COURSES A8 Alzheimer’s training- If a person takes the 80 hour program and completes the 12 hour Alzheimer’s training are they still required to take the 5 hour Alzheimer’s training and receive a certificate for that as well?</p>	<p>No, if the person has successfully completed the 80 hr. ALM training course, which includes 12 hours of Alzheimer’s training, they will have met the requirement for that year. (9/17/09)</p>
<p>.18 ALTERNATE ALM</p> <p>What is the definition of “health related field”?</p> <p>Does it matter if experience is full-time or part time?</p> <p>How is the experience verified?</p> <p>Will there be Grandfathering for those already in existence?</p>	<p>See Transmittal dated 1/14/09 on AL website in Transmittals.</p> <p>Yes. Experience should be full time. If the experience is part-time, the individual should have 4 years of experience.</p> <p>Resume and/or complete statement on application. The individual needs to affirm that information regarding experience is true and correct.</p> <p>Yes-New licensure requirements will take effect when the new application packet is posted on the OHQC website (after which AALM’s need to meet appropriate requirements.) (1/13/09)</p>

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<p>.19 OTHER STAFF</p> <p>What staff is actually included in “other staff” (e.g. housekeeping, maintenance, etc.)?</p> <p>Contractual Staff- If a family has hired a private duty or sitter for the resident, does that person need a TB test or background check, and do they need to take any of the staff training?</p> <p>Citizenship status-What if a facility has illegal aliens, can they work in assisted living? If employees are here legally, what documents does an ALP have to have from the immigrant to permit them to work?</p> <p>B (1)-Do all employees that work in AL have to be 18?</p> <p>B (3) Criminal background checks- What are the requirements for criminal background checks if the employee lives or has worked out-of-state?</p>	<p>Staff is defined as “supervisors, assistants, aides, or other employees including independent contractors retained by an ALP, to provide the care and services required by this chapter. (Definitions).</p> <p>A private duty contractual person dedicated to an individual resident’s care would be required to have documentation they are free from (a) Tuberculosis, measles, mumps, rubella, and varicella through appropriate screening procedures such as tuberculosis skin tests, positive disease histories, or antibody serology’s. The accepted documentation can include: 1. Physician’s statement or, 2. Positive disease histories (affirmed by employee signature) or, 3. Antibody serologies or titer or, 4. skin tests or, 5. statement of vaccinations (affirmed by employee signature). They also will need a criminal background check/criminal history check. Copies of this documentation should be maintained by the ALP. The private duty staff/sitter should be able to demonstrate competency to provide the required resident care to the delegating nurse. (9/17/09)</p> <p>Illegal aliens are not permitted to work anywhere. All employers are required to have employees complete an I-9 form verifying their legal status to in the country and to work in the country. A link to the I-9 form: http://www.uscis.gov/files/form/i-9.pdf. However, there is nothing in the state regulations that authorizes OHCQ to require an ALP to show surveyors that this documentation is in the program’s files. (9/17/09)</p> <p>Regulation .19B(1) states other staff at a minimum shall be 18 years old or older unless licensed as a nurse or the age requirement is waived by the Department for good cause shown. (5/26/09)</p> <p>The ALP is required to research other states as to criminal backgrounds of employees. Health-General Article, Section 19-1902(d) reads: “If an adult dependent care program requests a private agency to conduct a background check, the private agency shall</p>
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<p>How often does the ALP need to update criminal background checks for employees?</p> <p>B6 Training-Is there a minimum number of training hours? Surveyors have noted documentation which implies that staff received a host of trainings in 8 hours.</p> <p>Can training be obtained within 90 days of hire?</p> <p>Is annual staff training due every 12 months or anytime in the year?</p> <p>GNA/CMA/Licensed Nurses- Are GNA's/CMA's and licensed nurses required to have basic first aid and CPR as well as the 5 hours of dementia/Alzheimer's training?</p>	<p>conduct a background check in each state in which the adult dependent care program knows or has reason to know the eligible employee worked or resided during the past 7 years." An assisted living program is an adult dependent care program. (6/3/10)</p> <p>AL regulations require a criminal background check on employees be completed within 30 days before employment to ensure that there are no behaviors that are potentially harmful to residents. Regulations do not address a requirement for repeating criminal background checks on employees after the initial background check is completed. Remember, the Department holds a facility to minimum standards as prescribed in regulation. However, facilities at their discretion may exercise their rights to exceed these standards for resident safety. (6/3/10)</p> <p>Unless specified in regulation, there is not a minimum number of training hours.</p> <p>Regulations do not stipulate a time frame for initial training. Training should be provided within a reasonable period of time to meet the needs/safety of the residents, as the regulations require trained staff be available at all times to meet the needs of the residents. (2/5/09)</p> <p>Annual training is required at least every 12 months. (2/16/10)</p> <p>YES. Also, please refer to additional training information on the grid under specific areas i.e. First Aid, Other Staff, and Delegating Nurse/Case manager for training requirements. (6/3/10)</p>
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<p>B(6)e First Aid- In regards to staff training for First Aid, is it only staff who provide hands on care that need first aid?</p> <p>I need to clarify the requirement for teaching the First Aid Class for assisted living. If RNs from a facility were taught the course by a certified first aid instructor, would they then be qualified to teach other staff the course required under staff training?</p> <p>B2 (a) TB/MMR-Please clarify the new MMR (measles/mumps/rubella) process. Do we need to have all of our current employees bring in their MMR vaccinations? If they cannot produce this paperwork do they all need to get a titer? For new employees do they need to get a titer if they cannot produce the paperwork?</p> <p>Our facility sometimes pulls employees from other units to work in the AL facility. How are we supposed to monitor those employees's immunity status?</p>	<p>Staff assigned to provide care to meet the specific conditions of the resident(s) the AL program intends to serve shall be required to have First Aid Training. This would typically exclude staff such as housekeepers and maintenance workers <i>who do not provide direct care</i> to meet specific conditions of the residents residing in the facility, assuming there are other staff present to meet direct care needs. (2/5/09)</p> <p>The new regulations require first aid to be taught by a certified first aid instructor. If the RN (or any other employee for that matter) is a certified first aid instructor then they are qualified to teach the course. RN's may not teach the first aid course unless they are certified first aid instructors. (5/26/09)</p> <p>Per regulation, employees, as evidenced by a physician's statement, shall be free from (a) Tuberculosis, measles, mumps, rubella, and varicella through appropriate screening procedures such as tuberculosis skin tests, positive disease histories, or antibody serology's so the "as evidenced by" is:</p> <ol style="list-style-type: none"> 1. Physician's statement or 2. Positive disease histories (affirmed by employee signature) or 3. Antibody serology's or titer 4. Skin tests 5. Statement of vaccinations (affirmed by employee signature). <p>The facility is responsible for determining what their policy will be and what they will accept. The burden is on the provider to ensure employee immunity. Remember, the Department holds a facility to minimum standards as prescribed in regulation. However, facilities at their discretion may exercise their rights to exceed these standards for patient safety. (3/19/09)</p> <p>The facility is responsible for determining what their policy will be and what they will accept. The burden is on the provider to ensure employee immunity. (9/17/09)</p>
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<p>Are these regulations regarding employee immunity, applicable from January 2009, or are they retroactive?</p>	<p>All employees, regardless of hire date, should have documentation of immunity status. (9/17/09)</p>
<p>Household members-Are ALP's required to have documentation household members are free from TB, etc?</p>	<p>The facility should take all precautions necessary to ensure their residents are not exposed to TB and other communicable disease. (9/17/09)</p>
<p>B7- What is acceptable "experience"-how is this validated?</p>	<p>Experience may be in the form of working experience and may be validated on a resume and/or application. (1/13/09)</p>
<p>F- With regard to verification for education and training are both participant and the instructor signatures required as documentation if recorded in an electronic format? Will the OHCQ accept electronic tracking of training and are electronic signatures acceptable?</p>	<p>At minimum, the licensee is required to document and retain the following:</p> <ol style="list-style-type: none"> (1) Date of class; (2) Course content; (3) Documentation of successful completion of the training content; (4) Signatures of the trainer and attendees; and (5) Qualifications and contact information for the trainer. <p>With regard to the signature requirements, an electronic attendance sheet which is readily available and includes all participants' signatures or typed names and the trainer's signature or typed name validating that each participant whose name appears on the electronic attendance sheet has successfully completed the training will suffice. Considering that the attendance sheet is in an electronic format, the trainer must disclose that his/her electronic signature validates the training(s). (5/26/09)</p>
<p>G-Cognitive Impairment Training- If a person was employed in an ALF prior to 2006 are they exempt from the 5 hours of Cognitive impairment training required within 90 days of employment.</p>	<p>If the direct care staff person was working at the ALF prior to 2006, they will only need to have documentation of the required annual updates. If employed after August, 2006, direct care staff should have documentation of initial 5 hour training and any required annual updates. (9/17/09)</p>
<p>I- Are videos still permissible for training and how</p>	<p>Yes, videos still are permissible. When training does not involve direct interaction</p>

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<p>should their use be documented?</p>	<p>between faculty and participant, the ALP shall make available a trained individual to answer questions and respond to issues raised by the training. Documentation shall include: a.) date of the training, b.) signatures of the trainer and attendees, c.) course content (e.g. video), and d.) documentation of successful completion. (2/5/09)</p>
<p>TRAINING GRID Is there a timeframe for updating the training grid?</p> <p>If an ALM has been employed for a minimum of three years in an out-of-state program, does the ALM meet the requirements to permit them to do the trainings identified on the training grid?</p> <p>If the ALM takes the 80 hour course, does that make them exempt from the three years experience to teach the training course on the training grid?</p>	<p>Yes, the training grid was updated 02/18/09: http://dhmh.state.md.us/ohcq/download/training/al_train_req_qualifi_other_staff.pdf (2/5/09)</p> <p>No, the employment must be in Maryland. (6/3/10)</p> <p>No. (4/5/11)</p>
<p>.20 DELEGATING NURSE/CASE MANAGER (DN/CM) Background Checks- Do DN/CM's need background checks?</p> <p>ALM Training- Can a DN/CM give the 20 hours of required training for the ALM?</p> <p>C-Contract Termination-How can OHCQ validate notification of the contract termination? What form of notification should be expected (phone mail, e-mail)?</p>	<p>Yes. (9/17/09)</p> <p>Yes, but only if the DN/CM has been approved by the Office of Health Care Quality to Teach the 20 hours of required ALM training. Please refer to the OHCQ website for information: www.dhmh.state.md.us/ohcq. (6/3/10)</p> <p>A note should be placed in the facility file. All forms are acceptable. Phone: 410-402-8217 Fax: 410-402-8212 Mail: OHCQ/Assisted Living Unit</p>

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<p>Are there time frames?</p> <p>Initial Nursing Assessment- Would you please clarify the time frame that a DN/CM has to do an initial assessment on a new admission?</p> <p>Assessments- What is the difference between the Health Care Practitioner's Physical Assessment (HCPPA) and the Nursing Assessment?</p> <p>Is the DN/CM responsible for completing the full assessment (HCPPA) upon resident's return from the hospital (i.e. 48 hr/7 days) as stated in the regulation?</p>	<p>Spring Grove Center/Bland Bryant Bldg. 55 Wade Avenue Catonsville, MD 21228</p> <p>No, but the time frame should be reasonable. (1/13/09)</p> <p>While the AL regulations do not stipulate a precise time frame for an initial nursing assessment the DN/CM is responsible for a comprehensive nursing assessment to identify resident's needs, to collaborate on the development of a plan to ensure services are implemented, and to determine tasks/care that may need to be delegated and the staff competency to perform delegated tasks. The MBON Nurse Practice Act 10.27.11 and 10.27.09 governs the DN/CM's practice and states that prior to delegation the DN/CM must make an assessment of the resident's nursing care needs BEFORE delegating the task. (Refer to COMAR 10.27.11.03D1&F) (9/17/09)</p> <p>The HCPPA, which is part of the Resident Assessment Tool incorporated by reference into COMAR 10.07.14, is the form AL regulation requires facilities to utilize for resident assessments. The HCPPA form may be completed by an RN, including the DN/CM, but also may be completed by other identified healthcare professionals. The DN/CM for the ALF is responsible for the comprehensive nursing assessment of the resident on discharge from the hospital for readmission to the ALF and any other time the resident has a change in condition. So even if someone other than the DN/CM completed the HCPPA form, the DN/CM would need to assess the resident on re-admission to the facility or when the resident's condition changes. (3/19/09)</p> <p>The resident assessment form (HCPPA) may be completed by an RN, Physician, physician's assistant, CRNP or CRNM therefore any of the healthcare professionals identified in the AL regulations as able to complete the HCPPA may complete the form-HOWEVER, the DN/CM for the ALF would be responsible for assessing the resident on discharge from the hospital for readmission to the ALF and at time of a change in</p>
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<p>Are other health care professionals allowed to complete the HCPPA and the DN/CM is required to ensure the HCPPA was appropriately done by reviewing it and documenting the review (i.e. 48hr. /7days)?</p> <p>Regulatory requirement .26 and .27 requires that the DN/CM complete the full assessment within 48 hours when a resident returns from a non-routine hospitalization or with significant change in condition. I work with an ALF that has RN supervisor coverage at all times. Is it possible for the RN supervisor to assess the resident upon return to the ALF and make the determination on whether or not a full assessment is needed vs. calling the DN/CM at home? i.e.-The RN supervisor vs. the DN/CM would be the nurse to sign in the medical record that a full assessment is not required within 48 hours.</p> <p>Some Delegating Nurse's state that as long as their Nursing Assessment forms have the same information on them as the Health Care Practitioner's Form that they only need to do their Nursing Assessment form and the ALM needs to have the physician or some other health care practitioner do the Health Care</p>	<p>resident condition. If someone other than the DN/CM completed the HCPPA form the DN/CM would still need to assess the resident on re-admission to the facility of with a condition change. (3/19/09)</p> <p>No. The DN/CM may not countersign the HCPPA form. The DN/CM for the ALF is responsible for assessing the resident directly not by reviewing and countersigning the HCPPA completed by someone else. (3/19/09)</p> <p>The RN supervisor can assess the resident upon return to the facility. However, the DN/CM would need to be notified upon the resident's return to the ALF and would need to be notified of the RN supervisor's assessment. The DN/CM would then exercise clinical judgment to determine when the full assessment would be completed. The DN/CM would consider the RN supervisor's assessment, the resident's condition, and the task(s) to be delegated. Only the DN/CM can determine and document when the full assessment is not required within 48 hours.</p> <p>The regulation notes the full assessment shall be completed within 48 hours "but not later than required by nursing practice and the patient's condition" and "When the delegating nurse determines in the nurse's clinical judgment that the resident does not require a full assessment within 48 hours, the delegating nurse shall (a) document the determination and the reasons for the determination in the resident's record; and (b) ensure that a full assessment of the resident is conducted within 7 calendar days." (3/19/09)</p> <p>Services required by residents cannot be based on cost; the Resident Assessment Tool and the comprehensive nursing assessments are required services. The HCPPA which is a part of the Resident Assessment Tool incorporated by reference into COMAR 10.07.14, is required but may be completed by a primary physician, certified nurse practitioner, registered nurse, certified nurse-midwife or physician assistant. Healthcare practitioner's other than the DN/CM can complete the HCPPA. The DN/CM</p>
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<p>Practitioner’s form. If the DN/CM is being asked to do that form instead of their nursing assessment the DN/CM is stating that it is not necessary and if they do have to do it, there would be an additional cost. Since the Health Care Practitioner’s form is needed to be able to do the Level of Care Scoring Tool, this presenting a problem for that ALM who is trying to comply with the regulations.</p>	<p>for the ALF is responsible for the comprehensive nursing assessment of the resident on discharge from the hospital for readmission to the ALF and any other time the resident has a change in condition. So even if some other the DN/CM completed the HCPPA the DN/CM would need to assess the resident on re-admission to the facility or when the resident condition changes. So, if the ALP is contracting with DN/CM to complete the HCPPA in addition to the comprehensive nursing assessments then there may be a fee involved. (5/26/09)</p>
<p>I suppose it is up to the DN/CM and the ALM the procedure they want to implement on who completes the HCPPA form?</p>	<p>While the DN/CM can complete the HCPPA form, other healthcare practitioner’s (primary physician, certified nurse practitioner, registered nurse, certified nurse-midwife or physician assistant) can also complete the tool. The facility should discuss with the DN/CM its expectations regarding who will be responsible for the form’s completion. (5/26/09)</p>
<p>The DN/CM is not obligated to complete the HCPPA form and if this is her policy then is probably should be stated in her contract?</p>	<p>The Department requires in Regulation .20A that the ALP “shall have a current signed agreement with a registered nurse for services of a delegating nurse and delegation of nursing tasks. If the delegating nurse is an employee of the assisted living program, the employee’s job description may satisfy this requirement.” Since DN/CM services may vary based on ALP needs the regulations do not stipulate what specific services are included in the contract; the DN/CM and the ALP should discuss the specific services the DN/CM will provide and include the services in the contract. (5/26/09)</p>
<p>In this case, can the DN/CM refuse to complete the HCPPA form in addition to her nursing assessment? Is so, that would make it potentially difficult for the ALP to get that form done.</p>	<p>The DN/CM is responsible for completing the comprehensive nursing assessment upon the resident’s admission/readmission. (5/26/09)</p>
<p>If the resident is readmitted, the DN/CM should be called and the ALP document that in the notes and then it would be her clinical judgment when to</p>	<p>Yes. (5/26/09)</p>

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<p>reassess the resident?</p> <p>If she is talking about the initial admission to the ALP, then the assessment done within 30 days of admission is the only assessment required. Other assessments would be required if the resident was absent from the facility for any of the stated areas in the regulations?</p> <p>Can the DN/CM refuse to complete a Health Care Practitioner Physical Assessment and if so should that be specified in the DN/CM contract?</p> <p>LPN's-Will there possibly, in the future, be a chance that LPN's that have been in Assisted Living over 5 years be allowed to do delegating nursing or able to teach the medication training class for assisted living?</p> <p>Most ALP's are predominately LPN's or caregivers. Will LPN's ever be included as an integral part in AL?</p> <p>MT Training- I received a call tonight from a delegating nurse stating that there is a COMAR regulation that states the delegating nurse for the facility is the only one allowed to teach the medication technician class and trainings for their facility. I asked her exactly which COMAR regulation this was and she said it was a new COMAR regulation. Is this valid?</p> <p>Training- Are nursing staff required to have the trainings required by other staff?</p>	<p>The Resident Assessment Tool must be completed within 30 days prior to admission as per Regulation .21B for all residents. In addition, the DN/CM must complete an initial comprehensive nursing assessment upon the resident's admission. (5/26/09)</p> <p>Yes. In addition, it is recommended the facility should have a written policy on who will complete all components of the initial Resident Assessment Tool. (9/17/09)</p> <p>No. Only the RN scope of practice permits the RN to delegate nursing functions and to teach the CMT Training Program. (3/19/09)</p> <p>LPN's already are an integral part of many ALP's and function as important parts of the health care team. (3/19/09)</p> <p>The certified Medication Technician (CMT) Training Program was designed so that the RN for the AL facility could teach the MT training program to the people to whom the RN is delegating and supervising medication administration. However, there are NO specific Board of Nursing regulations that require the individual DN/CM of the ALF to do the MT training for the staff of the AL site where the DN/CM is employed. The RN teaching the CMT training must be an individual who is identified on the MBON web page as a Registered Nurse, Case Manager/Delegating Nurse authorized to teach the CMT training program in AL. (5/26/09)</p> <p>Yes, however licensed nurses will be given credit for training in infection control. (5/26/09)</p>
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<p>C (2)- I have a question regarding the DN. The regulation states “the delegating nurse be available on call or have a qualified alternate delegating nurse available on call.” Currently our ALU is based on a hospital campus. We have an RN that supervises the ALU and has taken the delegating nurse class. Her normal hours are Monday thru Friday 7:00 am to 3:30 pm. My question is, is it necessary to have a second nurse that has taken the delegating nurse class to cover her while she is on vacation or off sick? Currently on the off hours, weekends, and holidays the RN manager covers the hospital which would include the ALU, so there is always an RN available for consultation and/or assessment.</p>	<p>Regulation .20C(2) requires the delegating nurse “be available on call as required under this chapter or have a qualified alternate delegating nurse available on call” therefore the alternate delegating nurse should have successfully completed the MBON’s Delegating Nurse course. (5/26/09)</p>
<p>Our DN/CM does not delegate as the staff of the ALU operate under their own licenses (LPN’s doing medications, dressing changes). Is it necessary for us to have the back-up Delegating nurse or should we request a waiver for this?</p>	<p>Regulation .20C identifies the overall responsibilities required by the DN/CM to include managing the clinical oversight of resident care, issuing nursing or clinical orders, and reviewing the ALM’s assessments of residents. The DN/CM 45 day nursing assessment is required when a medication technician is performing a delegated nursing function. Therefore, if the LPN is administering all the medications, a 45 day DN/CM site visit is not required. HOWEVER, because nursing oversight is required under OHCQ regulations a DN/CM is required to be involved in the facility’s care to patients. Nursing oversight is different from Delegation of Nursing functions. .20C also requires the DN/CM to be available on-call as required under this chapter or “have a qualified alternate delegating nurse available on call.” There is no waiver from the Department waiving this regulatory requirement. (9/17/09)</p>
<p>Delegation to MT- Can a CMA/CMT give subcutaneous (SQ) injections or gastrostomy tube (GT) feedings?</p>	<p>The Maryland Board of Nursing’s (MBON) Nurse Practice Act regulates delegation of nursing tasks. The DN/CM must determine if the nursing task can be safely delegated to the CMA/CMT and is responsible for appropriate oversight of the delegated nursing task. If the DN/CM, in his/her clinical judgment, feels SQ or GT feedings can be safely delegated then they can delegate these tasks. Please refer to the MBON Assisted Living</p>

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<p>Can residents in AL have a PRN (as needed) anti-anxiety agent?</p> <p>Adult Medical Daycare (AMDC) RN in AL-Can an AMDC nurse function as the Delegating Nurse/Case Manager in AL?</p> <p>Delegation to a Certified Medicine Aide (CMA) - Does the DN/CM need to follow the same duties required in AL for a CMT when a CMA is working in an AL facility?</p>	<p>Medication Technician Training for further information related to delegation of specialized routes. (6/3/10)</p> <p>The assisted living regulations do not prohibit residents from receiving PRN anti-anxiety medications that are prescribed for the resident and used appropriately. Medications may not be used improperly to restrain a resident; please refer to regulation .37C regarding improper use of chemicals or drugs. If the administration of the PRN medication is delegated to a CMT(certified Medication Technician), the DN/CM should use his/her clinical judgment based on: 1.) the knowledge, skill set, and competency of the staff administering the medication, 2.) the DN/CM's assessment of the individual resident, 3.) the frequency and routineness with which the PRN medication is utilized for the specific resident, and 4.) specific clinical nursing directives provided by the DN/CM to staff administering the medication. Continued evaluation by the DN/CM should occur during the 45 day reviews. (6/3/10)</p> <p>Yes, providing that RN has successfully completed the MBON AL Delegating Nurse/Case Manager (DN/CM) course and meets all the regulatory requirements of COMAR 10.07.14 including having a contract with the AL provider, providing nursing oversight for all residents residing in the AL home, participating in all required quality assurance activities for the facility, performing the initial nursing assessment, making all the necessary 45 day on-site nursing visits, and delegating to and supervising the certified medication technician (CMT), certified nursing assistant (CNA), and unlicensed nursing staff. (4/5/11)</p> <p>Yes. The DN/CM needs to follow the same duties as required with the CMT. It makes no difference whether the individual is a CMT or a CMA, the DN/CM is required to provide all appropriate nursing oversight. The CMA is certified and is not licensed. Regulations apply if "the administration of medications has been delegated to an unlicensed staff person." Therefore all requirements for the DN/CM are the same. (4/5/11)</p>
<p>.21 PREADMISSION REQUIREMENTS B-Resident Assessment Tool-Are the new HCPPA</p>	

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<p>(Healthcare Practitioner Physical Assessment) forms to be used for all move-ins starting February 1, 2009? If we moved someone in after February 1, 2009 but used the regular HCPPA form as opposed to the new one, should we now have those forms re-done?</p>	<p>Yes, AL residents admitted to the facility on or after February 1, 2009 should be assessed utilizing the new HCCPA forms. Refer to the 1/14/09 Transmittal on the AL website. (3/19/09)</p>
<p>On the resident assessment tool, if the healthcare professional completes the healthcare practitioner assessment form, can the ALM complete the ALM guide and level of care scoring tool?</p>	<p>Yes. (5/26/09)</p>
<p>Must this assessment be completed within the 48 hour to 7 day timeframe as well after an admission? It says that review of the assessment occurs after 6 months, but does this mean that if a resident is admitted for a routine matter, as long as the service plan reflects current needs, it may not have to be changed?</p>	<p>The Resident Assessment Tool must be completed within 30 days prior to admission as per Regulation .21B for all residents. Thereafter, for residents that do not have a change in condition as identified in Regulation .26B (Assessment of Condition), a review of the assessment shall be conducted every 6 months. Regulation .26C (3) requires that the service plan is reviewed by staff at least every 6 months and updated if needed. (5/26/09)</p>
<p>The initial Resident Assessment to the ALP is to be done within 30 days of admission. Is this the only assessment required?</p>	<p>The Resident Assessment Tool must be completed within 30 days prior to admission as per Regulation .21B for all residents. In addition, the DRN/CM must complete an initial comprehensive nursing assessment upon the resident's admission per the Nurse Practice Act. In addition other assessments may be required by OHCQ if the resident was absent from the facility for any of the stated areas identified in COMAR 10.07.14.26 & 27. (9/17/09)</p>
<p>C- Functional Assessment- According to the COMAR 10.07.14.21C, the completion of the HCPPA, Functional Assessment of the Resident Assessment, is required to be completed 30 days prior to admission. Would it be possible to consider changing the time frame of this in the revised regulations to 14 days after admission?</p>	<p>NO. (5/26/09)</p>

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<p>E-Short Term Residential Care Requirements- If a family wants to have a resident at an ALF for more than 30 days per calendar year for short term/respite care can the ALP admit the resident as a full admission and then discharge them when the stay is over?</p> <p>Does an ALF have to do the Level of Care (LOC) scoring tool for short term/respite admissions?</p>	<p>Yes. (4/5/11)</p> <p>Yes. (4/5/11)</p>
<p>.22 RESIDENT SPECIFIC LEVEL OF CARE WAIVER Can AL facilities care for HIV/AIDS residents?</p> <p>For the resident specific level of care, it states that a facility can no longer apply for a waiver for residents requiring treatment for an active communicable disease. How does this apply to those residents who have been diagnosed with C-diff, MRSA, or VRE?</p>	<p>Yes. (3/19/09)</p> <p>ALP's may provide care for residents with diagnoses that require standard precautions and/or contact isolation if the facility has the ability, skilled staff, and appropriate nursing oversight. (5/26/09)</p>
<p>.24 RESIDENT AGREEMENTS Must a resident agreement be provided to the resident if the resident's representative doesn't want the resident to have the agreement because it may agitate the resident because of his dementia etc?</p> <p>If the ALP is admitting a resident who has the Medicaid Waiver contract, does the AL also have to have a signed resident agreement?</p>	<p>There may be circumstances, if a resident is incapacitated, for a representative to review and sign the Agreement on behalf of the resident. That representative must, however, have legal authority to act on behalf of the resident, and we would encourage a facility to review the specific facts of the case with the facility's legal counsel. There should be documentation in the resident's record reflecting the representative's authority to act on behalf of the resident with respect to health and financial decisions. (2/5/09)</p> <p>Yes, the AL program will need to have a signed resident agreement that meets the COMAR 10.07.14 section .24 (Resident Agreement-General Requirements and Nonfinancial Content) and .25 (Resident Agreement-Financial Content) regulations.(2/16/10)</p>

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<p>.25 RESIDENT AGREEMENT-FINANCIAL CONTENT Do ALP's need to revise the Resident Agreement for current residents since the regulations have been revised?</p>	<p>As per Regulation .25B, when a resident's needs significantly change and the level of service provided needs to be increased or decreased, the resident agreement shall be amended by the parties to reflect the change in services being provided and any applicable increase or decrease in charges. (5/26/09)</p>
<p>.26 SERVICE PLAN B(2)- Is the "full assessment" that needs to be completed at the identified intervals the Health Care Practitioner Physical Assessment Form (HCPPA), Assisted Living Manager's Assessment, and Level of Scoring Tool?</p> <p>Is the delegating nurse the only one who can complete the full assessment at the indentified intervals?</p> <p>With regards to the resident assessment tool, if the delegating nurse (DRN) is unable to come to the facility, is it sufficient for the nurse on-site to document that the delegating nurse was notified as long as the full assessment is completed within 7 days?</p> <p>With the requirement of the 48 hr assessment being</p>	<p>Yes.</p> <p>No. While it is the Delegating RN's responsibility to ensure the forms are completed, the HCPPA form can be completed by an RN, physician, certified nurse practitioner, certified nurse midwife, or physician's assistant. The ALM's Assessment and Level of Care Scoring Tool can be completed by the ALM or designee. **Please note the Delegating RN is responsible for also complying with the Nurse Practice Act. (1/13/09)</p> <p>The Resident Assessment Tool cannot be completed by an LPN but ANY registered nurse may complete the Resident Assessment Tool therefore the Resident Assessment Tool may be completed by an on-site RN. The DRN is required to complete a comprehensive nursing assessment and would need to be notified of the resident's return or significant change in condition. The DRN would then exercise clinical judgment to determine when the full nursing assessment would be completed. Only the DRN can determine and document when the full assessment is not required within 48 hours. (5/26/09)</p> <p>The facility is responsible for notifying the delegating nurse upon the resident's return</p>

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<p>needed after re-admission, if the resident is admitted on a Friday and the 48 hr ends up on Sunday, will the surveyor determine this is a deficiency if the assessment is not done until Monday, after the 48 hr has expired?</p> <p>If the full Assessment was done within 5 days before the admission, is the full assessment needed again within that 48 hr period?</p> <p>When a resident returns from the hospital with only a medication change, does the entire Health care Practitioner's Physical Assessment (HCPPA), Manager's Assessment, and Scoring Guide need to be completed?</p> <p>B(4)- Is this a review of the HCPPA Form, ALM Assessment, and Level of Care Scoring Tool?</p> <p>What is needed to validate the review?</p>	<p>regardless of the day of the week. The ALP should document in the resident care notes that the DRN was notified. The delegating nurse then will determine, in their clinical judgment, when the assessment will be completed and document their determination in the resident record. Only the DRN can determine and document when the full assessment is not required within 48 hours. (5/26/09)</p> <p>Within 30 days prior to admission, the Resident Assessment Tool must be completed. If the resident has a significant change in condition as documented in Regulation .26B, then another full assessment must be done. (5/26/09)</p> <p>Yes. (5/26/09)</p> <p>Yes.</p> <p>Signature and date (person doing the review needs to be someone eligible to complete the assessment.)(1/13/09)</p>
<p>.27 RESIDENT RECORD/LOG</p> <p>B-Readmission- If a RN sees the resident within 48 hours prior to the return from a prolonged hospitalization or rehab, does that meet the 48 hour timeframe, or does the RN also or still need to do a full assessment after the return, within 48 hours?</p> <p>Can I photocopy parts of the Resident Assessment if there is no change?</p> <p>Do I have to fill out a new Resident Assessment</p>	<p>Per 10.07.14.27(B)(1), the AL delegating nurse in his or her clinical judgment may conclude that the resident does not require a full assessment within 48 hours. In that case, he/she must document that determination and its reasons in the resident's record and ensure that a full assessment is conducted within 7 calendar days. (2/5/09)</p> <p>No (3/19/09)</p> <p>A new Resident Assessment Tool should be completed when a resident reassessment is</p>

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<p>each time or can I add addendums and/or update a form?</p> <p>D (2)-Care Notes- Can you clarify the format the Department will be looking for the chronological weekly care note documentation? Our ALP is using one of the sample forms; this form allows for a month's worth of entries and is chronological on this form. My question is, does this form satisfy the "chronological" regulation for .27 (2), or do we need to incorporate a single form to be in our progress notes, that we may reference as "see attached form," or does everyone need to write in the progress notes to satisfy chronological?</p>	<p>required. The Resident Assessment Tool is not developed as a multi-use tool therefore adding addendums and/or updates on a form already completed should not be a standard practice. (3/19/09)</p> <p>Whatever care note documentation procedure the facility implements should ensure that the care notes communicate care issues to the reader in the chronological order in which the issues occurred. If more than one format is utilized they should be clear, easy to follow, and written in chronological order. (9/17/09)</p>
<p>.29 MEDICATION MANAGEMENT & ADMINISTRATION I -Pharmacy Review-</p> <p>Does a pharmacist have to be licensed in Maryland to act as the consultant pharmacist in an ALF?</p> <p>Does a resident who self administers medications have to have on-site pharmacy reviews if they take 9 or more medications?</p> <p>Is the 6-month pharmacy review required every 6 months for each specific resident or just every 6 months at the facility?</p>	<p>Pharmacists who desire to practice pharmacy in Maryland should contact the Maryland Board of Pharmacy with any licensure/practice questions or issues. Contact information: http://www.dhmf.state.md.us/pharmacyboard/ (2/16/10)</p> <p>YES. (3/19/09)</p> <p>A pharmacy review for each resident who takes 9 or more medications must occur every six (6) months. Facilities may "group" reviews together on the same day to avoid multiple trips by the pharmacist, even if it means some disruption of the six month rule for some residents. (5/26/09)</p>

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<p>Does the pharmacist actually have to do his review on-site at the facility?</p>	<p>Yes. (5/26/09)</p>
<p>Who is responsible for the pharmacist's payment?</p>	<p>The facility needs to determine its' policy/procedure for payment to the pharmacist. (5/26/09)</p>
<p>Where can I obtain a list of consultant pharmacists?</p>	<p>The University of Maryland School of Pharmacy will be hosting a list of consultant pharmacists for AL. The list will be housed at http://geri-ed.umaryland.edu/ and located in the "Med Management" tab section. The anticipated date of availability is July, 2010. (6/3/10)</p>
<p>.29I (2) (a)-(n) - Does the on-site pharmacist need to look at the medications kept in the resident rooms if they self administer medications? Does this mean the pharmacist should be including the medications stored in the resident's room as part of their overall medication review; or is it to be interpreted more literally as the pharmacist should be physically inspecting any medication(s) in a resident's room?</p>	<p>Regulation .29I (2) (a)-(n) addresses the regulatory requirements of the on-site pharmacist review. The intent of the regulation is to have the pharmacist review medication(s) being self-administered as part of the medication regimen review and the pharmacist should look at how all medications, including those maintained by the resident, are stored. If the resident refuses to allow the pharmacist to assess their medications then that should be noted by the pharmacist and no further action is necessary. (12/13/10)</p>
<p>Medication Administration by a pharmacist-Is a pharmacist, who intends to work in an ALP and administer medications, required to take the AL Medication Technician certification program?</p>	<p>Yes. (6/3/10)</p>

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<p>Are licensed pharmacists allowed to administer medications to AL residents? How about pharmacy technicians?</p>	<p>Only if they have successfully completed the MBON MT in AL class, have been certified by the MBON as a CMT(certified Medication Technician), and are under the supervision of a DN/CM. (6/3/10)</p>
<p>L- What will be accepted for OTC (over the counter) medications as far as labeling? What information is required?</p>	<p>The facility must have a current physician's order for OTC medications. The OTC medication must be received at the ALP in the unopened, manufacturers, sealed container. At a minimum, the current physician's order should be entered onto the Medication Administration Record (MAR) and the OTC medication should be identified with the resident's name. The ALP may want to check with their pharmacy; some pharmacies may label the OTC medication if it is purchased from the pharmacy and the physician's order is provided to the pharmacist. (5/21/09)</p>
<p>When physician's make changes to a prescription medication (i.e. change in frequency/dose) the pharmacy will not re-label the medication therefore, the medication container label does not match the MAR. Standard medication administration practice requires staff administering medication to complete a three way check (order/MAR/medication label) to ensure safe administration. What should the facility do?</p>	<p>Standards of Medication Administration, as taught by the Maryland Board of Nursing (MBON), require persons administering medications to verify the medication label, physician's order, and medication administration record match before administering medications therefore, facilities will continue to be required to ensure staff administering medications follow safe medication administration practice. (5/6/09)</p>
<p>L (1) - Regarding residents who are able to self medicate in AL, the regulations reference that all medications must be kept in their original containers. We have residents who would like to put their medications in a weekly pill reminder for convenience. They have their original containers secured in their rooms to reorder their medications, etc., but like the organizer. Can they do this?</p>	<p>No. The regulations require medications to be stored in original containers and do not differentiate between self administration vs. staff administration. Therefore pill reminders do not meet the regulation.</p>

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<p>M- How often do POF (Physician order forms) need to be signed by the prescriber?</p>	<p>COMAR 10.07.14.29M requires “current” signed orders; this will depend on the resident’s frequency of healthcare provider visits/medication adjustments. (2/16/10)</p>
<p>Interim/Emergency medication boxes-Can ALF’s have interim (emergency) medication boxes?</p>	<p>ALF’s may keep an interim medication box with a limited number of emergency medications in conjunction with pharmacy overview. The AL must have licensed staff on site available 24 hours/7 days a week. Only licensed staff can access the interim medication and pharmacy would then refill the box. Certified medication technicians MAY NOT have access to the interim (emergency) medication box or administer emergency medications. (12/13/10)</p>
<p>O-Narcotics/Controlled Medications- Some of the small facilities have live-in staffs that are on-duty 24 hours –when do the drugs have to be counted?</p>	<p>It is facility’s responsibility to ensure the narcotic count is accurate, regardless of the number of shifts. (A sample narcotic count sheet is available on the OHCQ website.) (1/13/09)</p>
<p>Do all controlled substances have to be counted at the end of each shift-Schedules II-V?</p>	<p>Regulation .29 (O)(1) does not limit the specific controlled drugs that need to be counted, however, it does give the example of narcotics. If there is a need to limit the types of drugs, then the regulations would need to be amended. Please note that this language is unchanged from the previous regulations, except that instead of a daily count, the count is at the end of each shift. (2/5/09)</p>
<p>What is the proper procedure when disposing of medications?</p>	<p>ALP’s should contact their pharmacist(s) to determine the appropriate procedure for disposing of medications. The U.S. Food and Drug Administration Webpage (http://www.fda.gov/) also offers information on medications and may be a useful website for ALP’s to consult.</p>
<p>Can a resident who self-administers medications keep controlled medications in their room if they are double locked? What is the facility required to do as far as</p>	<p>Yes, a resident who has been assessed by the facility to have the ability to safely administer medications may keep controlled medications in a secure, double locked container in their room. However, the facility's assessment of such a resident must</p>

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<p>still need to be completed?</p> <p>Leave of Absences- For residents who go on Leave of Absence (LOA), can the facility put their medications in a baggy to be given to them by someone else while on LOA?</p>	<p>The DRN/CM, or other licensed nurse, may place medications for SHORT-TERM Leave of Absences (LOA's) in an individual dose container labeled with the resident's name and instructions for administration according to medical orders. A copy of the medical orders should be sent with the resident and staff should write a care note. It is recommended that LOA's be planned in advance so that pharmacy can dispense LOA medications. (9/17/09)</p>
<p>.31 Incident Reports</p> <p>If a resident does not want the family notified that an incident has occurred and the resident is competent, does the facility have to notify the family?</p>	<p>If a resident is competent and has not designated a health care agent to act on the resident's behalf and has not authorized another person to obtain access to the resident's records, the resident has the sole authority over the release of information regarding the resident's medical condition regardless of the familial status of the person to whom the information would be released. Thus, usually in such a situation a facility would not be obligated to release the information to the family. For such an obligation to exist there would either have to be a court order or a provision in Health-General Article, Title4, Subtitle 3 authorizing the release of information without the resident's consent. (/9/17/09)</p>
<p>.32 Records</p> <p>C (1) - What is required for Changes of Ownerships? Is it expected that all of the resident's files, in their entirety, will be left with the new owner?</p> <p>C (2)-Release of Information- Does the ALP have to have a release from the resident to provide medical information to other healthcare providers? If the resident refused to allow the discharging ALP to release medical information to the new care provider, including the required information in the regulations, can the facility release it to the new ALP? (Regulation .32C(2) states an ALP shall:"release medical records or</p>	<p>The full record (original or copy) should be left for the new owner. (1/13/09)</p> <p>As you have stated, COMAR 10.07.14.32C(2) requires that an ALP release medical records or medical information about a resident only with the consent of the resident or resident's representative, or as permitted by Health General Article, Title 4, Subtitle 3, Annotated Code of Maryland. Unless a provision in the statute authorizes a health care provider to release documents without the consent of the resident, a release must be obtained. One of the provisions authorizing disclosure of medical information without consent is to the health care provider's "authorized employees, agents, medical staff, medical students, or consultants for the sole purpose of offering,</p>

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<p>medical information....only with the consent of the resident or resident's representative, or as permitted by Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland..")</p>	<p>providing, evaluating, or seeking payment for health care to patients or recipients by the provider." Health General Article section 4-305(b) (1) (i). If another health care provider's consultation is sought in the course of treating the resident, the resident's prior consent is not necessary. If the resident is changing health care providers, the resident would have to authorize the disclosure of medical information to that new care provider. (9/17/09)</p>
<p>.34 RESIDENT'S REPRESENTATIVE Can a Group Home/Assisted living provider be the Power of Attorney (POA) for their residents?</p>	<p>The Department does not have knowledge of a legal barrier prohibiting a care provider from being POA, although of course this power should only be used on the resident's behalf. If the POA is attempting to grant health care agent powers to the provider, it must do so in compliance with the Health Care Decisions Act to be valid. Generally, a provider cannot act as a health care agent, although there are limited exceptions. For a financial POA, I do not believe there is any such limitation except that the provider would have a fiduciary duty to the resident. It is recommended that the provider and resident discuss this arrangement with their own legal counsel. (3/19/09)</p>
<p>.35 RESIDENT RIGHTS Are spouses allowed to share a room? Is it permissible to have a male and female who are not related in a semi-private room?</p>	<p>Yes. As with other preferences and quality of life issues, the residents' wishes should be respected as to living arrangements. (1/13/09) Yes, if both parties are consenting adults, competent to make decisions, and without coercion freely choose to occupy the same room. A resident has a right to privacy, which right would include not having a member of the opposite sex as a roommate. Because of this right to privacy, it is important that the facility be very careful that the resident truly does not mind having a roommate of the opposite sex. (9/17/09)</p>
<p>.36 NEGLECT, FINANCIAL EXPLOITATION C&E- Do we have to report incidents that we investigated and determined there was no resident harm if the resident has unexplained bruising/injury and someone reported it to us as possible abuse?</p>	<p>Yes, if the licensee or employee has witnessed, or otherwise has reason to believe, that abuse/neglect/financial exploitation may have occurred they are required to report the alleged incident within 24 hours to 1.) the appropriate local department of social services, Adult Protective Services Program and one or more of the other agencies identified in section .36C (1) (b). The licensee, per section .36D, is required to</p>

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<p>E-Investigation-How should investigation records be kept? (Can they be kept in a separate file from the resident file and for how long should they be maintained?)</p>	<p>thoroughly investigate all allegations and maintain written documentation of the investigation. (2/16/10)</p> <p>Assuming the question is referencing “investigation records” as a result of an incident or abuse/neglect investigation, in general, both incident reports and internal abuse investigation records may be kept separate from the resident record but must be available on-site. Under Maryland law applicable to all health care records, unless the resident is notified that a record will be destroyed, all resident information is required to be maintained for five years. (2/5/09)</p>
<p>.37 RESTRAINTS Under restraints, are they considering Ativan a potential chemical restraint this saying we cannot have an order for PRN Ativan , and that any order for Ativan would have to be renewed every 7 days?</p>	<p>Ativan and other benzodiazepines may be considered a chemical restraint depending on the drug’s intent and effect. If the drug is being used as a chemical restraint, then the order must be renewed every seven days and there may not be an as needed order. (2/5/09)</p>
<p>.38 PROTECTION OF A RESIDENT’S PERSONAL FUNDS H-Fire/Theft- Are ALF’s required to have fire and theft insurance? Regulation .38H stipulates “For all resident funds entrusted to an ALP the ALP shall establish and maintain adequate fire and theft coverage to protect a resident’s funds that are on the premises of the ALP”. Would this be the only time ALP’s are required to maintain fire and theft insurance?</p>	<p>The regulations do not stipulate that the facility carries fire or theft insurance to cover the facility’s losses; that appears to be a business decision left to the judgment of the facility. (9/17/09)</p>
<p>.40 BURIAL ARRANGEMENTS What happens if the provider has requested burial information but the resident still hasn’t made decisions within the 14 day time frame? Can the provider document the communications with the resident and satisfy this requirement?</p>	<p>Yes ...we understand that the provider cannot force this decision, however, the provider should document and make faithful attempts to obtain this information in an effort to comply with this requirement. (2/5/09)</p>
<p>.41 GENERAL PHYSICAL PLANT REQUIREMENTS Swimming Pools -.41A(3)-What are the requirements for ALF’s that want to have swimming pools?</p>	<p>Any ALF that has a swimming pool on the premises, or intends to have a swimming pools available for AL resident use, is expected to meet COMAR 10.07.14.41A(3)</p>

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	<p>requirements ensuring that buildings, common areas, and exterior grounds are kept free of any object, material, or condition that may create a health hazard, accident, or fire. Additionally, the AL facility will be required to meet all applicable requirements of COMAR 10.17.01 (Department of Health and Mental Hygiene Subtitle 17 Sanitation Chapter 01 Public Swimming Pools and Spas) and any local laws and regulations applicable to swimming pools. (12/13/10)</p>
<p>.46 EMERGENCY PREPAREDNESS Training-Who do I contact in my county to get the new emergency disaster training?</p> <p>A-For those AL homes attached to a nursing home, does the State Fire Marshal do the fire inspection, or is it done by the local fire department?</p> <p>If the AL is 6 or more beds, and is not attached to a nursing home, does the state fire marshal do the fire inspection, or is it done by the local fire department?</p> <p>F-Generators-Section 10.07.14.46, Part F, Emergency Generator. Paragraph F1 states that a generator is required by October 1, 2009. It then references Paragraph F7. When you go to paragraph F7 it states that "Within 36 months of the effective date of this chapter, existing programs with 50 or more beds shall complete the installation...." When specifically do ALP's have to have generators installed and working in</p>	<p>It is recommended that the ALP contact the local emergency management personnel and/or the Maryland Emergency Management Administration. (6/3/10)</p> <p>Fire inspections are done by either depending on the jurisdiction; contact the fire department in the jurisdiction where your AL facility is located to determine who will be responsible for the inspection. (2/16/10)</p> <p>Contact the local fire department in your jurisdiction to determine responsibility for the fire inspection. Please check the AL website periodically; Fire/Life Safety Inspections survey lists will be posted on the OHCQ AL website at a future date.(2/16/10)</p> <p>The requirement is effective in October, 2009. The effective date of October 1, 2009 is in the statute (HG19-1812). The 36 month requirement was written in anticipation of the regulation being approved three years ago, which did not happen. The statute's requirement trumps the regulation. Therefore, the effective date is October 1, 2009. (9/17/09)</p>

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<p>an assisted living of more than 50 beds- by Oct.1, 2009 or 36 months from Oct. 1 (or some other date)?</p>	
<p>.49 RESIDENT ROOMS/FURNISHINGS</p> <p>A (1) - Currently we're licensed for 30 beds in 24 rooms; does our license specify which rooms are the semi-privates?</p> <p>A (2)-Is there a requirement that each resident must have a minimum number of square feet in a semi-private room?</p>	<p>The AL license from the Department only identifies the bed capacity; however your floor plan should designate which resident rooms are private vs. semi-private. (9/17/09)</p> <p>No. The total functional square feet for a double occupancy resident room is 120 square feet. (9/17/09)</p>
<p>.52 Heating, Ventilation, and Air Conditioning</p> <p>A-Space Heaters-When are space heaters appropriate?</p>	<p>Space heaters that require liquid fuel may not be used at any time. Electric heaters may be used if UL (Underwriter Laboratory) approved and the heater has an automatic shut off if tipped over. An ALP may not use space heaters unless approved by the State or local fire authorities per regulation .52. (6/3/10)</p>