Basic Orientation Manual

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION

BASIC ORIENTATION TRAINING
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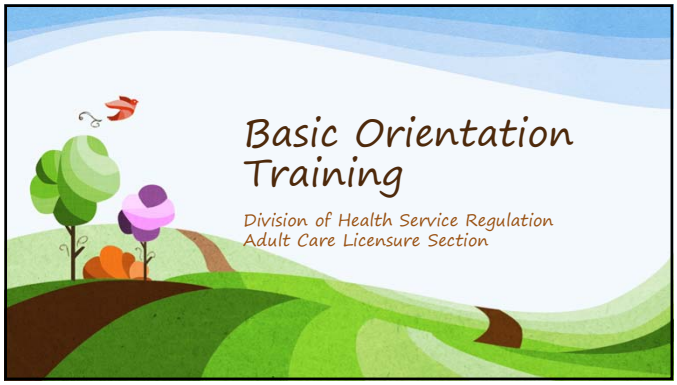
ADULT CARE LICENSURE SECTION

Forms are located behind each Chapter.

Overview



Overview

- Oversight
- DHSR Management
- Mandated Training
- Rules & Statutes
- Communication
- SharePoint

Oversight

- DHSR-ACLS
- Local County DSS
- Ombudsman Program

DHSR	DSS	Ombudsman
Policy Oversight & Training	Consultation & Technical Assistance	Residents' Rights
Licensure & Enforcement	Monitoring	Community Advisory Committee
Multiunit Assisted Housing	Investigations	Complaints

DHSR-ACLS Management

- Raleigh Office
- Main: 919-855-3765
- Fax: 919-733-9379

Megan Lamphere
Section Chief

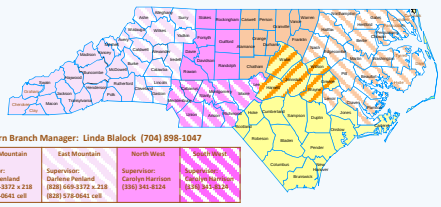
Vancant
Assistant Section Chief

Jan Brickley
Director of Quality Management/Pharmacist

Libby Kinsey
Program Development/Licensure

Karisa Merrill
County Liasion

ADULT CARE LICENSURE REGIONS



Western Branch Manager: Linda Blalock (704) 898-1047

West Mountain	East Mountain	North West	South West
Supervisor: Darlene Penland (828) 669-3372 x 218 (828) 578-0641 cell	Supervisor: Darlene Penland (828) 669-3372 x. 218 (828) 578-0641 cell	Supervisor: Carolyn Harrison (336) 341-8124	Supervisor: Carolyn Harrison (336) 341-8124

Eastern Branch Manager: Marie Rodgers (919) 896-3771

Central	North East	Central East	South East
Supervisor: Vacant (919) 227-6655	Supervisor: Vacant (919) 227-6655	Supervisor: Bridget Rackley (919) 817-4580	Supervisor: Bridget Rackley (919) 817-4580

Regional Offices

DSS Submit Reports

West & East Mountain Regions: (Asheville - Green)
DHSR.DSS.West-East.Mountain@dhhs.nc.gov
North West/South West Regions: (Lexington - Pink)
DHSR.DSS.North-South.West@dhhs.nc.gov
Central/North East Regions: (Raleigh - Blue)
DHSR.DSS.Central.Northeast@dhhs.nc.gov
Central East/South East Regions: (Clinton - Yellow)
DHSR.DSS.Centraleast.Southeast@dhhs.nc.gov

State Mandated Training Requirements

Pre-basic Training
- 8 hours
- Within 60 days of employment

DSS accompany state surveyors on facility inspections.

Basic Training
- 32 hours
- Within 6 months of employment

DSS staff attend 4-day basic training workshop provided by ACLS.

Continued…

Post-basic Training
- 24 hours
- Within 6 months of completing basic training course

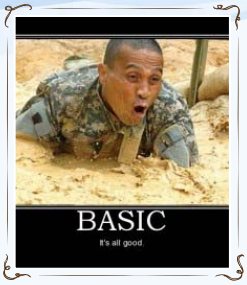
DSS accompany state surveyors on facility inspections.

Complaint Investigation Training
- 8 hours
- Within 6 months of employment

DSS staff attend 2-day complaint training workshop provided by ACLS.

Annual Training
- 16 hours
- Provided by DHSR
  - 1068 Training twice a year

Ongoing training and technical assistance by ACLS staff.



Training Workshops

Basic Orientation

Complaint Investigation

1068 Training

How to Read…

10A NCAC 13G/F

- Title Number (i.e., 10A)
- Chapter Number (i.e., 13)
- Subchapter (i.e., F)
- Section Number(s) (i.e., .0700)

G.S. 131D

- Basis for adult care home rules.
- Some of the laws are referred to in the rules themselves.
- Other laws are included because they add additional requirements
- There are also laws that did not need rules to implement such as smoking prohibition, criminal background checks and drug testing.

Communication

- DHSR.AdultCare.Training@dhhs.nc.gov
  - Training questions, opportunities
- DHSR.AdultCare.Questions@lists.ncmail.net
  - "Anything Adult Care" questions
- DHSR.AdultCare.Star@lists.ncmail.net
  - Star Rating program questions
- DHSR.ACLS.News@lists.ncmail.net
  - ACLS News Listserv

SharePoint

- DSS Resources

https://www2.ncdhhs.gov/dhsr/index.html

State Mandated Training Requirements for County Departments of Social Services (DSS):

The County DSS Adult Home Specialists and Supervisors are required to complete the following training (per G.S. 131D-2.12.):

- 8 hours of pre-basic training within 60 days of employment
  - DSS staff accompany state surveyors on facility inspections (annual, follow-up, and/or complaint investigations)
- 32 hours of basic training within 6 months of employment
  - DSS staff attend 4-day basic training workshop provided by the Adult Care Licensure Section (ACLS)
- 24 hours of post-basic training within 6 months of completing the basic training course
  - DSS staff accompany state surveyors on facility inspections
- 8 hours of complaint investigation training within 6 months of employment
  - DSS staff attend 2-day complaint training workshop provided by ACLS
- 16 hours of statewide training annually by the Division of Health Service Regulation (DHSR)
  - DSS staff attend 1068 training twice per year
  - ACLS staff members provide ongoing training and technical assistance support

Training Workshops:

The ACLS offers the following training workshops at least twice per year. Additional training opportunities will occur as needed and upon request.

- Basic Orientation Training Workshop: This workshop is for new ACLS survey staff, County DSS Adult Home Specialists, and County DSS Supervisors. The primary goal of Basic Orientation Training is to enhance the knowledge and skills of new staff in the inspection and monitoring of adult care homes. Topic areas include: monitoring/inspecting protocol; compliance tools; principals of documentation; medication management; food service; staff competency; health care; personal care; and licensed health professional support.

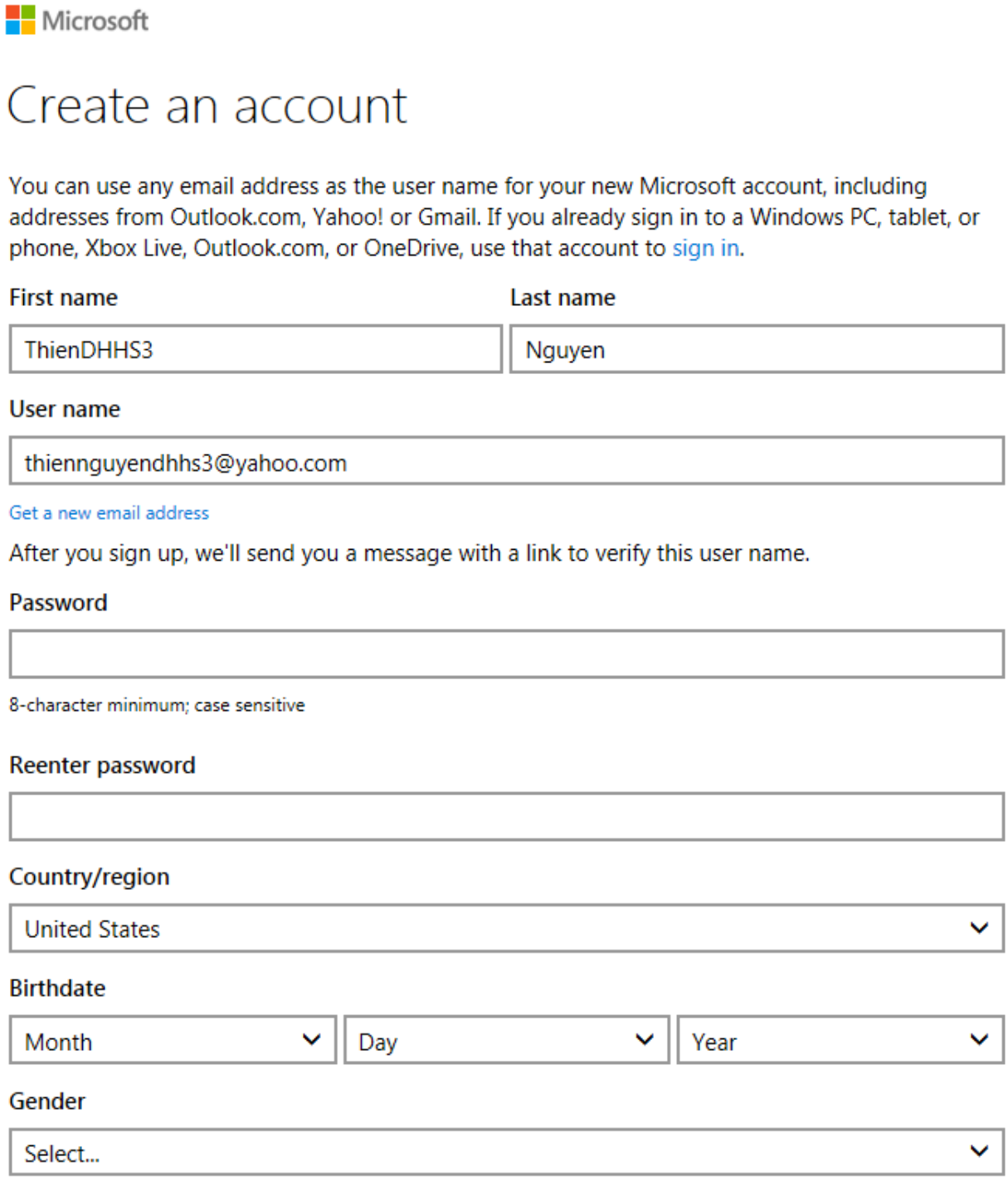
- Complaint Training Workshop: This workshop is for new ACLS staff and County DSS staff. The primary goal of this training is to enhance the knowledge and skills of Adult Home Specialists, Supervisors and ACLS surveyors in investigating rule-based allegations in adult care homes. Topics include: intake and analysis; investigative planning; investigation techniques and procedures; findings analysis; and written documentation.

- 1068 Training: This training is open to currently employed staff of adult care homes and family care homes as well as ACLS staff and County DSS staff who are involved in surveying and/or monitoring adult care homes. 1068 Training is a state-mandated program from House Bill 1068 from the 2001 session of the N.C. General Assembly. The content of the training is based on at least one of the ten deficiencies cited most frequently by the State during the preceding calendar year. The primary goals of this workshop are to increase the level of understanding between providers and regulators and to reduce inconsistencies in the survey process.

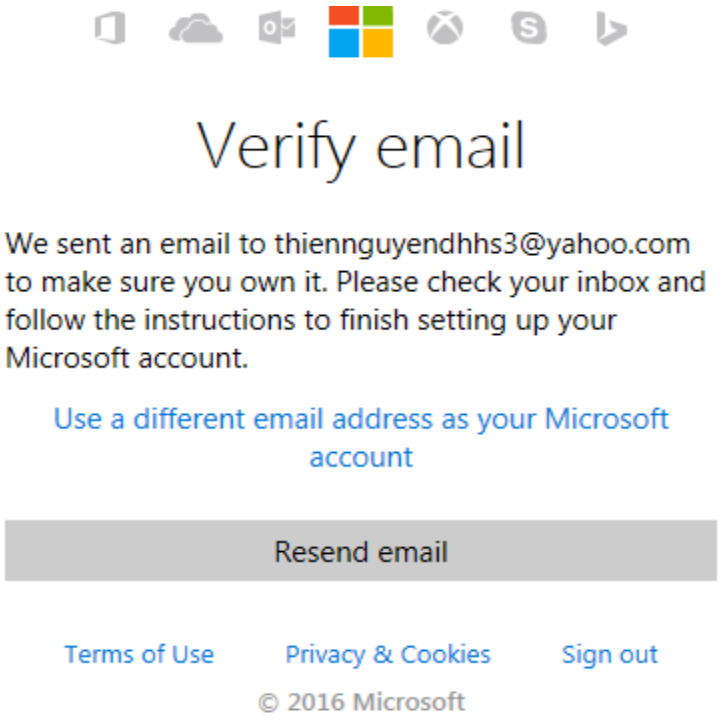
How to create a Microsoft Account

Please carefully follow the below steps in order to avoid problems

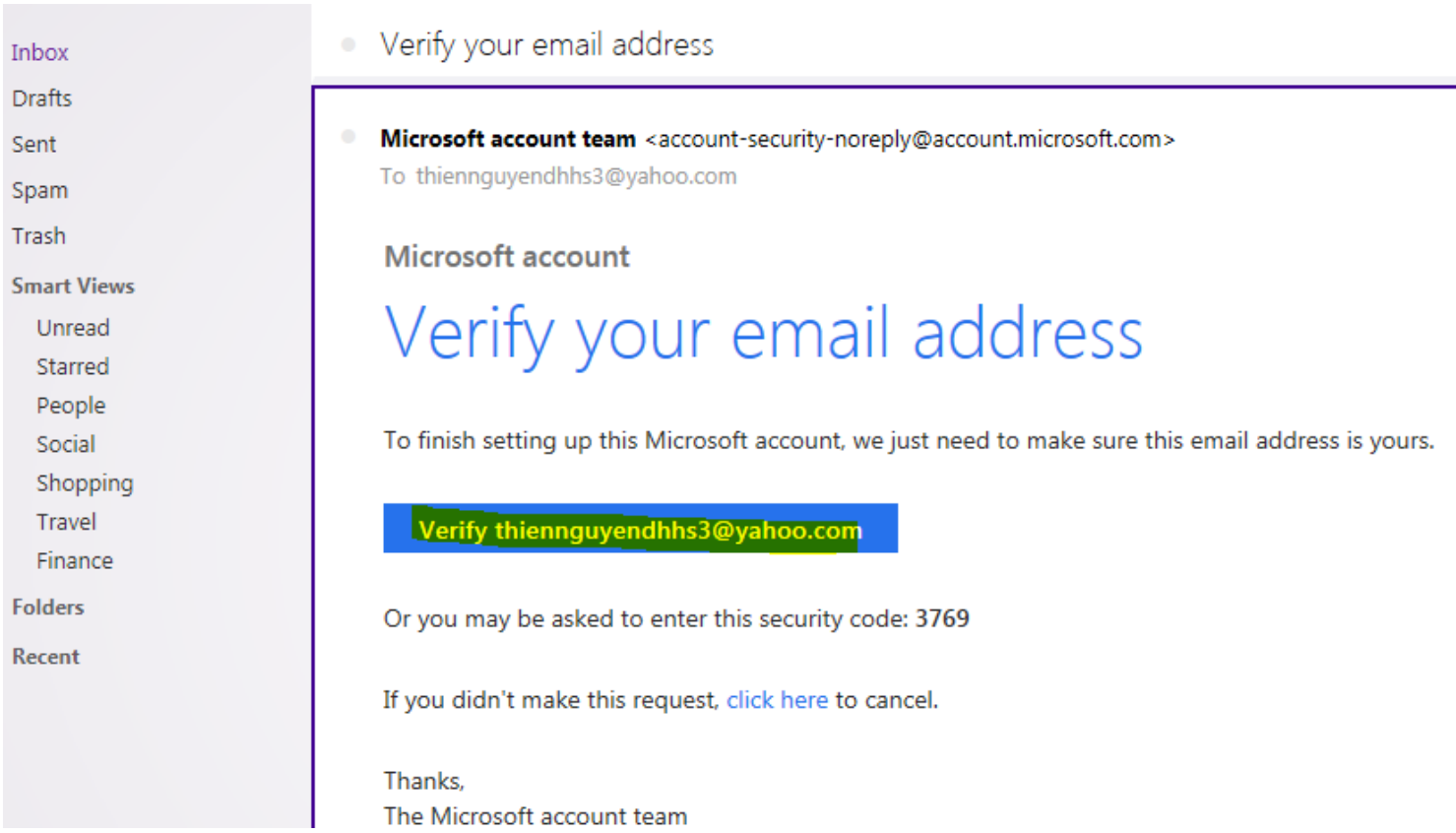
1. Login into your windows login account on your work or home computer. **Do not use someone else's login account to setup your SharePoint access for the first time**.
2. Go to MS Account Signup to register for a Microsoft account. The email address that you use for creating a new Microsoft account must be the same email address that you will provide to the site owner for granting you access to the SharePoint site.



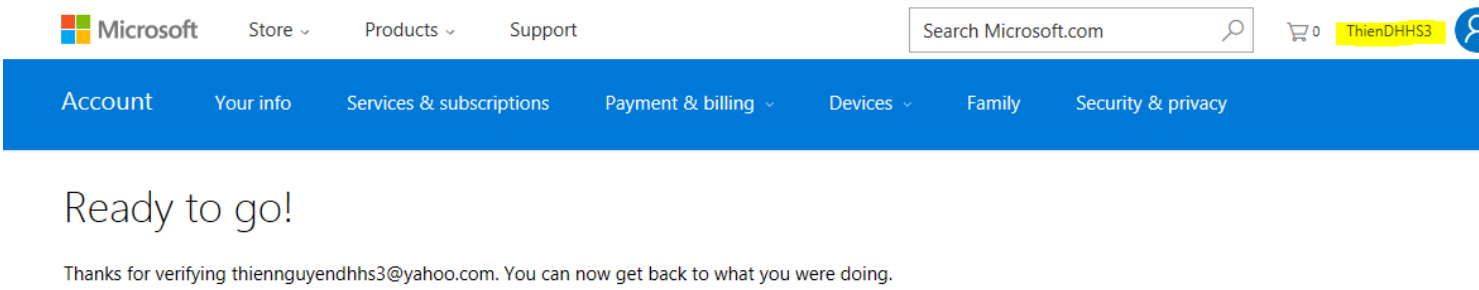
3. After the account is created, you will see this page



4. Login into your email account; go to the verification email and click the Verify button.

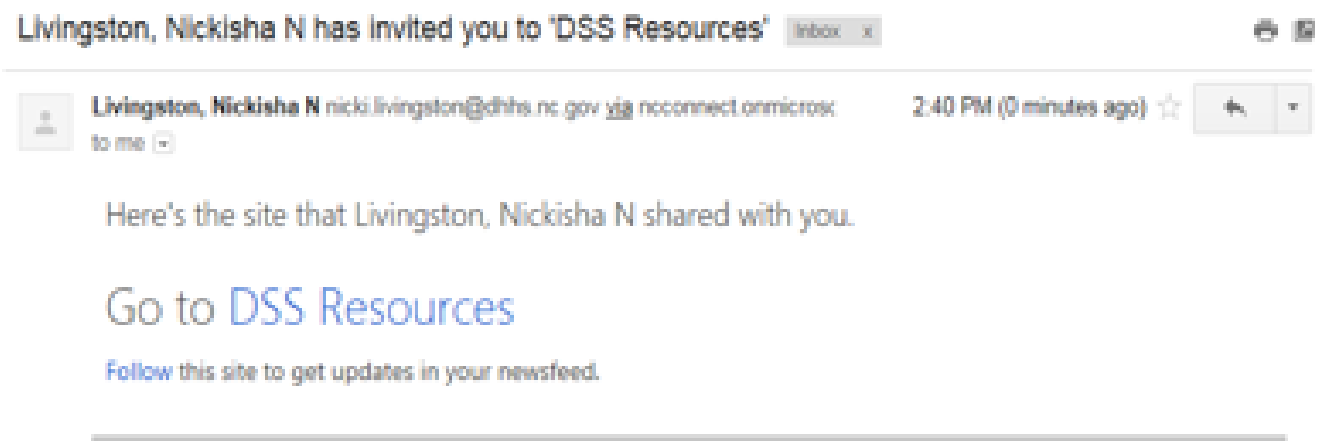


5. Hover over your name (top right) and click on “Signout”.

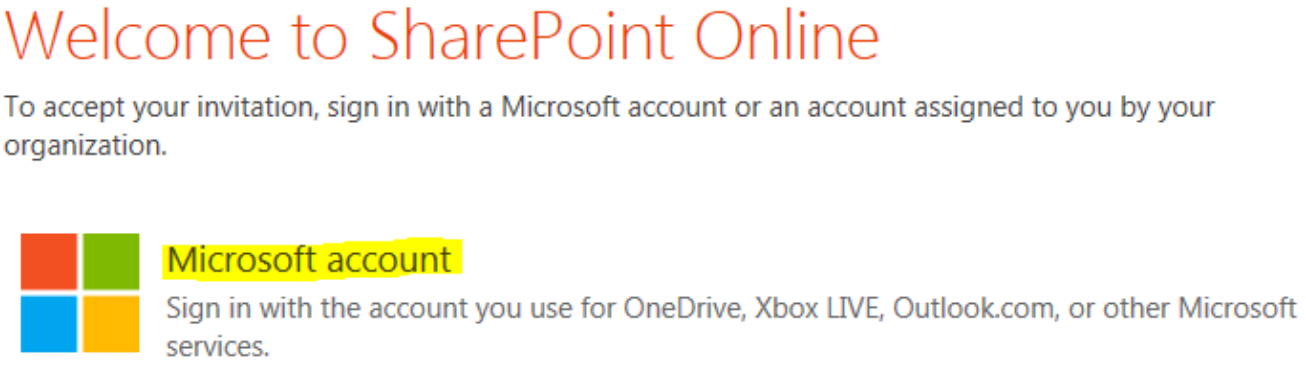


6. **Provide the MS account username that you just created to Debbie Price.** In this example, the MS account username is thiennguyendhhs3@yahoo.com

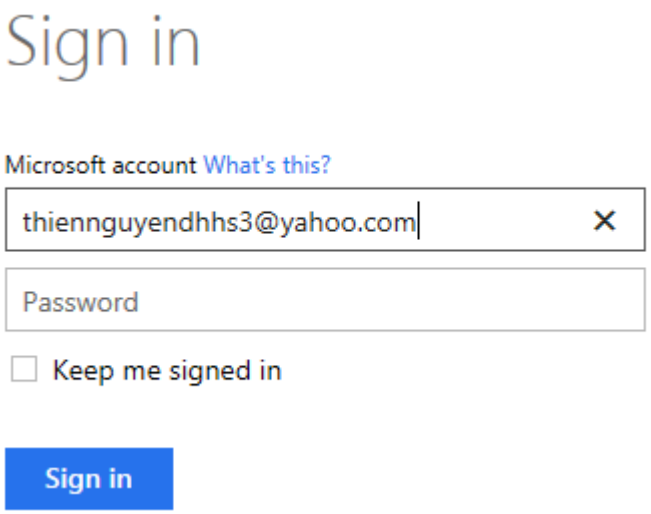
7. After Debbie Price invites you to the SharePoint site, you will receive an invitation through email from Debbie. Click on **DSS Resources** link to access the SharePoint site.



One the welcome page, click on **Microsoft account** only**!**



8. After clicking the Microsoft account link; on the **Sign in** page, you need to enter your MS username, password and then click on “Sign In”.



9. You should now have access to the DSS Resources SharePoint site.

Chapter 1: Monitoring and Inspection Protocol

Monitoring & Inspection Protocol

Division of Health Service Regulation
Adult Care Licensure Section

Goals

The Purpose
Types of Monitoring
General Protocols
The 6 Step Process

Purpose

Rule Compliance

NC Adult Care Home Residents

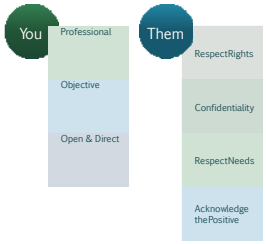
Monitoring Types

- Quarterly
- Complaint Investigations
- Death Investigations
- Follow-Up

Frequency	Complaint Investigations	Death Investigations	Follow-Up
DSS (Quarterly & Routine)	DSS	DSS	DSS
ACLS (Annual)	ACLS	ACLS	ACLS

General Protocols

- Interpersonal Skills
- Planned Visits
- Resident & Staff Interactions



The 6-Step Monitoring Process

Step 1: Plan & Prepare

Monitoring Type:	Plan Based on:
Quarterly (Routine)	Annual Survey Findings
Complaint Investigation	Potential Rule/Rights Non-Compliance
Follow-Up	Previous Rule/Rights Non-Compliance

Step 2: Entrance Conference

- Meet with the Administrator or Designee
  - Explain purpose of visit (rule area)
  - Staff assistance
  - Notice of Exit Conference

Observations, Interviews & Record Reviews

Step 3: Collect & Evaluate Data

Step 4: Pre-Exit Conference Planning

- Monitoring Report?
- Corrective Action Report?
- Do you have a Violation?
- Do you need a Plan of Protection?

Step 5: Exit Conference

Present Findings
No Surprises...

Step 6: Complete Follow-Up

- Provide Monitoring Report
- Provide additional reports within the required time
- Repeat steps for each follow-up visit


Questions
DHSR.AdultCare.Questions@lists.ncmail.net

Chapter 2: Principles of Documentation

Principles of Documentation

Division of Health Service Regulation – Adult Care Licensure Section

Objectives

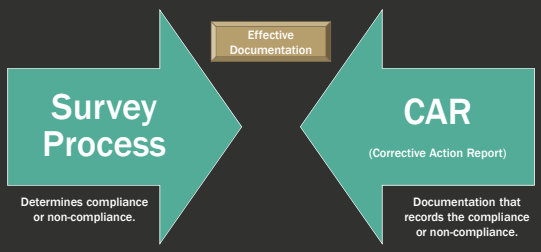
- Understanding the importance of legal aspects of regulatory documentation.
- How to use the principles of documentation to communicate findings.

What is expected of us as Regulators?

Integrity – Our reputations of professional investigators rest on our ability to honest and remain professional in conduct.

Mature Judgment – Our judgment must be guided by known facts and reasonable assumptions based on those facts.

Principles of Documentation



Importance of Effective Documentation

- Cannot rely on memory.
- Allows you to record in detail the 5 W's – Who, What, Where, When & Why.
- Foundation for decision-making.
- Becomes part of subsequent legal proceedings arising from contested decisions.
- Provides the facility with the information needed to correct the problem(s).

3 Sources of Evidence

Observations

Goals:

- Resident-specific information.
- Impact on quality of life.
- Resident and staff interactions.
- How care is provided.

- Who, what, where, when and how questions.
- Information gathered based on input from the senses.
- Be specific.

Interview

Goals:

- Collect information regarding rule compliance.
- Interview information is **verified** through observation and record review.
- Information can be obtained through multiple interview sources.

- Information obtained can support a deficiency.

Record Review

Goals:

- To determine the needs of the resident and if the provider has addressed those needs.
- Identify the record that contained or failed to contain the documentation.

- Review of administrative and clinical documents.
- If documentation is lacking, ask staff if additional documentation is available.

Outcomes

When possible, include the outcomes in the findings.

Include the specific results or consequences of the provider's deficient practice for individual cases.

"Principles of Documentation"

5 Principles

Principle #1

Use Plain Language

I. Write Clearly
- For the reader
- Laymen's terms
- As you speak
- To inform – not impress
- Relevant facts in hronological order
- Keep it short

II. Best Practice:
- Active Voice
- Ensure accuracy of quoted material
- Avoid unnecessary words
- Avoid vague words/phrases
- Use descriptions
- Avoid words that imply

Do or Don't?

	Do	Don't
The dining room was yellow.	✓	
The resident was approached by the personal care aide.		✓
The personal care aide was rude to the resident.		✓
There were brown and green spots, 1 diameter in size along the baseboard of the bathroom.	✓	
The resident had a large ulcer on the ankle.		✓

Principle #2

Components of a Citation

1. Regulatory Reference
2. Statement of Deficient Practice (Practice Statement)
3. Relevant Findings

Regulatory Reference

Composed of:

- 10A NCAC 13 F/G
- General Statute
- Explicit statement that the requirement was "NOT MET" *(Practice Statement)*

The language of the regulation:

- What does it say?
- What does it require?
- What piece of the regulation did the provider violate?

Example:

10A NCAC 13F .1210 RECORD OF STAFF QUALIFICATIONS

An adult care home shall maintain records of staff qualifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities.

Determining the Deficiency, Scope & Severity

Concern vs Deficiency

- Concern = scope and/or severity not present
  Document on a Monitoring Report
- Deficiency = scope and/or severity is present
  Document on a Corrective Action Report (CAR)
  A failure to comply with licensure rule/law.

Scope & Severity

- Scope = number of residents potentially or actually affected
- Severity = the effect on resident outcomes
- *The total number of residents affected by the failed practice.*

Statement of Deficient Practice

- A summary of the problem.
- Source: Observation, Interview, Record Review
- Identifies Scope & Severity
- Includes what provider did or did not do to cause the non-compliance.
- Specific actions, errors or lack of action.
- Outcome (when possible)
- Identifiers of individuals

Extent of the deficient practice (#of deficient cases relative to total in the sample)

Census	Sample
0-30	3
31-80	5
81 and greater	7

Example of a Deficient Practice Statement

Based on observations, interviews and record reviews, the facility failed to ensure licensed health professional support reviews were completed for 3 of 5 residents (#1, #3 and #5) requiring insulin administration.

Relevant Findings…What to include?

- How – source of evidence.
- What – the facility failed to do.
- What – was the impact on the resident?
- Who – were the staff or resident(s) involved?
- Where – it occurred.
- When – the problem occurred and how long it lasted.

Regulatory Reference

Statement of Deficient Practice (Practice Statement)

Relevant Findings

Complete Example

1. Regulatory Reference

10A NCAC 13F .0902(b) Health Care

(b) The facility shall assure referral and follow up to meet the routine and acute health care needs of residents.

2. Statement of Deficient Practice
(Practice Statement)

Based on observations, interviews and record reviews, the facility failed to assure follow up appointments for daily radiation treatments for 1 of 1 (#1) residents where the physician stated the resident is at risk for anticipated death and harm.

3. Relevant Findings

The findings are:

Review of Resident #1's current FL-2 dated 6/1/16 revealed: Resident is intermittently disoriented with diagnosis of Alzheimer's Dementia and Prostate Cancer w/Mets.

Review of Resident #1's record on 8/4/16 at 2:30pm revealed:
- A Physician's report dated 7/6/16, stating Resident #1 was simulated for Radiation Therapy to Prostate and will be scheduled for 39 Radiation Therapy Visits.
- A note dated 7/25/16 from Residents' Physician about Resident #1 was not going to his radiation treatments.

Interview with Administrator on 8/3/16 at 3:15pm revealed: Administrator was not sure if family had taken Resident #1 out of facility for his 2:30pm Radiation appointment.

Findings Continued...

Interview with Resident #1 on 8/3/16 at 3:25pm revealed:
- Resident #1 was lying in bed.
- The resident said he had not had any visitors today.
- The resident didn't know if he had an appointment or who takes him to appointments.

Telephone interview with hospital staff on 8/3/16 at 3:50pm revealed:
- Resident #1 had missed four Radiation Treatments.
- Resident #1's ongoing failure to get scheduled Radiation Treatments may cause the tumor to get larger and the treatment to loose its effectiveness.

Interview with the Physician on 8/4/16 at 9:30am revealed:
- The facility did not notify the office when a appointments were missed.
- The facility has not rescheduled any missed appointments.
- The resident is at risk for anticipated death and harm due to missed treatments.

Key Notes

Identifiers

- Residents are assigned Numbers.
- *Use Resident Roster*
- Staff are assigned Letters.

Example:

- 2 of 5 residents (#3 and #4).
- 5 of 5 Personal Care Aides (A, B C, D and E).
- Confidential Interviews
  - Do not use a date, time or Identifier.
  - Information could be subpoenaed.

Findings

- Chronological and logical order.
- Most compelling scope and severity are listed first.
- Include relevant background events.
- Not necessarily organized in the order found.
- Most compelling scope & severity listed first.

Principle #3

Onsite Correction

What if the provider corrects the deficiency during a survey?

- Deficiency is still documented.
- Correction does not eliminate the presence of the problem.
- Correcting the problem for the identified resident does not mean it has been corrected for all.

Principle #4

Interpretive Guidelines

The deficiency demonstrates how the provider fails to comply with the rule requirements, not interpretations.

Guidelines designed to assist DSS/DHSR and providers to develop a better understanding of the requirements.

Guidelines **do not** replace or supersede the law or regulation.

Example

Activities 10A NCAC 13G .0905

Question: Is it realistic to expect a family care home with only a few residents to have planned group activities?

Answer?

Principle #5

Adverse Actions

Impact to the resident(s)

Findings explain how the scope/severity of the deficient practice justifies a Standard Deficiency, Type A1, A2 or Type B Violation.

Standard Deficiency

- Noncompliance with any single requirement or several requirements within a particular rule.
- Doesn't substantially limit a facility's capacity to furnish adequate care, or doesn't jeopardize the health or safety of patients if the deficient practice recurred.

Types of Violations

- Type A1 Violation:
  - Results in death or serious physical harm, abuse neglect, or exploitation.
  - Requires a written *Plan of Protection*.
  - Requires a *Plan of Correction*.
- Type A2 Violation:
  - Results in substantial risk that death or serious physical harm abuse, neglect, or exploitation will occur.
  - *"substantial risk"* – the risk of an outcome that is substantially certain to materialize if immediate action is not taken.
  - Requires a written *Plan of Protection*.
  - Requires a *Plan of Correction*.

Types of Violations

- Type B Violation:
  - Detrimental to the health, safety, or welfare of any client or patient, but does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.
  - Requires a written *Plan of Protection*.
  - Requires a *Plan of Correction*.

Plan of Protection (DHSR/AC 4659)

- The plan of protection must include: (Type A Violations)
  - actions the provider will take to eliminate the threat(s) of serious physical harm, abuse, neglect, exploitation or death to residents.
- The plan of protection must include: (Type B Violations)
  - actions the provider will take to eliminate the non-compliance that is identified as detrimental to the health, safety and welfare of residents.
- Failure to submit a plan of protection may result in a summary suspension of the license to operate if the risk to residents requires emergency intervention by DSHR.
- If there is imminent risk to one or more residents, local APS staff will be notified before leaving the facility.

Violations & Penalties

- A Type A1, Type A2 or Type B Violation shall not be cited if **all** of the following criteria are met:
  a. The violation was discovered by the facility.
  b. The Department determines that the violation was abated immediately.
  c. The violation was corrected prior to the inspection by the Department.
  d. The Department determines that reasonable preventative measures were in place prior to the violation.
  e. The Department determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.

Factors to be Considered

The following factors assist in determining the amount of the initial penalty to be imposed.

- Unabated Violations
  - Violations not corrected by the date specified
- Reasonable Diligence Exercised
- Compliance History (36 months)
- Facility's Effort to Correct
- Severity and Number of Residents at Risk

Penalties & Training

- In lieu of assessing all or some of the administrative penalty, the facility may be ordered to provide staff training or consider the approval of training completed by the facility after the violation, if all of the following criteria are met:

1) The training is determined by the department to be specific to the violation.
2) The training is approved by the Department.
3) The training is taught by someone approved by the Department.
4) The facility has corrected the violation and continues to remain in compliance with the regulation.

Abuse, Neglect and Exploitation

§ 131D-2.1. Definitions.

(1) Abuse. – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(8) Exploitation. – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(11) Neglect. – The failure to provide the services necessary to maintain a resident's physical or mental health.

Documentation Tools

- Monitoring Report (Form 4606 & 4606b)
- Corrective Action Report (CAR) (Form 4607)
- *Plan of Protection (Form 4659)*
- *Penalty Recommendation Forms (4610, 4610b, 4660)*

Monitoring Report (DHSR/AC 4606 & 4606b)

- G.S. 131D-2.11(b)(1a)
  - Used to document all on-site visits, including monitoring visits, revisits, and complaint investigations.
  - Submitted to the Department within 20 working days of the visit.
  - Completed prior to Exit or during Exit Conference.
  - Provider Signature & Copy

Corrective Action Report (DHSR/AC 4607)

- G.S. 131D-26(a)(1)
  March 2012 Memo Update
- Used to document non-compliance that rises to a standard level deficiency or a Violation.
- A written enforceable agreement between the facility and the regulatory agency.
- The investigation shall be *completed within 60* days.
- Delivered or mailed to the facility within 10 business days from exit date of CAR.

Starting the Investigation

Immediately
- If allegation is life threatening

Within 24 hours
- If allegation is abuse

Within 48 hours
- If allegation is neglect

Within 2 weeks
- All other complaints

- LAW or RULE BASED:
  - G.S. 131D-26(a)(1)
- NON-RULE BASED:
  - Referral Made
  - APS, HCPR, Law Enforcement, Department of Labor, OSHA

Penalty Recommendation Forms

- AHS completes all sections of the appropriate Penalty Recommendation Form(s) except for the recommended penalty amount. This amount will be determined by the ACLS Branch Manager.
  - *Type A1 Violation*: Include completed "Type A1/A2 Violation Penalty Recommendation" Form (DHSR/AC 4610). If there is more than one Type A Violation, complete *one 4610 Form* for each violation.
  - *Type A2 Violation*: Include completed "Type A2 Determining if a Penalty Should be Proposed" Form (DHSR/AC 4660). If there is more than one Type A2 Violation, complete one *4660 Form* for each violation.
  - *Unabated Violations*: Include completed Form *4610b* for each Unabated Violation.

Conclusions

Correct documentation is the key to success of the monitoring process.

- Knowledge of the regulations and how to apply them.
- Consistency in the process.
- The goal is to improve the quality of care and quality of life of residents in adult care homes.

Principles of Documentation Exercises

Adult Care Licensure Section Basic Orientation Training

Is this a deficiency…

TRUE or FALSE?

During a routine visit to a Family Care Home, you determine that 3 of 5 residents did not receive their therapeutic diet as ordered.

Correct

- This IS a failure to comply with the licensing rules and IS a deficiency.
- **10A NCAC 13F/G .0904 (e)(4)**
  - Three residents did not receive their therapeutic diets as ordered.
  - Therapeutic diet orders were for No Concentrated Sweets (NCS).

Is this a deficiency…

TRUE or FALSE?

During a routine monitoring of a 40 bed Adult Care Home, it is determined that the residents' weights are not being documented monthly.

Correct

- This is NOT a failure to comply with the licensing rules and is NOT a deficiency.
- **10A NCAC 13F/G .0801(c)(1)(4)**
  - Monitoring of residents for a significant change in weight is rule based.
  - A citation in this rule would be based on resident outcomes.

Is this a deficiency…

TRUE or FALSE?

During a routine monitoring of a 12 bed Adult Care Home, it is determined that a resident is transported to dialysis by a family member rather than the facility.

Correct

- This is not a failure to comply with the licensing rules and is not a deficiency.
- **10A NCAC 13F/G .0906 (A)**
  - Rule states that "the administrator must assure provision of transportation".

Record Review

No.

Revealed an order dated 01/21/15 for Lasix daily. Is this a complete order?

Regulatory Reference

- Part of the rule that was NOT met: Medication Orders
- 10A NCAC 13F/G .1002 (a)(2) physician contact for clarification if orders not clear or complete.
- (c)(2) The medication orders shall be complete and include the strength of the medication.

Cite the rule that most clearly and specifically addresses the identified problem.

Statement of Deficient Practice

- A summary of the problem.
- Source: Observation, Interview, Record Review
- Identifies Scope & Severity
- Includes what provider did or did not do to cause the non-compliance.
- Specific actions, errors or lack of action.
- Outcome (when possible)
- Identifiers of individuals

Extent of the deficient practice (#of deficient cases relative to total in the sample)

Census	Sample
0-30	3
31-80	5
81 and greater	7

Writing a Deficient Practice Statement

What information would you include in your practice statement?

During a routine visit to a Family Care Home, you determine that 3 of 5 residents did not receive their therapeutic diet as ordered.

Practice Statement

Based on observations, interviews and record reviews, 3 of 5 residents (#2, #3 and #4) did not receive the therapeutic diet as ordered by the physician.

RESIDENT REGISTER

The following resident information is to be completed and signed by the Administrator or Supervisor-in-Charge/Administrator-in-Charge and the resident or his/her responsible person within 72 hours of admission and kept in the resident's record in the home. Write "N/A" if the requested information is not applicable to the resident.

NAME OF HOME/FACILITY _____

A. IDENTIFYING INFORMATION

1. NAME_____
   (first) (middle) (last) (what resident prefers to be called)
2. DATE OF ADMISSION_____
   (month) (day) (year)
3. FORMER ADDRESS _____COUNTY:_____

   ADMITTED FROM: ☐ Own Residence ☐ Another's Residence

   A facility:_____
   (Name) (Address)
   Other:_____
4. BIRTHDATE_____ BIRTHPLACE_____ SS#_____
5. MEDICARE #_____MEDICAID #_____OTHER INSURANCE #'S_____
6. MARITAL STATUS ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated
7. GENDER ☐ Female ☐ Male
8. RACE ☐ Caucasian ☐ African-American ☐ Native-American ☐ Hispanic ☐ Other_____
9. FAMILY Father_____ Mother_____
   (include maiden name)

   CHILDREN_____

   SIBLINGS_____

   SPOUSE/PARTNER (Address if applicable)_____
10. RESPONSIBLE PERSON (if applicable)_____

    Address_____ Phone ( )_____

    Nature of Responsibility: ☐ Guardian ☐ Power of Attorney ☐ Payee
11. CONTACT PERSON (If responsible person is not designated)_____

    Address:_____ Phone ( )
12. PERSON IDENTIFIED BY THE RESIDENT TO RECEIVE A COPY OF THE DISCHARGE NOTICE

    Name _____

    Address_____ Phone ( )_____

B. RESOURCE INFORMATION

1. ATTENDING PHYSICIAN:_____

   Address_____

2. PREVIOUS PHYSICIAN_____

Address_____ Phone ( ) _____

PLANS MADE FOR PAYMENT OF: Personal Needs_____

Other_____

C. **PERSONAL INFORMATION**

1. ASSISTANCE REQUIRED FOR: (Check all that apply)

☐ Dressing	☐ Correspondence	☐ Mouth Care
☐ Bathing	☐ Getting In/Out of Bed	☐ Feeding
☐ Nail Care	☐ Toileting	☐ Positioning/Turning
☐ Shaving	☐ Hair/Grooming	☐ Scheduling Appointments
☐ Ambulation	☐ Skin Care	☐ Orientation to Time and Place

☐ (Other)_____

If different from information contained on the FL-2, home must contact resident's physician for clarification.

2. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

3. SPECIAL AIDS: (Check all that apply)

☐ Walker	☐ Hearing Aid	☐ Wheelchair
☐ Eyeglasses	☐ Dentures (Type)_____	☐ Other_____

4. PERSONAL HABITS: ☐ Smoking ☐ Alcohol ☐ Other_____

5. **KNOWN ALLERGIES OR SUBSTANCES NOT TO BE ADMINISTERED (Drug, Food, or Otherwise):**

---

6. FOOD PREFERENCES: If special diet, please describe:_____

_____

	FAVORITES	LEAST FAVORITES
Vegetable		
Fruit		
Meats		
Meat Substitutes		
Cereals and Breads		
Milk or Buttermilk		
Other Beverages		

7. COMMUNITY INVOLVEMENT

a. FAITH COMMUNITY_____ PASTOR_____

Address_____ Phone ( ) _____

b. CLUB, GROUP OR ORGANIZATIONAL MEMBERSHIPS_____

c. SPECIAL SKILLS OR TALENTS_____

d. PAST WORK AND VOLUNTEER SERVICE_____

e. HOBBIES_____

f. ACTIVITY INTERESTS: (Review *Listing of Suggested Activities with resident*).

	Favorites
Games	
Music	
Exercises	
Outdoor Activity	
Crafts	
Outings	
Social Activity	
Work Type/Volunteer Activity	
Intellectual Activity	

g. ACTIVITIES STRONGLY DISLIKED OR TO BE AVOIDED:_____
_____

If there is a question about a resident's ability to participate in an activity, the home must obtain a statement from the resident's physician regarding the resident's capabilities.

D. **REQUEST FOR ASSISTANCE**

Below are some areas in which the home can assist a resident upon the request of the resident or his/her responsible person. The administrator or supervisor-in-charge/administrator-in-charge must explain and complete each statement with the resident or his/her responsible person. The resident or his/her responsible person may subsequently change his/her mind and make a new request in writing at any time using Section H or some other notice. An equivalent signed record can be substituted for Section D.

1. I, as resident or the resident's responsible person, request that pertinent information be secured from the facility from which I just left. Signature:_____

2. I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time. Signature:_____

3. I, as resident or the resident's responsible person, request the use of lockable space for the security of personal valuables. I understand that I am entitled to one key at no charge and this space is accessible only to me and the administrator or supervisor-in-charge. Signature:_____

4. I, as resident or the resident's responsible person, request that the management of this home –
   a. Open my personal mail in my presence to read and explain the contents to me; and
   b. Assist in handling my mail that pertains to my financial or medical affairs.
   Signature:_____

E. **RECEIPT OF MATERIALS**

I, as resident or the resident's responsible person, acknowledge receipt of the following information which the management of the home reviewed with me:

- Home's resident contract specifying rates for the resident services and accommodations;
- House Rules which include policies on refunds, smoking, alcohol consumption, visitation, and reasons for discharge;

- Declaration of Residents' Rights;
- Home's grievance procedures for residents to present complaints and make suggestions as to the home's policies and services; and
- Home's willingness to comply with Title VI of Civil Rights Act.

Other:_____

_____

Signature_____

F. **SIGNATURES**

The resident or his/her responsible person should be asked to sign this form only after Sections A-E have been completed. The administrator or supervisor-in-charge/administrator-in-charge is to review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H. Section G is to be completed at the time the resident is discharged or transfers from the facility.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

G. **DISCHARGE/TRANSFER INFORMATION**

1. NOTICE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)
2. INITIATED BY: ☐ Administrator ☐ Other_____
Reason(s)_____
3. DATE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)
To: ☐ Own Residence ☐ Another's Residence (Name)_____
☐ A Facility ☐ Other_____
4. NEW ADDRESS_____ Phone ( )
5. COPY OF THE DISCHARGE NOTICE HAS BEEN GIVEN TO THE PERSON IDENTIFIED BY THE RESIDENT IN SECTION A, #12 OF THIS FORM AS REQUIRED BY GENERAL STATUTE 131D-4.8? ☐ **Yes** (required)

I acknowledge the above information to be complete and accurate.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

H. **REVIEW/REVISION**

The space below may be used to revise the information contained on the form.

Changes:_____

_____

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator –in-Charge) (Date)

AHS Facility Report

Purpose of Visit:

☐ **Monitoring** ☐ **Complaint Investigation** ☐ **Complaint Investigation Summary** *(see Attachment B))*

☐ **Deliver CAR** ☐ **Follow Up to CAR issued on: _____** ☐ **Technical Assistance**

☐ **Deliver Correspondence** ☐ **Death Investigation** ☐ **Other: _____**

Date Onsite: _____ Time: _____ Previous Onsite Date: _____

County:	**Facility:**	**License #:**
Address:		
Administrator/Designee:		

Section A:	**Current Census:** **Sample Size:**	☐ **Unannounced Visit**

Section B:	*Complete this section during onsite visit*
Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued ☐ Plan _____
Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued ☐ Plan _____
Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued ☐ Plan _____

Section C:	*Brief Description of Visit/Discussion With Staff in Charge*

Section D:	*Signatures*
Administrator/Designee:	**Date:**
Adult Home Specialist:	**Date:**

Check if Attachment: __

County:	**Facility:**	**License #:**
Address:		
Administrator/Designee:		

Section A: *Complete this section when initiating and conducting a **Complaint Investigation***

Date onsite: _____

Date Received: _____ **Date Initiated: _____** **Date Completed: _____**

Complaint #: _____ **Rule(s)/Description:**

Section B: *Upon Completion of a Complaint Investigation*

Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ Unsubstantiated ☐ Substantiated ☐ CAR to be Issued
Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ Unsubstantiated ☐ Substantiated ☐ CAR to be Issued
Rule Number: **Description:**	☐ Observations ☐ Interviews ☐ Record Reviews ☐ Unsubstantiated ☐ Substantiated ☐ CAR to be Issued

Section C: *Complete this section when any Report of Abuse, Neglect or Exploitation of a Resident(s) has been made*

Rule Number: 10A NCAC 13F .1205/G.1206 **Description:** Investigation and Reporting Health Care Personnel	☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued

Section D: *Complete with initial monitoring of facility, when new hire(s), and as appropriate*

Rule Number: 13F .0407 (a)(5)/G.0406(a)(5) **Description:** Facility compliance with Health Care Personnel Registry for negative findings (G.S. 131E-256)	☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued
Rule Number: 13F.0407 (a)(7)/G.0406(a)(7) **Description:** Facility compliance with criminal history background checks (G.S. 114-19.3)	☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued
Rule Number(s): **Description:** Rules in Sections .0400 Staff Qualifications & Section .0500 Staff Orientation, Training, and Competency	☐ Observations ☐ Interviews ☐ Record Reviews ☐ No Deficiency ☐ Deficiency ☐ CAR to be Issued

Adult Home Specialist:	**Date:**

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: _____ County: _____
Address: _____ License Number: _____
II. Date(s) of Visit(s): _____ Purpose of Visit(s): _____
Exit/Report Date: _____

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). When an Administrative Penalty will be recommended, the facility will have an opportunity to schedule a conference or submit additional information within **10 days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: Rule/Statutory Reference: Level of Non-Compliance: Findings:	☐ POC Accepted _____ *DSS Initials*	

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):
	Signature: Date:
	Title:

VI. Plan of Correction Submitted by:	Administrator (print name):
	Signature: Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

Facility Name:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		

Surveyor's Initials: _____

ADULT CARE LICENSURE RESIDENT RECORD REVIEW

Resident: _____ **Date:** _____ **Facility:** _____

Diagnoses: _____ **Date of Birth:** _____

_____ **Date of Adm:** _____

_____

Check appropriate:
☐POA
☐Guardian
☐Resp. Person

Name: _____

Address: _____

_____

FL-2 Date:

ambulation:
☐ non-amb
☐ semi-amb
☐ ambulatory

disorientation
☐ constant
☐ intermittent
☐ oriented
☐ no info

assistive device:
☐ none
☐ cane
☐ walker
☐ w/c
☐ other:
_____
_____

bladder:
☐continent
☐incontinent
☐int catheter
☐ext catheter

bowel:
☐continent
☐incontinent
☐colostomy

TB Testing

2-Step / Chest X-Ray

STEP 1

given:

read as: on:

STEP 2

given:

read as: on:

Diet Order

Date	Diet Order
	supplements: ☐Y ☐N
	thickener: ☐Y ☐N

Health Care

Date	Orders / TX:	Date	Referral / FU:
	☐BS: ☐B/P: ☐HR: ☐WT: ☐O_2: ☐TED: ☐ROM: ☐DSG:		☐PT/OT/SLP: ☐HH: ☐POD: ☐MD: ☐LAB:

Medication Review

Quarterly: ☐Y ☐N
Complete: ☐Y ☐N

Date of Review: _____

Last date: _____

recommendations:
☐none
☐yes:
_____
_____

follow-up:
☐none
☐yes:_____
_____
_____
_____

LHPS Review

Quarterly: ☐Y ☐N
Complete: ☐Y ☐N

Date Task Ordered:	Tasks:	Phys.Assess.

Date of Review: _____

recommendations:
☐none
☐yes:_____
follow-up:_____
_____

Mental Health

☐Seen by MH

Provider: _____
Provider Number: _____

Facility Addressed ☐Y ☐N

Interventions:_____
_____
_____
_____
_____

Assessment & Care Plan

Assessment Date

☐MD signed
☐ Annual
☐ Significant Δ

☐72-hour: (Res. Reg)
_____

CP Date

ADLs

	eating
	toileting
	ambulation
	bathing
	dressing
	grooming
	transfer

Restraints

☐ Order: _____
☐ Assessment_____
☐ Consent:_____

Special Care Units

☐Disclosure
☐Pre-screening
☐Diagnosis
☐Resident Profile – 30 days

Weight Management

Significant Δ: ☐Y ☐N
MD Notified: ☐Y ☐N

Notes:

_____
_____
_____

_____ _____
_____ _____
_____ _____

Resident's Name_____ **Surveyor's Initials: _____**

Notes:

ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY RECOMMENDATION
Type A1 and Type A2 Violations
(Internal Document Do NOT Send to Provider)

FACILITY INFORMATION

Facility Name: _____

SOD Event #: _____ Facility Type: ☐ HA ☐ FCH

License#: _____ Census (at time of violation): _____

LICENSEE INFORMATION

Licensee: _____
Email Address: _____
Executive Officer: _____

Correspondence Mailing Address: _____

_____

PENALTY INFORMATION

Proposal Submitted by: ☐ DSS ☐ DHSR

VIOLATION: ☐ Type A1 ☐ Type A2

Rule/Regulatory Area: _____

Statute(s)/Statutory Area: _____

Statute(s)/Statutory Area: _____

SEVERITY *Select Only One*

	Outcome to Affected Resident(s)	Points
☐ 5 points	Substantial risk that serious harm, abuse, neglect, or exploitation will occur	0
☐ 10 points	Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur	0
☐ 15 points	Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur	0
☐ 25 points	Resident died	0
☐ 30 points	Resident died & there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation	0
☐ 35 points	Resident died, there is substantial risk further resident death	0
	Total Point Range = (5-35)	**0**

COMPLIANCE STATUS

Yes= Compliance No= Not in Compliance N/A=Not Applicable

					Points
G.S. 131E-256 (d2) (HCPR Verification)	Date:	☐ Yes (0)	☐ No (2)		0
G.S. 131E-256 (g) (HCPR Reporting of Allegations)	Date:	☐ Yes (0)	☐ No (2)	☐ NA (0)	0
G.S. 131D-40 Criminal Record Check	Date:	☐ Yes (0)	☐ No (2)		0
G.S. 131D-34.1 (a) Death Report to DHHS within 3 days of death of any resident resulting from violence, accident, suicide, or homicide	Date:	☐ Yes (0)	☐ No (2)	☐ NA (0)	0
G.S. 131D-34.1 (a) Death Report to DHHS immediately when physical restraint or physical hold was used within seven days of resident death	Date:	☐ Yes (0)	☐ No (2)	☐ NA (0)	0
	Total Point Range = (0-10)			**Subtotal**	**0**

FACILITY' S EFFORT TO CORRECT *Select Only One*		Points
☐ 1 Point	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action will not result in correcting the violation(s).	0
☐ 2 Points	Prior to the initiation of the survey, the facility identified and implemented corrective actions to correct the violation but the corrective action did not result in correcting the violation(s) and/or furthered noncompliance and serious outcomes occurred.	0
☐ 3 Points	Prior to the initiation of the survey, the facility had identified the specific violations but had not responded with corrective actions.	0
☐ 4 Points	The facility was unaware or denies the existence of a violation(s). The survey team identfied the violation(s).	0
	Total Point Range = (1-4) **Subtotal**	**0**

NUMBER OF RESIDENTS PUT AT RISK *Select Only One*		Points
☐ One (1 Point)	☐ More than one (3 Points) ☐ All (5 Points)	0
	Subtotal	**0**

Severity	0.0
Compliance Status	0.0
Compliance History (36 Months) *See attached*	0.0
Facility's Efforts To Correct	0.0
Number of Residents Put at Risk	0.0
Subtotal	0.0

Grand Total	**0.0**	**Date:**	

INTERVENTION TIMELINE

Date(s) of Survey/Investigation:	
Date SOD Mailed or CAR Delivered or Mailed to Licensee:	
Date of Receipt of Additional Information:	
Date of IDR Held or Scheduled Date of IDR (ACLS only):	
Date of Penalty Conference/Additional Information Submitted (County DSS Only):	
Date Proposal Submitted to DHSR:	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Contact Information (Confidential - Mark as Confidential)				
Other Documentation				
Copy of Post Conference Letter (County DSS only)				
Copy of IDR Results Letter (ACLS only)				

Completed by: _____

DHSR/DSS Staff (to QIC) Date

Submitted by: _____

DHSR/DSS Staff (to DHSR/Branch Manager) Date

Recommended Penalty Amount $_____ **(Completed by DHSR management only)**

Branch Manager Signature Date: _____

DHSR QIC Review Date of QIC Review: _____

_____ _____

Name Name

_____ _____

Name Name

COMPLIANCE HISTORY FOR THE PAST 36 MONTHS

		Select point value based on violation type and place under Points for each listed Violation					**Points**
Date	*Rule Number Violation*	Brief Rule Area Description	Type B (enter 0.5)	Unabated B (enter 1)	Type A (enter 2)	Unabated A (enter 3)	
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
							0.0
If no previous violations in past 36 months = 0						**Subtotal**	**0.0**

ADULT CARE LICENSURE
ADMINISTRATIVE PENALTY PROPOSAL and RECOMMENDATION
Unabated Violation
(Internal Document Do NOT Send to Provider)

FACILITY INFORMATION

Facility Name: _____

SOD Event #: _____ Facility Type: ☐ HA ☐ FCH

License#: _____ Census (at time of violation): _____

LICENSEE INFORMATION

Licensee: _____ Email Address: _____

Executive Officer: _____

Correspondence Mailing Address: _____

_____

PENALTY INFORMATION

Proposal Submitted by: ☐ DSS ☐ DHSR

VIOLATION: ☐ Type A1 ☐ Type A2 ☐ Type B

Rule/Regulatory Area: _____ Correction Date: _____

Statute(s)/Statutory Area: _____ Correction Date: _____

Statute(s)/Statutory Area: _____ Correction Date: _____

Description of Events: ☐ CAR Attached ☐ SOD Attached ☐ Supporting Documents Attached Exit Date: _____

Date Violation was corrected: _____

Number of days Violation continued beyond date specified for correction: _____

Number of Days _____ X Amount _____ = $ -

INTERVENTION TIMELINE

Date(s) of Survey/Investigation:	
Date(s) of Original Citation:	
Specified Time for Correction:	
Date(s) Follow-up/Revisit for Violations(s):	
Date(s) of Receipt of Additional Information:	
Date Violation Abated:	
Date Proposal Submitted to DHSR:	

ATTACHMENTS

	Attachment(s)	Yes	No	NA
CAR/SOD With Signed Plan of Correction				
Copy of Notifications to Licensee				
Copy of Licensee's Receipts of Notifications				
Copy of Information Submitted by Facility (not POC)				
Contact Information (Confidential - Mark as Confidential)				
Other Documentation				
Copy of IDR Results Letter (ACLS only)				
Copy of Post Conference Letter (County DSS only)				

Completed by: _____

DHSR/DSS Staff (to QIC) Date

Submitted by: _____

DHSR/DSS Staff (to DHSR/Branch Manager) Date

Recommended Penalty Amount _____ **(Completed by DHSR management only)**

Branch Manager Signature Date: _____

DHSR QIC Review Date of QIC Review: _____

_____ _____

Name Name

_____ _____

Name Name

North Carolina Department of Health & Human Services
Division of Health Service Regulation
Adult Care Licensure Section

CONTACT INFORMATION

Affected Resident Name:	**CAR/SOD Resident Identifier Number:**
Address:	
Date of Birth:	
Facility Name:	
Resident has a Legal Representative? ☐ **No** ☐ **Yes (check one and complete next section):** ☐ **Power of Attorney** ☐ **Legal guardian**	

POWER OF ATTORNEY OR LEGAL GUARDIAN CONTACT INFORMATION

Name:		
Street Address:		
City:	**State:**	**Zip:**
Phone #:		

Information is to be disclosed as required by NC GS 131D-34 for **Type A1 and Type A2 Violations and Unabated Type A1, Type A2 and Type B Violations**.

Date:_____ Surveyor Signature:_____

NC Division of Health Service Regulation ---Adult Care Licensure Section
Plan of Protection

To be completed by DHSR/DSS Staff

Facility Name: _____ License #: _____

Rule Violation Cited: _____

(Complete separate form for each Rule Violation)

PLAN OF PROTECTION

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Describe your plans to ensure residents are protected from further risk or additional harm?

For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:

Please provide a date by which the facility will be in compliance with the rule area cited *(required).* Date: _____

Facility staff completing this form:

_____ _____

Name/Title Date DHSR/DSS staff Date

NC Division of Health Service Regulation ---Adult Care Licensure Section
Plan of Protection

To be completed by DHSR/DSS Staff

Facility Name: _____ License #: _____

Rule Violation Cited: _____

(Complete separate form for each Rule Violation)

PLAN OF PROTECTION

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Describe your plans to ensure residents are protected from further risk or additional harm?

Regarding A1 or A2 Violations - if you believe this to be a Past Corrected Violation, please answer the questions below.

Describe the preventative measures in place prior to the violation.

Describe how and when the violation was corrected.

Describe the corrective measures the facility implemented to achieve and maintain compliance.

Describe the facility's system to ensure compliance in maintained and how the system will continue to be implemented.

For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:
Please provide a date by which the facility will be in compliance with the rule area cited *(required)*. Date: _____

Facility staff completing this form:

_____ _____

Name/Title Date DHSR/DSS staff Date

TYPE A2 - Determining if a Penalty Should be Proposed

Facility Name: _____ License #: _____

Date of Violation: _____ Rule Area: _____

PREVENTATIVE MEASURES

Did the facility have policies/procedures specific to the violation?	☐ Yes	☐ No
Had staff been trained in the policies/procedures specific to the violation?	☐ Yes	☐ No
Had staff implemented the policies/procedures specific to the violation?	☐ Yes	☐ No

(If "No" is checked for any question above, a Penalty Proposal is to be completed)

COMPLIANCE HISTORY

Were there any previous violations in the past 36 months? ☐ Yes *(list below)* ☐ No

Rule Area (number/brief description)	Date	Type	**Points**
		Subtotal =	

Were there standard deficiencies in the same rule area as the current violation in the past 36 months? ☐ Yes *(list below)* ☐ No

Rule Area (number)	Date	**Points**
	Subtotal =	

RESPONSE TO PREVIOUS VIOLATIONS BY THE FACILITY

Were there any unabated Type A or B Violations in the past 36 months? ☐ Yes *(list below)* ☐ No

Rule Area (number)	Date	Type	**Points**
		Subtotal =	

Criteria to propose a penalty: 3 points or greater	**Total Points =**	

Points Assessed Per Citation/Violation

Standard Deficiency	Type B Violation	Unabated Type B Violation	Type A Violation	Unabated Type A Violation
.25	**0.5**	**1**	**2**	**3**

Completed by: Date:

RESIDENT SELECTION

(Clean Copy for Facility & Team Leader)

Facility Name: _____ Date of Survey: _____

License #: _____ Licensed Capacity: _____ Current Census: _____

Resident Selection:

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

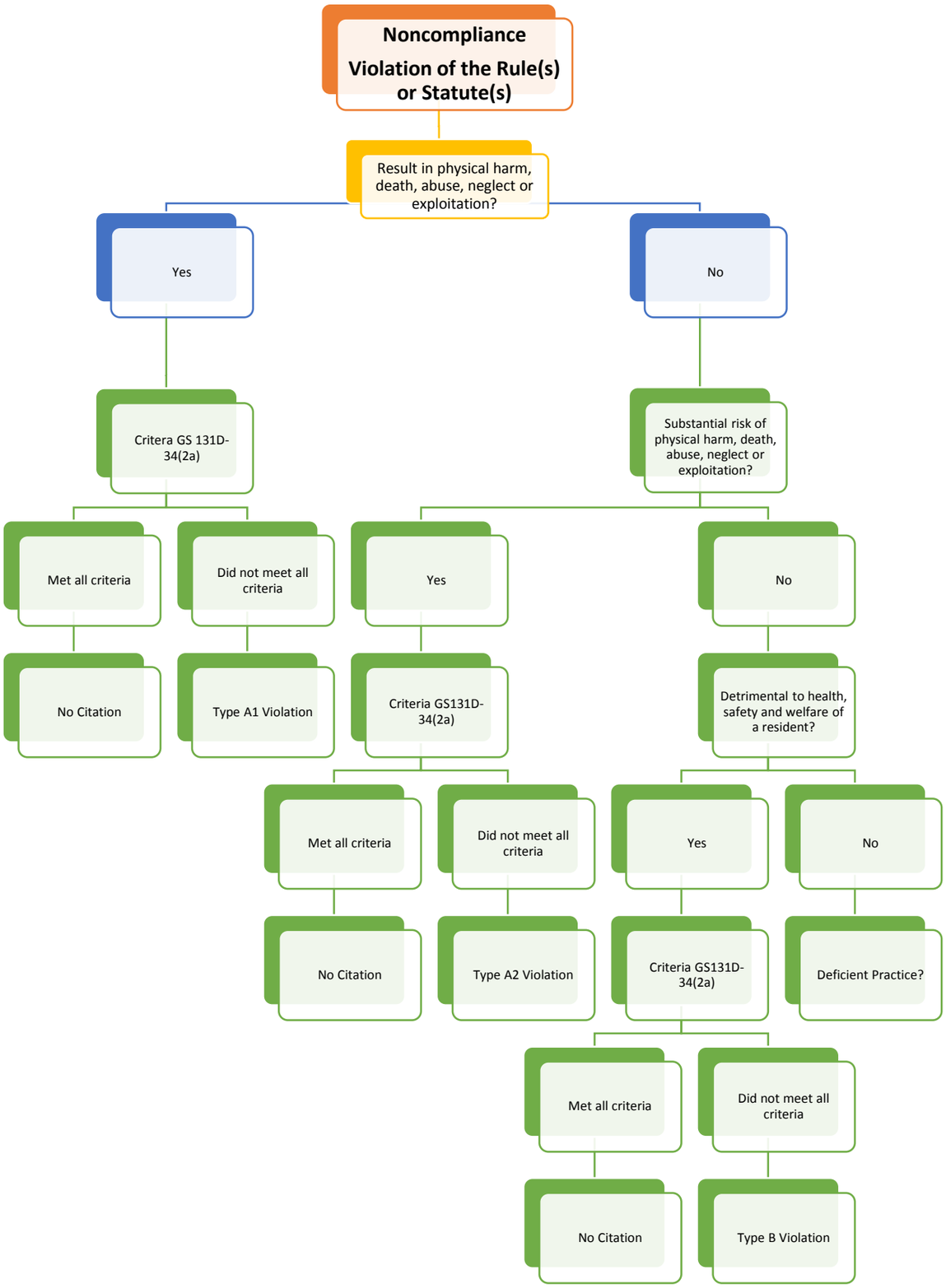
12. _____

13. _____

14. _____

15. _____

Violation Decision Tree



GS131D-34(1C) The definition is: As used in this section, "substantial risk" shall mean the risk of an outcome that is substantially certain to materialize if immediate action is not taken.

GS 131D-34 (2a) A Type A1, Type A2, or Type B Violation as defined above shall not include a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility if all of the following criteria are met:

a. The violation was discovered by the facility.
b. The Department determines that the violation was abated immediately.
c. The violation was corrected prior to inspection by the Department.
d. The Department determines that reasonable preventative measures were in place prior to the violation.
e. The Department determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.

Chapter 3: Medication Monitoring

MEDICATION MONITORING IN ADULT CARE HOMES

Presented by
NC Division of Health Service Regulation
Adult Care Licensure Section

Drug Management

Objectives:

- Access and utilize the medication administration and pharmaceutical care regulations for Adult Care Homes
- Monitor and encourage medication administration rule compliance in Adult Care Homes using a systematic approach

Preparation

Materials needed:

- Licensure Rules and General Statutes
- Monitoring Report
- Corrective Action Report
- Medication Aide Qualifications Worksheet
- Medication Monitoring Work Sheet
- Resources

Resources

- **ACLS Consultants:** Nurse, Pharmacist, Social Worker, or Dietician
- **Drug Reference Manuals:** PDR, Drug Information Handbook, Complete Guide to Prescription and Non-Prescription Drugs, The Pill Book, etc.

Monitoring Medication Administration

- 10A NCAC 13F / 13G .0403
- 10A NCAC 13F / 13G .0503
- 10A NCAC 13F / 13G .0505
- 10A NCAC 13F / 13G .1000
- 10A NCAC 13F / 13G .1211
- G.S. 131D-4.5B and 4.5C

Medication Aides and Supervisors

Who must meet these qualifications?

- Staff who administer medications, including staff who only prepare the medications
- Staff who directly supervise the administration of medications
- Exemption: Persons authorized by state occupational licensure laws to administer medications (e.g., registered nurses)

Medication Aide Training

G.S. 131D-4.5B

Medication Training Programs:

- 5-hour training program
- 10-hour training program
- Option available to complete a 15-hour training program (instead of 5 and 10 hour)
- Website for training programs: http://www.ncdhhs.gov/dhsr/acls/training/medaide.html

Medication Administration
5-Hour Training Course for
Adult Care Homes
Instructor Manual

North Carolina Department of Health and Human Services
Division of Health Service Regulations • Division of Public Health
Center for Aide Regulation and Education
Adult Care Licensure Section

Medication Administration

10/15-Hour Training Course for Adult Care Homes

Instructor Manual

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Center for Aide Regulation and Education
Adult Care Licensure Section

G.S. 131D-4.5B

Who does it apply to?

- All licensed adult care homes under 131D
- New staff hired on or after 10/01/2013 to perform medication duties (unless staff can verify prior employment per 131D-4.5b and passed written medication exam)
- Any current staff with new responsibilities of medication duties on or after 10/01/2013

What changed on October 1, 2013?

Prior to 10/01/2013:

- Competency validation by a RN or RPh prior to administration of medications (non-transferable)
- Pass written State medication exam for unlicensed staff in adult care homes within 90 days of competency validation

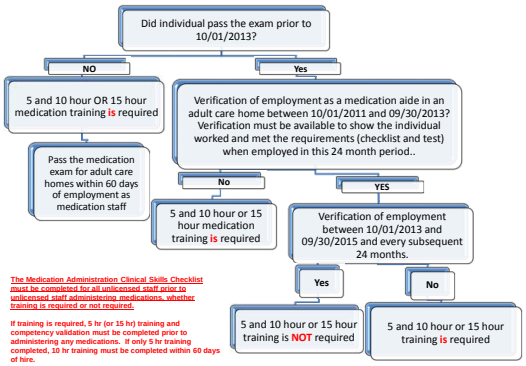
Effective 10/01/2013:

- Verification of employment as a medication aide in an adult care home within past 24 months; competency validation prior to administration of medications, and passed State written exam prior to 10/01/2013 **OR**
- 5-hour training developed by DHHS
- Competency validation by a RN or RPh

Within 60 days of hire:

- 10-hour training developed by DHHS
- Pass written State medication exam for unlicensed staff in adult care homes

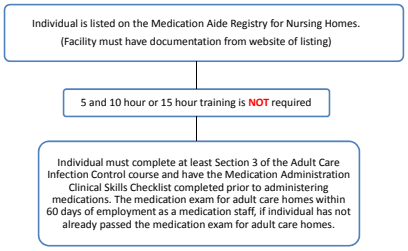
Guide to Determine if Medication Training is Required



The Medication Administration Clinical Skills Checklist must be completed for all unlicensed staff prior to unlicensed staff administering medications, whether training is required or not required.

If training is required, 5 hr (or 15 hr) training and competency validation must be completed prior to administering any medications. If only 5 hr training completed, 10 hr training must be completed within 60 days of hire.

Guide to Determine Training Requirements for Staff listed on the Medication Aide Registry for Nursing Homes



Competency Evaluation

Clinical Skills Validation:

- Completed prior to staff being assigned to administer medications
- Medication Administration Skills Validation Form
- Non-transferable between licensed facilities

Written Exam:

- Administered by DHHS
- Completed within 60 days of hire as medication staff
- Passing score of at least 90%
- Transferable

Medication Administration Clinical Skills Checklist

- Validation by RN or RPh
- Only form used for competency validation
- Certain tasks may only be validated by RN
- Complete checklist for all tasks employee will be responsible for performing
- Required for all new staff regardless of whether or not staff was required to complete training
- Maintain in the facility for review

Revalidation of Medication Staff

- No revalidation required of employees:
  - Who remain employed by new ownership
  - Are rehired by facility
- Facility is responsible for assuring that staff is competent to administer medications and oriented to facility's policies and procedures

Medication Testing Questions and Materials

- Center for Aide Regulation and Education (CARE) Medication Testing Unit: 919-855-3793
- DHSR Website: http://www.ncdhhs.gov/dhsr/acls/index.html
- Medication Testing Website: https://mats.dhhs.state.nc.us:8598/default2.aspx

Infection Control
for Adult Care Homes
Instructor's Manual

North Carolina Department of Health and Human Services
Division of Health Service Regulation • Division of Public Health
Center for Aide Regulation and Education
Adult Care Licensure Section

EXERCISE

Data Collection

- Documentation / Resident Records
- Observations of Staff and Residents
- Interviews with Staff and Residents

Resident Record Review

- Sample size based on survey protocol
- Target new admissions, re-admissions, residents receiving insulin, Coumadin or multiple changes in medication orders
- Medication Monitoring Form: Begin with FL-2 form or discharge summary and follow subsequently dated medication orders

Observation and Interview of Residents

- Sometimes necessary to confirm how / if medication was / is given
- Helpful in determining staff procedures within the facility
- Use open-ended questions during interviews

Observation and Interview of Staff

- Indirectly observe staff during medication passes
- Ask staff to tell you about facility procedures
- Determine if staff is following proper procedures for:
  - ✓ Pre-pouring and infection control
  - ✓ Reordering of medications
  - ✓ Medication administration techniques
  - ✓ Administering within 1 hour grace period
  - ✓ Documentation on the MAR

Policies and Procedures

- Individualized procedures in the facility
  - Who is responsible for doing what?
  - How is it done?
  - When is it done?
  - Where is it done?
- If there are inconsistencies among staff, refer to policy and procedure manual (e.g., MAR documentation, reordering of meds, etc.)

Medication Orders

- FL-2 or Discharge Summary
- Report of Health Services Form
- Telephone Order Slips
- Prescriptions
- Physician's Order Sheet
- Other: Lab Reports, DRR

Medication Orders

To be complete:

- Medication name and strength
- Dosage of medication to be administered
- Route of administration
- Specific directions for use including frequency
- If ordered PRN, an indication for use
- If an order is incomplete, staff should clarify the order with doctor and document the clarification

Medication Administration Record (MAR)

Current and Accurate:

- Resident's name
- Each medication dose administered
- Name, strength, and dosage administered
- Instructions for administering
- Date and time medication is administered
- Reason for omissions
- Reason and resulting effect of PRN medications
- Name / initials and equivalent signature

Monitoring MARs

- Are there omissions or blanks?
- Is the reason / effect documented for administration of PRN's?
- Is the medication scheduled for administration at appropriate times?
- Is staff documenting immediately after administration to each resident prior to administering medications to the next resident?

Drug Storage

- Drugs should be stored in a clean, orderly, well-lit, and well-ventilated area
- External / internal drugs stored separately
- Refrigerated agents: 36 - 46°F
- Expired / discontinued drugs
- Security

Labeling

- Prescription medications
- Non-prescription medications (OTCs)
- Direction changes
- Samples
- Leave of absence

Prescription Label Requirements

- Resident's name
- Dispense date
- Prescriber's name
- Name / strength of medication
- Instructions for administration
- Generic equivalency statement
- Expiration date
- Name of dispensing pharmacist and pharmacy

Controlled Substances

- Accountability / retrievable record
  - Receipt
  - Administration
  - Disposition
- Storage
- Disposition / destruction
- Is the MAR documentation sufficient as a controlled substance record, too?

Medication Errors

- Error = an act or belief that unintentionally deviates from what is correct, right or true
- Medication error occurs when a medication is not administered as prescribed
- ALL errors, including documentation errors, should be entered on appropriate form
- Omissions and unavailability of medications are errors!

Pharmaceutical Care and Services

- **Components of medication review:**
  - On-site
  - At least quarterly
- **Responsibilities of Licensed Health Professional and follow-up by facility:**
  - Summary report
  - Maintain on file in facility (not necessarily in resident's record)
- Adult Care Homes (7+) vs. Family Care Homes (<7)

Evaluating Scope and Severity

- Pre-exit
- Scope of the deficiency
  - How many residents were affected?
- Severity of the deficiency
  - How serious was it?
- Monitoring report, corrective action, or penalty?

EXERCISES

Instructions for Completing the Medication Administration Clinical Skills Checklist Developed by the Division of Health Service Regulation, Adult Care Licensure Section 2708 Mail Center, Raleigh, NC 27699-2708 (919) 855-3793

TO ALL INSTRUCTORS:
Unlicensed staff who administer medications and supervisors of staff responsible for administering medications in adult care homes must have a registered pharmacist or registered nurse validate the staff's competency for tasks or skills that will be performed in the facility prior to the unlicensed staff administering medications. Competency validation for **all** unlicensed staff must be completed using this checklist, prior to staff administering medications. Staff is required to also have documentation of successfully completing the required medication aide training for adult care homes or verification of employment **and** pass a written competency test approved by the Department of Health and Human Services within 60 days of hire date as a medication aide in accordance with NCGS 131D-4.5B. The Medication Administration Clinical Skills Checklist is a standardized checklist and the **only one to be used for validating staff.** Refer to regulations 10A NCAC 13F/13G .0503 and NCGS 131D-4.5B.

The guidelines and attachments are provided to assist with training and validation, as well as, provide the minimum standards for staff administering medications in adult care homes. Tasks listed in the left column of the guidelines match the tasks on Medication Administration Clinical Skills Checklist and the right column of the guidelines provides information for training and validation. It will be the instructor's responsibility to determine that the employee has demonstrated competency in performing the tasks or skills by using the guidelines and checklist.

The instructor needs to be knowledgeable of the regulations and interpretations of regulations related to medication administration for adult care homes. As indicated on the checklist, the instructor is to review the guidelines and checklist prior to the observation of the tasks or skills.

Directions for completing checklist

1. The name of the employee and adult care home are to be written on each page of the checklist. The checklist is not transferable.

2. All documentation on the checklist is to be in ink. Items that have an (*) by the tasks or skills must be checked off only by a registered nurse.

3. When the employee has demonstrated competency for a task or skill, the instructor is to complete the "Satisfactory Completion Date" block and the "Inst. Initials/Signature" block to the right next to the completion block. The "Needs More Training" and "Inst. Initials/Signature" is to be completed if the employee needs further training in an area or needs to be observed again.

4. **Sections 1 through 14** - Must be completed for each unlicensed staff person, unless otherwise indicated on the checklist or guidelines. **** Section 13 K through P – tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504, .0505 and .0903 and the instructions on the Guidelines for Completing the Medication Administration Clinical Skills Checklist.**

5. **Section 1-** Competency may be determined by asking the employees questions or by a written test.

6. **Sections 2 through 13 -** The employee is to be observed actually performing the task or skill or at least be able to verbalize and demonstrate competency to perform the task or skill. Further instructions are provided in the guidelines for the tasks or skills in Section 13.

7. The employee and instructor are to sign and date the checklist after the completion of tasks.

8. If competency validation for additional tasks on the Medication Administration Clinical Skills Checklist is needed after the employee and instructor have signed the checklist, then the additional tasks/skills may be checked off, initialed and dated by the instructor on the original checklist and signed and dated by the instructor and employee again in the "Comment" section or a new checklist may be used and attached to the original checklist.

9. The "Comment" section may be used to document any additional information, including signatures.

10. The checklist must be maintained on file in the facility.

If you have any questions about completing the checklist or comments, please call the Adult Care Licensure Section at the above phone number.

Medication Administration Clinical Skills Checklist

The unlicensed staff must (without prompting or error) demonstrate the following skills or tasks in accordance with the guidelines on the attachments with 100% accuracy to a registered nurse or pharmacist. Competency validation by the registered nurse or pharmacist is to be in accordance with their occupational licensing laws. Items that are (*) must be checked off **only** by a registered nurse.

Instructor – Refer to attachment on instructions and guidelines for completing this checklist prior to beginning observation of skills or tasks.

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
1. Basic Medication Administration Information and Medical Terminology (Refer to attachment)				
A. Matched common medical abbreviations with their meaning				
B. Listed/Described common dosage forms of medications and routes of administration				
C. Listed the 6 rights of medication administration				
D. Described what constitutes a medication error and actions to take when a medication error is made or detected				
E. Described resident's rights regarding medications, i.e., refusal, privacy, respect				
F. Defined medication "allergy"				
G. Demonstrated the use medication resources or references				
2. Medication Orders (Refer to attachment)				
A. Listed or Recognized the components of a complete medication order				
B. Transcribed orders onto the MAR 1. Used proper abbreviations 2. Calculated stop dates correctly 3. Transcribed PRN orders appropriately 4. Copied orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinued orders properly				
C. Described responsibility in relation to telephone orders				
D. Described responsibility in relation to admission and readmission orders and FL-2				
E. Described or Demonstrated the process for ordering medications and receiving medications from pharmacy				
F. Identified required information on the medication label				
3. Demonstrated appropriate technique to obtain and record the following: (Refer to Attachment)				
A. * Blood Pressure				
B. * Temperature				
C. * Pulse				
D. * Respirations				
E. Fingersticks/Monitoring Devices such as glucose monitoring (Only required to be validated if the employee will be performing this task.)				

EMPLOYEE NAME :_____

ADULT CARE HOME NAME: _____

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs More Training	Inst. Initials/ Signature
4. If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (Refer to Attachment)				
5. Administration of Medications (Refer to attachment)				
A. Identified resident				
B. Gathered appropriate equipment and keeps equipment clean				
C. MAR utilized when medications are administered and also when medications are prepared or poured (if prepouring is allowed)				
D. Read the label 3 times; Label is checked against order on MAR				
E. Used sanitary technique when pouring and preparing medications into appropriate container				
F. Offered sufficient fluids with medications				
G. Observed resident taking medications and assures all medications have been swallowed.				
6. Utilized Special Administration/Monitoring Techniques as indicated(vital signs, crush meds. check blood sugar, mix with food or liquid) (Refer to Attachment)				
7. Administered medications at appropriate time (Refer to attachment)				
8. Described methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status (Refer to Attachment)				
9. Utilized appropriate hand-washing technique and infection control principles during medication pass (Refer to Attachment)				
10. Documentation of Medication Administration (Refer to Attachment)				
A. Initialed the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.				
B. Documented medications that are refused, held or not administered appropriately				
C. Administered and documented PRN medications appropriately				
D. Recorded information on other facility forms as required				
E. Wrote a note in the resident's record when indicated				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME:_____

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
11. Completion of Medication Pass (Refer to Attachment)				
A. Stored medications properly				
B. Disposed of contaminated or refused medications				
C. Rechecked MARs to make sure all medications had been given and documented				
12. **Medication Storage (Refer to Attachment)**				
A. Maintained security of medications during medication administration				
B. Stored controlled substances appropriately and counted and signed controlled substances per facility policy				
C. Assured medication room/cart/cabinet is locked when not in use				
13.Administered medications using appropriate technique for dosage form/route & administered accurate amount: (Refer to Attachment)				
A. Oral tablets and capsules				
B. Oral liquids				
C. Sublingual medications				
D. Oral Inhalers				
E. Eye drops and ointments				
F. Ear drops				
G. Nose drops				
H. Nasal Sprays/Inhalers				
I. Transdermal medications/Patches				
J. Topical (creams and ointments; **not dressing changes**)				
K. *Clean dressings				
L. * Nebulizers				
M. * Suppositories 1. Rectal 2. Vaginal				
N. * Enemas				
O. * Injections 1. Insulin** 2. Other subcutaneous medications				
P. * Gastrostomy Tube				

EMPLOYEE NAME: _____

ADULT CARE HOME NAME:_____

Medication Administration Clinical Skills Checklist

Skill/ Tasks	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
Section 14: Other Tasks/Skills				
A. Self-Administration of medications				
B. Received orientation to facility's policy and procedures for medication administration				

EMPLOYEE NAME _____

EMPLOYEE SIGNATURE & DATE:_____

ADULT CARE HOME NAME:_____

The employee at the above named facility has demonstrated competency validation in the areas as indicated on this checklist. The instructions/guidelines were used to determine the employee's competency.

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:

_____

INSTRUCTOR'S NAME, SIGNATURE, TITLE AND DATE:

_____

(If more than one instructor completes the checklist, the initials of each instructor is to documented by the instructor's signature and title. The section for comments may be used if additional space needed.)

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surveyor's Initials: _____

Resident's Name_____ **Medication Monitoring Form** **☐Standing Orders:_____**

FL-2 **LOC:** **Date:**	**Subsequent Orders**	**Medication Administration Record** *(Please review 2 months of MARs)*			**Medication on Hand / Labeled?**

Resident's Name_____ **Medication Monitoring Form** ☐**Standing Orders:**_____

FL-2 **LOC:** **Date:**	**Subsequent Orders**	**Medication Administration Record** *(Please review 2 months of MARs)*			**Medication on Hand / Labeled?**

MEDICATION ADMINISTRATION RECORD (MAR)
INSPECTION WORKSHEET

Date **Time** **MARs reviewed**

Person Conducting Inspection: _____

MEDICATION ADMINISTRATION RECORDS	YES	NO	COMMENTS
• Orders are transcribed completely - no abbreviations	☐	☐	
• Orders are transcribed immediately from physician's order with transcriber's initials and date.	☐	☐	
• Orders are transcribed from physician's order, not from pharmacy label	☐	☐	
• Order changes are properly documented, including discontinuation of old order and entry of new order	☐	☐	
• Medication administration is documented in ink and errors are crossed out and initialed – **no white out or pencil**	☐	☐	
• Medication administration records are checked for order accuracy at the beginning of each month	☐	☐	
• Medication administration records have been checked by authorized personnel at the beginning of each month and corrected / signed / dated	☐	☐	
• The pharmacy is notified of any MAR discrepancies resulting from the monthly review	☐	☐	
• Medication orders with special or unusual instructions (e.g. every other day, once weekly / monthly) have been transcribed appropriately	☐	☐	
• Scheduled administration times are appropriate with physician's order or facility policy	☐	☐	
• Scheduled medication administration times reflect administration before, after, or with meals as required of physician's order	☐	☐	
• Medication administration records clearly show documentation of omission of medications, including refusals, unavailability, resident out of facility, etc.	☐	☐	
• Routine medication administration properly on the MAR and no blank spaces are found	☐	☐	
• PRN (as needed) medications have no schedule for administration	☐	☐	
• PRN (as needed) medications have a time / date / dose / reason / effectiveness documented for **every administration**	☐	☐	
• For each staff member initialing the front of the MAR, an equivalent signature is documented on the designated area of the MAR	☐	☐	

Reviewed by Facility Personnel *Date*

MEDICATION ADMINISTRATION OBSERVATION WORKSHEET

Staff person observed	**Date**	**Time**

Observer: _____

Please mark all boxes in which proper medication administration procedures were utilized.
For areas with concern, please use the available space at the end of the form to enter comments.

GENERAL MEDICATION ADMINISTRATION

- ☐ Only proper personnel administering medication
- ☐ Infection control methods utilized as required
- ☐ Pre-poured medications prepared according to facility policy and state regulation
- ☐ Used sanitary technique when handling medications
- ☐ Identified resident prior to administration of medications
- ☐ Observed each resident's privacy, dignity and treated residents with respect
- ☐ Maintained confidentiality of MAR
- ☐ Medication container label was checked with MAR
- ☐ Medication container labels were check for expiration date
- ☐ Observed all pharmacy warning labels (Shake Well, Give with 8 ounces of Water)
- ☐ Obtained & recorded BP, pulse, BS, or other data as ordered and used proper technique
- ☐ Observed orders to "hold meds" when above data was outside of limits specified
- ☐ Administered only those medications ordered
- ☐ Administered medications exactly as ordered
- ☐ Administered dose exactly as ordered
- ☐ Administered medications at scheduled administration time
- ☐ Administered before, after, or with meals as prescribed
- ☐ Measuring device supplied with product was used only for that product
- ☐ Medications administered within one hour of scheduled time of administration
- ☐ Observed resident taking medications
- ☐ Offered sufficient fluids with medications
- ☐ Disposable medication cups were not reused
- ☐ Cleaned equipment (pill crusher, etc.) after use
- ☐ Maintained security of medications during medication administration
- ☐ Charted medications when administered
- ☐ Administered PRN medications using proper indication and reason / response
- ☐ Documented the following: administration time, refused/held medications, injection sites

MEDICATION ADMINISTRATION OBSERVATION WORKSHEET

MEDICATION ADMINISTRATION TECHNIQUE

- ☐ Only appropriate medications were crushed and proper technique used
- ☐ Medications ordered to be taken "with food" administered with food / snack up to 1 hour after food / snack
- ☐ Medications ordered to be taken "before meals" administered 15-30 minutes prior to food / snack
- ☐ Medications administered by G-Tube flushed with water before and after medication administration
- ☐ Appropriate medication preparation used (shake well, mix, dilute, dissolve, crush, etc.)
- ☐ Medications requiring dilution: diluted appropriately (KCL liquid, Miralax, etc.)
- ☐ Liquid medications measured at eye level and with appropriate measuring device
- ☐ Liquid suspensions shaken several times (Dilantin, Tegretol, etc)
- ☐ One-minute spacing between each puff of metered dose inhalers (Albuterol, Atrovent, etc.)
- ☐ 3-5 minute spacing allowed between 2 or more eye drops in the same eye
- ☐ Injection site or patch location documented on the MAR
- ☐ Insulin administered approximately 30 minutes before meals (unless ordered otherwise)
- ☐ Gloves worn when performing fingerstick blood sugar monitoring
- ☐ Gloves worn and hands washed before and after applying or removing transdermal products, or applying ophthalmics
- ☐ Hand-washing occurred when there was contact with the resident's body or bodily fluid.
- ☐ If required by facility policy, pulses and blood pressures checked prior to administration of certain medications, if not ordered otherwise by physician.

Comments: _____

MEDICATION RELEASE FORM
FOR RESIDENT LEAVE OF ABSENCE

Facility Name: _____

Resident: _____ **Room #:** _____

Date of Departure: _____ **Date of Return:** _____

_____ **Day(s) Supply of the Following Medication(s) Provided:**

	Medication	**Strength**	**Directions & Cautionary Information*** **provide Cautionary Info if not on label*	**Quantity upon leaving**	**Quantity upon return**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Verbal instructions from staff to resident or person accompanying resident to include the following:

1. Review above information for each medication.
2. Read all directions carefully.
3. Give each dose exactly as ordered by
4. Store all medications away from children.
5. Staff/Resident/Person accompanying resident check to ensure sufficient
6. Discuss facility policy and procedure for return of unused
7. Other -

****

Staff Signature*: _____ **Date:** _____

Staff Printed Name:

**Signature of staff person who released medications and provided verbal instructions above.*

Receipt Acknowledgement:

I have been instructed in the proper usage, dosage, frequency and reason for each medication provided. I accept responsibility for the medication and will assure that it is properly stored and that it is properly administered. I understand that in the event that the drugs are accepted in non-child proof containers, I hereby release the facility named above and the pharmacy from responsibility.

Signature of Resident or Person Accompanying Resident: _____ **Date:** _____

_____ **(Relationship)**

****

Medications Returned (Quantity returned documented above.)

Date and Time:

Staff Signature:

Signature of Resident or Person Accompanying Resident:

MEDICATION AIDE QUALIFICATIONS CHECKLIST

NCDHHS, Division of Health Service Regulation, Adult Care Licensure Section

Facility Name/Location _____ Survey Date(s)_____

Name of Staff Person	*Title of Staff Person*	*Date of Hire*	*Medication Training or Verification Yes or No & Date*	*Clinical Skills Checklist?* ***YES or NO***	*If Yes, Date Completed*	*Pass Med Test?* ***YES or NO***	*If Yes, Date Passed*

Notes:

Guidelines for Completing the Medication Administration Clinical Skills Checklist

Section 1: Basic Medication Administration Information and Medical Terminology	**Section 1**: **The employee must be knowledgeable of at least:**
A. Match common medical abbreviations with their meaning	A. The common abbreviations on ATTACHMENT A. The employee is to be familiar with the common medical abbreviations and be able to find a list when needed.
B. List/Describe common dosage forms of medications and routes of administration	B. The common dosage forms and routes of administration on ATTACHMENT A & B. The employee is to be familiar with the common dosage forms. Medications are available as different dosage forms, e.g., tablets, capsules, liquids, suppositories, topicals which include lotions, creams, ointments and patches, inhalants and injections. An order is to indicate the route of administration. Some medications may come in several dosage forms. An example is Phenergan. It is available in tablet, liquid, suppository and injectable.
C. List the 6 rights of medication administration	C. Six Rights of Medication Administration: 1.Right Resident 2.Right Medication 3.Right Dose 4.Right Route 5.Right Time 6.Right Documentation
D. Describe what constitutes a medication error and actions to take when a medication error is made or detected	D. A medication error occurs when a medication is not administered as prescribed. Examples of medication errors include: omissions; administration of a medication not prescribed by the prescribing practitioner; wrong dosage; wrong time, wrong route; crushing a medication that shouldn't be crushed; and documentation errors. The employee must be able to explain the facility's medication error policy and procedure or at least be knowledgeable of where to find it. The procedure is to include who to notify, i.e., supervisor and health professional and forms to complete. The employee is to be able to recognize medication errors. The employee needs to understand that recognizing medication errors and acting quickly to correct them help prevent more serious problems.
E. Describes resident's rights regarding medications, i.e., refusal, privacy, respect	E. Medication administration can effect a resident's rights which include, but not limited to, the following: 1. **Respect** – How the resident is addressed; The resident should not be interrupted while eating for the administration of medications such as oral inhalers and eye drops. The resident should not be awakened to administer a medication that could be scheduled or administered at other times; Explain to the resident the procedure that the employee is about to perform; Answer questions the resident may have about the medication. 2. **Refusal** – The resident has a right to refuse medications. A resident should never be forced to take a medication. The facility should have a policy and procedure to be followed when residents refuse medications. The policy and procedure is to ensure the physician is notified timely (based on the resident's condition, physically and mentally and the medication.) 3. **Privacy** – Knock on closed doors before entering; Do not administer medications when the resident is receiving personal care or in the bathroom; Administration of injections outside the resident's room is not acceptable if the resident receiving the injection or other residents present are offended by this; Administration of medications requiring privacy, e.g., vaginal and rectal administrations, dressing changes and treatments requiring removal of clothing. 4. **Chemical Restraint** Medications, especially psychotropics, are not to be administered for staff convenience.

Guidelines for Completing the Medication Administration Clinical Skills Checklist

F. Define medication "allergy" and describe responsibility in relation to identified allergies and suspected allergic reactions	F. Medication Allergy: a reaction occurring as the result of an unusual sensitivity to a medication or other substance. The reaction may be mild or life-threatening situation. These may include rashes, swelling, itching, significant discomfort or an undesirable change in mental status, which should be reported to the physician. A severe rash or life-threatening breathing difficulties require immediate emergency care. The employee should understand that information on allergies should be reported to the pharmacy and physician and this information is recorded in the resident's record. Upon admission, it is important to document any known allergies. If there are no known allergies, this should be indicated also.
G. Demonstrate the use of medication resources or references	G. The employee should be familiar with medication resources or references, including the facility's policy and procedure manual, and be able to find information. Resources written for non-health professionals, including information sheets from the pharmacy, are recommended instead of references written for health professionals, such as the PDR.
Section 2: Medication Orders	**Section 2**
A. List/Recognize the components of a complete medication order	A. Components of a complete order: 1.Medication name; 2.Strength of medication (if one is required); 3.Dosage of medication to be administered; 4.Route of administration; 5.Specific directions for use, including frequency of administration; and, 6.PRN or "as needed" orders must also clearly state the reason for administration Orders for psychotropic medications prescribed for "PRN" administration must include symptoms that require the administration of the medication, exact dosage, exact time frame between dosages and maximum dosage to be administered in 24 hour period. Example: Ativan 0.5 mg. by mouth every 4 hours prn for pacing or agitation. Physician is to be contacted if more than 4 doses are needed in 24-hour period. **For items B. through E. of this section: If the employee has any responsibility for transcription of orders and processing admissions, the employee is to describe and demonstrate the procedures involved in these areas. If the employee does not have any responsibility for transcription or processing orders, the employee still needs to have general knowledge of the procedures and be able to screen orders to determine correctness.**

Guidelines for Completing the Medication Administration Clinical Skills Checklist

B. Transcribe orders onto the MAR 1. Use proper abbreviations 2. Calculate stop dates correctly 3. Transcribe PRN orders appropriately 4. Copy orders completely and legibly and/or checked computer sheets against orders and applied to the MAR 5. Discontinue orders properly	B. Transcription of orders onto the medication administration record is to include: 1. Orders are to be transcribed onto the medication administration record when obtained or written. The employee is to initial or sign and date orders written on the medication administration record. (Waiting until the medication arrives from the pharmacy before transcription of an order onto the medication administration record is not correct. The directions on the medication label from the pharmacy must be checked against the order on the medication administration record. If there is a discrepancy between the information on the medication administration record and the medication label, the order in the resident's record is to be checked. When there are discrepancies between the medication label and the order, the employee is to follow the facility's policy and procedure, which would address who to contact.) 2. Transcribe using proper abbreviations or written out completely. The order is to be complete. 3. When calculating stop dates for medication orders such as antibiotics that have been prescribed for a specific time period, the number of dosages to be administered should be counted instead of the number of days. 4. PRN orders are not scheduled for administration at specific times. PRN medications are given when the resident "needs" the medication for a certain circumstance. 5. Review medication administration records monthly at the beginning of the cycle to assure accuracy and the update the medication administration records as needed. 6. A discontinue order has to be obtained for an order to be discontinued, unless the prescribing practitioner has specified the number of days or dosages to be administered or indicates that a dosage is to be changed. For example, a prescription with "No Refills" does not automatically mean the order is to be discontinued.
C. Describe responsibility in relation to telephone orders	C. Telephone or verbal orders may be accepted only by a licensed nurse, registered pharmacist or qualified staff responsible for medication administration. The order is to be dated and signed by the person receiving the order and signed by the prescribing practitioner within 15 days of when the order is received. It is important that the employee understands that a copy of an order, including a telephone order, is always kept in the resident's record.
D. Describe responsibility in relation to admission and readmission orders and FL2 forms	D. A FL2 form is required for new admissions. It is important that all the information on the FL-2 is reviewed for accuracy. If any clarification is needed, the prescribing practitioner is to be contacted. If the FL-2 has not been signed within 24 hours of admission, the orders are to be verified by the facility with the prescribing practitioner. Verification of orders may be by fax or telephone. There has to be documentation of this verification in the resident's record, e.g., a note in the progress notes or the orders may be rewritten as telephone orders and signed by the prescribing practitioner. The orders could also be faxed to the prescribing practitioner for review, signature and date. Readmission from the hospital requires a transfer form, discharge summary or FL-2 signed by the prescribing practitioner. Often, the facility may receive a discharge summary or transfer form and a FL-2. The employee must be able to describe the procedures for readmission, especially when two or more forms with orders are received. Orders are to be verified by facility staff with the prescribing practitioner if the orders have not been signed within 24 hours of admissions, if clarification is needed or if the prescribing practitioner has not signed the orders. If a

Guidelines for Completing the Medication Administration Clinical Skills Checklist

	prescribing practitioner does not sign orders, the orders are to be processed per facility policy and signed by the prescribing practitioner. This may be by telephone or facsimile. Medication orders are to be reviewed and signed by the physician at least every 6 months. When the orders are renewed and there are changes without any reason, the physician or prescribing practitioner should be contacted for clarification. A medication could have been accidentally left off or the wrong dosage could have been written. Clarification is obtained whenever orders are unclear, incomplete or conflicting. New orders will need to be written as necessary for these clarifications. "Continue previous medications" or "Same Medications" are not complete medication orders and are not to be accepted for medication orders. An order has to be obtained for any medication administered, i.e., over–the–counter or prescription. The employee is to understand the difference between a prescription and an order. The facility needs an order to administer a medication. The prescription may be used for the signed order.
E. Describe or demonstrate the process for ordering medications and receiving medications from pharmacy	E. The employee should be knowledgeable of the facility's procedures on ordering medications, including refills, procedures for emergency pharmaceutical services and on receiving medications when delivered from the pharmacy. The facility is to be able to account for medications administered by staff; therefore, the facility is to have procedures to ensure that dispensing information, i.e., date, name, strength and quantity of medication, can be readily available. For situations such as admissions when the resident or responsible party brings medications into the facility, the name, strength and quantity of medication brought in should be documented.
F. Identify required information on the medication label	F. The employee has to be able to identify the following information on the label: medication name and strength; quantity dispensed and dispensing date; directions for use; the pharmacy that dispensed the medication and the prescription number; and expiration date. The employee should understand the difference between generic and brand names and know that an equivalency statement should be on the medication label when the brand dispensed is different than the brand prescribed. The employee should also know labeling requirements for over-the-counter (OTC) medications, according to the regulation 10A NCAC 13F/13G .1004.
Section 3 : Using appropriate technique to obtain and record the following:	**Section 3**
A. * Blood Pressure	A. Blood Pressure (B/P)– The employee is to know how to check a blood pressure by using the facility's blood pressure device. If electronic machines are used, the employee should understand that the device needs to be checked for accuracy according to the manufacturer's recommendations. The instructor needs to indicate on the checklist how the employee obtained the resident's blood pressure, i.e., electronically or manually with a stethoscope and blood pressure cuff. The employee should know that blood pressure cuffs that are too small or large for the resident's arm might result in an inaccurate reading. Ranges for high and low blood pressures that indicate the resident's blood pressure should be reported are to be established by the facility's policy or physician's order.

Guidelines for Completing the Medication Administration Clinical Skills Checklist

B. * Temperature	B. Temperature (T or TEMP.)– The employee should know how to obtain the resident's temperature using the facility's thermometer: i.e., electronic, glass or tympanic. The employee should know the normal oral temperature and that temperature is measured using either the Fahrenheit or Celsius scale. Normal oral temperature is 36.5 – 37.5 degrees Celsius or 96.7 – 99.6 degrees Fahrenheit. The employee should know that activity, food, beverages and smoking all affect body temperature.
C. * Pulse	C. Pulse – Number of heartbeats counted in one full minute. The employee should know how to take a radial (heart rate measured at the thumb side of the inner wrist) and apical pulse (heart rate measured directly over the heart using a stethoscope). A pulse may be obtained by using an electronic device. Normal range is 60 to 100 beats/minute.
D. * Respirations	D. Respirations (R) – Number of breaths a person takes per minute. The normal range is 10 to 24 breaths per minute. One full breath is counted after the resident has inhaled and exhaled. The most accurate rate is taken when the resident is not aware that his/her respirations are being monitored.
E. Fingersticks/Glucose Monitoring **(Only required to be validated if the employee will be performing this task.)**	E. The employee is to know how to operate devices used for the collection and testing of fingerstick blood samples, such as glucose monitoring devices. Staff is to know about calibrating and cleaning the machine per manufacturer's instructions. The range of a monitoring device should be posted with the MARs or available for staff for reference. Ranges for devices, such as glucose monitoring machines, may vary. The facility should have procedures developed when a reading is obtained, especially if the reading is low or high. The employee is to be knowledgeable of the procedures and know where to locate the information if needed. The employee is to be knowledgeable of infection control measures, such as wearing gloves, disposal of lancets in sharps container and the cleaning of machines per manufacturer's instructions, for procedures with which bleeding occurs or the potential for bleeding exists.
Section 4: If medications are prepared in advance, procedures, including documentation, are in accordance with regulation 10A NCAC 13F/13G .1004. (only has to be completed if applicable to facility)	**Section 4** The containers must be prepared and labeled according to regulation 10A NCAC 13F/13G .1004. If the medications are not dispensed in sealed packages, the container has to be capped or sealed and each medication prepared is to be identified on the container. The MAR is to be used when prepouring or preparing medications. If the person who prepares the medication is not the same person to administer the medication, the person preparing the medication must document each medication prepared. (This is in addition to documentation by the person who actually administers the medications. The administration of medications is not to be documented until after the resident is observed to take the medications.)
Section 5: Administration of Medications A. Identify resident	**Section 5** A. The employee is to know the procedures for identifying residents. The most common method used is photographs of residents in the medication administration records. The photos should be kept updated and the photograph is to have the name of the resident on it. Relying on other staff to identify residents is not appropriate.

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B. Gathered appropriate equipment and keeps equipment clean	B. This will depend on the medications to be administered. Supplies/equipment to have for medication administration need to include at least the following: 1. Medication administration records 2. Medication cups for oral medications, i.e., liquids and tablets 3. Sufficient fluids available to administer medications 4. Food substance, i.e., applesauce or pudding, if needed. 5. If soap and water is not available for washing hands, an appropriate antiseptic is to be available for use. Supplies and equipment used in the process of administering medications is to be kept clean and orderly, i.e., medication carts, trays and pill crusher.
C. Medication administration records utilized when medications are prepared and administered. They are also used when medications are prepoured, if prepouring is allowed.	C. Employee is to use the medication administration record when administering medications.
D. Read the label 3 times; Check label against order on the medication administration record.	D. Reading the label - The employee should compare the label to the MAR 3 times: 1. when selecting the medication from the storage area 2. prior to pouring the medication 3. after pouring and prior to returning the medication to the storage area. The information on the MAR and the medication label should match, unless there has been a change in the directions. The employee is to be familiar with the facility's policy on direction changes. A medication label can only be changed or altered by the dispensing practitioner.
E. Use sanitary technique when pouring or preparing medications into the appropriate container	E. Medications are not to be touched or handled by the employee's hands. Medications are to be poured from the medication container into an appropriate medication container or cup and given to the resident. It is not acceptable for the employee to use his/her hands to administer the medications or for the resident to have to use his/her hands to receive the medications. (This is referring to the facility not having adequate or appropriate supplies or the employee not using the supplies to administer medications. This is not referring to residents pouring the medication, e.g., tablet, or wanting the medication poured into their hands.)
F. Offer sufficient fluids with medications	F. The resident should be offered sufficient fluids following the administration of medications even if the medication is administered in a food substance.

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G. Observe resident taking medications and assures all medications have been swallowed.	G. The employee is to observe the resident taking the medication to assure the medication is swallowed. This must be before documenting the administration of the medications.
Section 6: Utilized Special Administration/Monitoring Techniques as indicated(vital signs, crush medications. check blood sugar, mix with food or liquid)	**Section 6** The employee is to be knowledgeable of the facility's policy on crushing medications and mixing medications in food. A current list of medications that should not be crushed may be available for staff to use or facility policy should require that no medications be crushed prior to checking with the pharmacist. Medications are not crushed until immediately before the medications are administered to a resident. One of the objectives with crushing medications is to avoid cross-contamination. Facilities may use different devices to crush medications. The most common method is using a pill crusher and crushing the medications using two medication souffle cups. If the medications are unit dose, the employee may crush the medication in the unit dose package and empty into a medication cup. If the facility uses a device such as a mortar and pestle, and the residue from the medications is present, the device has to be cleaned thoroughly before crushing another resident's medications. When a vital sign, i.e., pulse or blood pressure, is to be obtained prior to the administration of a medication, the employee should have the results prior to preparing the medications for administration.
Section 7: **Administer medications at the appropriate time**	**Section 7:** The employee is to be knowledgeable of what "before meals", "after meals" and "with meals" mean. Medications prescribed before meals are generally to be administered about 30 minutes prior to the resident eating. When the medications are prescribed to be administered with or after meals, the medication is to be administered sometime after the resident has started eating up to 60 minutes after the resident has finished eating. The employee also has to be knowledgeable of the time period allowed by state regulations to administer medications, one hour prior to and one hour after the scheduled administration time. The employee must know that this does not apply to medications prescribed for administration in accordance with meals or for medications such as insulin.
Section 8: Describe methods used to monitor a resident's condition and reactions to medications and what to do when there appears to be a change in the resident's condition or health status	**Section 8** The employee should know that there are various side effects of medications. Side effects of medications include but not limited to the following: change in behavior, change in alertness, change in eating or swallowing, change in mobility and skin rashes. When there is a change in the resident, the employee is to follow the facility's policy on what to do which may include the following: using a medication reference and looking up possible side effects of a medication, asking the resident how they are feeling, observing the resident and notifying the supervisor or a health professional. The employee is to know that information regarding the resident's behavior and action taken should be documented.

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Section 9: Utilize appropriate hand-washing technique and infection control principles during medication pass	**Section 9** Universal Precautions are to be implemented. This includes employees wearing gloves when there may be exposure to bodily fluids. The employee is to be knowledgeable of when to wear gloves and when to change gloves. Handwashing should be with soap and water. When soap and water is not readily available, an antiseptic gel or product must be used in place of soap and water. Handwashing is required when there has been contact with the resident's body or bodily fluids during the administration of medications. Gloves should be worn and handwashing must also be done when transdermal products, i.e., Nitroglycerin or Durgesic patches, are applied or removed.
Section 10 – Documentation of Medication Administration	**Section 10**
A. Initial the MAR immediately after the medications are administered and prior to the administration of medications to another resident. Equivalent signature for initials is documented.	A. The employee is to sign the MAR only after observing the resident take the medications. Precharting is not permitted and this includes signing the MAR anytime prior to the medications being administered. The MAR is to be signed immediately after the medications are administered and prior to the administration of the next resident's medications. The employee is also to document an equivalent signature to correspond with the initials used on the MAR.
B. Document medications that are refused, held or not administered, appropriately	B. The facility is to have procedures to ensure that there is a consistent method of documenting why a medication was not administered. The employee is to be knowledgeable of the facility's policy and procedures. If the facility uses abbreviations such as "R" or "H", there is to be documentation on the medication administration records of the abbreviations and what the abbreviations mean. The facility may have staff circle their initials and document the reason a medication was not administered on the back of the MAR. The employee is also to be knowledgeable of the facility's policy when a resident refuses medications, i.e., notifying the supervisor or physician. If the medications are not administered because the resident is out of the facility, i.e., leave of absence and workshops, there should also be documentation of the medications sent with the resident. (A medication release form is often used for leave of absence.)
C. Administer and document PRN medications appropriately	C. Documentation of PRN medications is to include the amount administered, the time of administration and the reason for administration. The reason a PRN medication is to be administered is to be indicated in the order. The effectiveness of the medication is to also be documented when determined. A different employee, depending on the time of administration and shift schedules may record the effectiveness of the medication. If a resident is requesting or requiring administration of a prn medication on a frequent or routine basis, the employee should report this to the supervisor or the physician. PRN medications are to be administered when a resident needs the medication but may not be administered more frequently than the physician has ordered. The need for medication may be based upon the resident's request for the medication or observation by staff, i.e., resident exhibiting pain but does not request medications or may not be able to request the medication.

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D. Record information on other facility forms as required	D. The forms to be completed would depend on the facility's policy and procedures. The employee is to be knowledgeable of forms to complete, i.e., administration of controlled substances and documentation of medications provided for leave of absence.
E. Write a note in the resident's record when indicated	E. Any contact with the prescribing practitioner is documented in the resident's record. The employee needs to be knowledgeable of how to write a note in the resident's record appropriately, i.e., date and employee's signature. The employee also must be knowledgeable of the facility's procedures for documenting information that needs to be communicated to other staff or health professionals. This may be in the resident's record or on some other document used to communicate with staff or health professionals.
Section 11:Completion of Medication Pass	**Section 11**
A. Store medications properly	A. External and internal medications are to be stored in separate designated areas. The employee should store refrigerated medications in the medication refrigerator or locked container. Medications requiring refrigeration are to be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C). A resident's oral solid medications should be stored together and separated from other residents' medications. It may not be possible for other medications, i.e., liquids and topical medications, to be separated by dividers for each resident. Medication storage areas need to be orderly so medications may be found easily.
B. Dispose of contaminated or refused medications per policy	B. Dosages of medications that have been opened and prepared for administration and not administered for any reason should be disposed of promptly. The disposal of these medications should be in accordance with the facility's policy and procedures. Loose medications are not to be kept in the facility or returned to the pharmacy.
C. Recheck medication administration records to make sure all medications are administered and documented	C. When the medication pass is complete, the employee is to recheck the medication administration records to make sure all medications have been administered and documented appropriately. At the end of the medication pass if a medication is not signed off upon recheck of the medication administration record, and the employee is certain the medication was administered, it is acceptable for the employee to document the administration. This is acceptable when there are only a few, i.e., one or two, omissions. It is not acceptable for the employee to have omitted documentation of the administration of medications for multiple residents.
Section 12: Medication Storage	**Section 12**
A. Maintain security of medications during medication administration	A. Medications are to be stored in a locked area, unless the medications are under the direct supervision of staff. Direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary.

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B. Store controlled substances appropriately and count and sign controlled substances per facility policy	B. The storage of controlled substances is to be in accordance with the facility's policy and procedures. Controlled substances may be stored in one location in the medication cart or medication room. When Schedule II medications are stored in one location together or with other controlled substances, the controlled substances are to be under double lock. When controlled substances, including Schedule II, are stored with the resident's other medications, only a single lock is required. There has to be a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. The employee is to be knowledgeable of any forms to be completed.
C. Assure medication room/cart/cabinet is locked when not in use	C. Medication room/cart/cabinet is locked when not in use. Unless the medication storage area is under the direct supervision of staff, the medication area including carts is to be locked. When the medication cart is not being used, it should be stored in a locked area or stored in an area where it is under the supervision of staff.
Section:13: Administer medication utilizing appropriate technique for dosage form/route and administer accurate amount	**Section 13** The employee is to actually perform or at least be able to demonstrate to the instructor the proper technique for administering the different dosage forms and routes of administration for A through J **prior** to the employee being assigned to administer medications in the adult care home. Routes of administration for K through P only have to be validated if the employee will be responsible for administering these medications or medications by these routes. **The information below does not provide step by step procedures for administering medications. It provides pertinent information on techniques and infection control that the employee is to know. Refer to the State Approved Medication Administration Courses for Adult Care Homes for step by step procedures.**
A. Oral tablets and capsules **B. Oral liquids**	**A. & B. Oral Medications** • Appropriate positioning of resident, elevation of head. • The amount of medication to be administered, such as liquids, is never to be approximated. The amount ordered is to be the amount administered; therefore, a calibrated syringe is often necessary for measuring liquids in amounts less than 5 ml. and unequal amounts. • Liquid medications must be measured in a calibrated medication cup/device. • Measuring devices used for administering medications are to be calibrated and designed for measuring medications. Eating utensils or other household devices are not to be used for administering medications. • When measuring liquids, the medication cup should be placed on a flat surface, and measured at eye level to ensure accuracy. • For liquids, hold the medication container so that the medication flows from the side opposite the label so it doesn't run down the container and stain or obscure the label. • Powdered medications such as bulk laxatives need to be given with the amount of fluids indicated. • More than one capsule or tablet may be in the same medication cup, but liquid medications are not to be mixed together.

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	• Special measuring devices for certain medications should only be used for that medication. (These measuring devices have increments marked off in "mgs." instead of "mls" and usually have the name of the medication on the measuring device.) • Liquids may have administration requirements such as Shake Well and Requires Dilution prior to administration. Examples of these liquids are Dilantin Suspension, which must be shaken thoroughly because the medication settles after administration and gives inconsistent dosing; Liquid Potassium and bulk laxatives have to be mixed with sufficient fluids to decrease side effects. • Refer to ATTACHMENT C for additional information.
C. Sublingual medications	**C. Sublingual** • The medication is to be placed under the resident's tongue. The resident should be instructed not to chew or swallow the medication. Do not follow with liquid, which might cause the tablet to be swallowed.
D. Oral Inhalers	**D. Oral Inhalers** • For information on technique for meter dose inhaler refer to ATTACHMENT D. • Spacing and proper sequence of the different inhalers is important for maximal drug effectiveness. • The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR. • The use of spacer or other devices to aid with administration should be discussed with the employee. • Wait at least one minute between puffs for multiple inhalations
E. Eye drops and ointments	**E. Eye drops and ointments** • Hands are to be washed prior to and after administration of eye drops and ointments. Gloves are to be worn as indicated. Gloves are to always be worn when there is redness, drainage or possibility of infection. • When two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. • Dropper or medication container should not touch the resident's eyes.
F. Ear drops	**F. Ear Drops** • Wash hands before and after administration of medication. Gloves are to be worn as indicated. • By gently pulling on the ear, straighten the ear canal • The employee should request the resident to remain in same position for 5 minutes to allow medication to penetrate. It may be necessary to gently plug the ear with cotton to prevent excessive leakage.
G. Nose drops **H. Nasal Sprays/Inhalers**	**G. & H. Nose Drops & Nasal Sprays/Inhalers** • Wash hands before and after. Gloves are to be worn as indicated. • For drops: Resident should lie down on his/her back with head tilted back and the employee should request the resident to remain in the position for about 2 minutes to allow sufficient contact of medication with nasal tissue. • For Sprays: Hold head erect and spray quickly and forcefully while resident "sniffs" quickly. It may be necessary

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	to have the resident tilt head back to aid penetration of the medication into the nasal cavity. • The dropper or spray should be at least wiped with a tissue before replacing the cap.
I. Transdermal medications/Patches	**I. Transdermal Products/Patches** • Application sites for transderm patches should be rotated to prevent irritation. The application sites should be documented on the MAR. • If the patch is ordered to be worn for less than 24 hours, documentation on the medication administration record is to reflect that the patch was removed and the time it was removed. • Gloves should be worn and hands washed after the patch is applied or removed. • When a patch is removed, the area should be cleaned to remove residual medication on the skin.
J. Topical (creams and ointments; not dressing changes)	**J. Topical** • Wearing gloves and use a tongue bade, gauze or cotton tipped applicator to apply the medication. • A new applicator should be used each time medication is removed from container to prevent contamination. • Privacy should be provided, as necessary. This would depend on the area to be treated. • The lid or cap of the container should be placed to prevent contamination of the inside surface. • Gloves and supplies used should not be discarded in areas accessible to residents.
	(Validation for items K. through P is only necessary if the employee will be performing the task. These are tasks under Licensed Health Professional Support. Refer to regulations 10A NCAC 13F/13G .0504; .0505 and .0903.)
K. *Clean dressings	**K. *Clean Dressing** • The employee is to be knowledgeable of techniques with dressing change to ensure there is no cross-contamination • Information under item J is also applicable to dressing changes.
L. *Nebulizers	**L. *Nebulizers** • Nebulizer equipment, tubing and mask, is to be cleaned and changed in accordance with the facility's policy.
M. * Suppositories **1. Rectal** **2. Vaginal** **N. * Enemas**	**M.&N. Suppositories & Enemas** • Wash hands before and after. Gloves are to be worn and properly disposed of. • Remove foil or wrapper from suppository. A small amount of lubricant applied to the suppository will aid with administration of rectal preparations. • Privacy is to be provided. • Reusable applicators are to be cleaned with soap and water and properly stored.
O. * Injections **1. Insulin**** 2. **Other subcutaneous medications**	**O. Injections** • Syringes are not to be recapped and must be disposed of in appropriate containers, i.e., Sharps. • ****For insulin, the employee is to have also received training according to regulation 10A NCAC 13F/13G .0505.

Guidelines for Completing the Medication Administration Clinical Skills Checklist

	• The employee is to be knowledgeable of the facility's policy on storage of insulin. • Employee is to be knowledgeable of technique for mixing different insulins. • Employee is to be knowledgeable of facility's policy and procedure of when insulin should be held and interventions for hypoglycemia and hyperglycemia reactions. • Wash hands before and after. Gloves are to be worn.
P. * Gastrostomy Tube	**P. Gastrostomy Tube** • Wash hands before and after. Gloves are to be worn. • Tube should be flushed with sufficient water prior to and after the administration of medications. The amount of water should be reflected in the physician's order or the facility's procedure. • Solid medications that are crushed or altered for administration should be dissolved well in water. Employee is to also check to check with the pharmacist to ensure medications may be crushed or altered.
Section 14: Other Tasks/Skills A. Self-Administration of medications by residents B. Received orientation to facility's policy and procedures for medication administration	**Section 14** A. The employee is knowledgeable of the facility's policy and procedure for self-administration. A physician's order is required for the resident to self-administer medications and be able to store medications in their rooms. B. The employee has been provided a copy of the facility's policy and procedures, knowledgeable of the facility's policy and procedures and able to locate the manual as a resource and reference.

Guidelines for Completing the
Medication Administration Clinical Skills Checklist

North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt
Division Director

April 9, 2015

MEMORANDUM

TO: N.C. Adult Care Home & Family Care Home Providers
Directors, N.C. County Departments of Social Services
Supervisors, Adult Services, N.C. County Departments of Social Services
Adult Home Specialists, Adult Services, N.C. County Departments of Social Services

FROM: Megan Lamphere, MSW
Section Chief, DHSR Adult Care Licensure Section

RE: Amended Licensure Rules 10A NCAC 13F & 13G .1003 and .1010
(*Regarding medications for a resident's leave of absence*)

Effective April 1, 2015, the requirements for adult care and family care home facilities related to the provision of a resident's medications for a leave of absence (LOA) were amended. Specifically, the following rules have been amended:

10A NCAC 13F .1003 Medication Labels
10A NCAC 13F .1010 Pharmaceutical Services

10A NCAC 13G .1003 Medication Labels
10A NCAC 13G .1010 Pharmaceutical Services

The N.C. Medical Care Commission initiated these rule changes on September 12, 2014 and adhered to the requirements of the rule-making process set forth in G.S. 150B. The Commission welcomed and incorporated feedback on the rule changes from a variety of stakeholders, including facility representatives, pharmacists, and other interested parties.

The final rule amendments, as well as the rule-making process, may be found on the DHSR Rule Actions webpage at http://www.ncdhhs.gov/dhsr/rules/acls2014 . The rules without the changes noted in the text of the rule are attached to this memo and will eventually be available on-line in the N.C. Administrative Code at http://reports.oah.state.nc.us/ncac .

In addition, the Adult Care Licensure Section has updated an optional form that has been available for providers to use when releasing a resident's medication for a LOA. Again, this form is optional. The form may be completed electronically, then printed out for signature by the staff and resident or person accompanying the resident on the LOA. We hope that facilities will find this form useful. The form can be found on the ACLS website at http://www.ncdhhs.gov/dhsr/acls/pdf/medreleaseform.pdf .

Adult Care Licensure Section
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An Equal Opportunity / Affirmative Action Employer

10A NCAC 13F .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

(1) the name of the resident for whom the medication is prescribed;

(2) the most recent date of issuance;

(3) the name of the prescriber;

(4) the name and concentration of the medication, quantity dispensed, and prescription serial number;

(5) unabbreviated directions for use stated;

(6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;

(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;

(8) auxiliary information as required of the medication;

(9) the name, address, and telephone number of the dispensing pharmacy; and

(10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 2005;
Amended Eff. April 1, 2015.

10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

(a) An adult care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:

(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;

(2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:

(A) the name and strength of the medication;

(B) the directions for administration as prescribed by the resident's physician;

(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

(f) A facility with 12 or more beds shall have a current, written agreement with a pharmacy provider for dispensing services. The written agreement shall include a statement of the responsibility of each party.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 2005;
Amended Eff. April 1, 2015.

10A NCAC 13G .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

(1) the name of the resident for whom the medication is prescribed;

(2) the most recent date of issuance;

(3) the name of the prescriber;

(4) the name and concentration of the medication, quantity dispensed, and prescription serial number;

(5) unabbreviated directions for use stated;

(6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;

(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;

(8) auxiliary information as required of the medication;

(9) the name, address, and telephone number of the dispensing pharmacy; and

(10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. April 1, 2015.

10A NCAC 13G .1010 PHARMACEUTICAL SERVICES

(a) A family care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:

(5) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;

(6) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:

(D) the name and strength of the medication;

(E) the directions for administration as prescribed by the resident's physician;

(F) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(7) The resident's medications shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(8) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 2005;
Amended Eff. April 1, 2015.

EXERCISE
Medication Aide Qualifications

The following checklist was completed during routine monitoring of medication aide qualification at Fruitful Living Rest Home of Raleigh. Based upon facility information the following were identified as medication aides. MAR review revealed that each had administered medications during the current month. The medication aide qualifications were completed based upon information gathered for each aide. Which medication aides, if any, do not meet the required qualifications? Which medication aides, if any, would be required to complete the required medication training? Why?

MEDICATION AIDE QUALIFICATIONS CHECKLIST
NCDHHS, Division of Health Service Regulation, Raleigh, NC

Facility Name/Location **Fruitful Living Rest Home of Raleigh** Survey Date(s) **11/18/13**

Name of Staff Person	***Title of Staff Person***	***Date of Hire***	***Clinical Skills Checklist?***	***If Yes, Date Completed***	***Med Test Certificate?***	***If Yes, Date Passed***	***Medication Training Required?***
Charles Cherry	Med Aide	12/05/12	Yes	12/08/12	Yes	03/01/13	
Patty Pear	NA and Med Aide	10/17/11	No		No		
Pricilla Peach	Med Aide	06/02/13	Yes	06/05/13 09/03/13	No		
Paul Pineapple	Med Aide	09/01/13	No		Yes	01/29/04	
Anne Apple	Med Aide	10/28/13	Yes	11/05/13	No		

Notes: Revised 11/13

MEDICATION AIDE QUALIFICATIONS CHECKLIST

NCDHHS, Division of Facility Services, Raleigh, NC

Facility Name/Location **Fruitful Living Rest Home of Raleigh** Survey Date(s) **11/18/13**

Name of Staff Person	
Charles Cherry	Training is NOT required.
Patty Pear	Training is required.
Pricilla Peach	Training is required. Cannot validate again to lengthen the time to take test.
Paul Pineapple	Training is required. Skills validation not done so the requirements not met by 10/01/13.
Anne Apple	Training is required – hired after 10/01/13 and had not taken test.

Notes: Revised 11/13

ABBREVIATIONS

DOSES

gm = gram
mg = milligram
mcg = microgram
cc = cubic centimeter
ml = milliliter
tsp = teaspoonful
tbsp = tablespoonful
gtt = drop
ss = 1/2
oz = ounce
mEq = milliequivalent

ROUTES OF ADMINISTRATION

po = by mouth
pr = per rectum
OD = right eye
OS = left eye
OU = both eyes
AD = right ear
AS = left ear
AU = both ears
SL = sublingual(under the tongue)
SQ = subcutaneous (under the skin)
per GT = through gastrostomy tube

TIMES

QD = every day
BID = twice a day
TID = three times a day
QID = four times a day
q_h = every __ hours
qhs = at bedtime
ac = before meals
pc = after meals
PRN = as needed
QOD= every other day
ac/hs= before meals and at bedtime
pc/hs= after meals and at bedtime
stat = immediately

OTHER

MAR = medication administration record
OTC = over the counter
SIG = label or directions

Chapter 4: Personal Care and Supervision

Monitoring Personal Care & Supervision

Division of Health Service Regulation
Adult Care Licensure Section

Objectives:

- Demonstrate knowledge of the rules pertaining to personal care, accident and incident reporting, restraints, resident assessment and care planning.
- Demonstrate the ability to monitor for compliance in the rule areas.

Related Rule Areas

- Personal Care & Supervision
  - 10A NCAC 13F/G .0901
- Reporting of Accidents & Incidents
  - 10A NCAC 13F/G .1212
- Use of Physical Restraints & Alternatives
  - 10A NCAC 13F/G .1501
- Resident Assessments & Care Plans
  - 10A NCAC 13F/G .0801, .0802

- (a) Provide care according to the residents' care plan.
  - Attend to other personal care needs the resident may be unable to do for themselves.
- (b) Provide supervision related to the care plan.
- (c)Respond immediately to accidents/incidents to provide care and intervention.
  - According to facility policies & procedures.

Personal Care & Supervision

10A NCAC 13F/G .0901

"Staff shall…"

- (a) Notify DSS of any accident/injury resulting in death or injury requiring referral for emergency medical evaluation or medical treatment. (other than first aid)
- (c) The report required in Paragraph (b) submitted to DSS within 48 hours of the discovery of the accident/incident.
- (d) Immediately notify DSS and local law enforcement.
- (e) Notify responsible person or contact from the Resident Register.
- (f) Report to law enforcement when a resident is at risk that death or physical harm will occur as a result of physical harm by another.
- (h) Report any assault resulting in harm to a resident or another person in the facility to law enforcement.

Reporting of Accidents & Incidents

10A NCAC 13F/G .1212

Are These Reportable Incidents?

- Skin Tear? — No
- A Fall? — If injury occurs
- Theft of personal belongings? — No
- Leaving the locked unit and going to the courtyard? — Is it considered elopement? No
- Visit to ER for chest pain? — No
- Abuse of a resident by a staff member? — Yes

Use of Physical Restraints & Alternatives

10A NCAC 13F/G .1501

"Shall assure…"

- (a) A physical restraint is only used when absolutely necessary and incompliance with all rule requirements.

1. Resident has medical symptoms that warrant the use of restraints
2. Written order from a physician
3. Least restrictive restraint
4. Last alternative
5. Assessment and care plan
6. Applied correctly
7. Attempt to reduce restraint use

Restraints

- Physical
  - Attached to or adjacent to the body that cannot be removed easily
  - Restricts freedom of movement
- Chemical
  - Medications: antipsychotics, sedatives
  - Behavior control
- Examples:
  - Side Rails – to keep resident in bed, Geri-chairs with locking trays

Enablers

Assistive devices used to enhance the resident's functional abilities.

- Side Rails used to increase mobility
- Geri-chairs used for positioning
- Lap belts that the resident can remove
- Wheelchair seatbelts that the resident can operate
- Pillows used for positioning

Resident Assessments & Care Plans

10A NCAC 13F/G .0801, .0802

- Resident Assessment
  - FL-2, Resident Register, DMA 3050-R
- Significant Change
  - Referral
- Care Plan
  - Physician Signature, identified needs, diagnosis

Resident Assessment 10A NCAC 13F/G .0801

- (a) Initial assessment is completed within 72 hours of admission using the Resident Register.
- (b) Assessment is completed within 30 days of admission and annually thereafter (DMA 3050-R).

Significant Change 10A NCAC 13F/G .0801(c)(1)(d)

- (c) An assessment is completed within 10 days following a significant change using the DMA 3050-R.
  - (1) Significant change is one or more of the following: (A-M)
  - (2) Significant change is not any of the following: (A-F)
- (d) A referral is made to the resident's physician or other appropriate licensed health professional – cannot exceed the 10 days and must be documented in the record.

Significant Change - Yes or No?

Skin Tear?	No
Antibiotic Therapy?	No
Change in ability to dress self?	Yes
Urinary Tract infection?	No
Change in ability to walk or transfer from wheelchair?	Yes
Change from continence to incontinence?	Yes

- (a) A Care Plan is developed in conjunction with the resident assessment within 30 days following admission.
- (b) Care Plan is revised as needed.
- (c) Care Plan includes:
  - (1) statement of the care or service to be provided based on the assessment
  - (2) frequency of the service
- (d) Signed by the assessor.
- (e) Physician must authorize, sign and date the care plan within 15 calendar days of the completed assessment.

Resident Care Plan

10A NCAC 13F/G .0802

- The care plan for residents under the care of a provider of mental health, developmental disabilities or substance abuse services include resident specific instructions on how to contact the provider, including emergency contact.
- Significant Change:
  - .0801(c)(1)(D)
  - .0801(d)

Resident Care Plan

10A NCAC 13F/G .0802(f)

ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ____ DOB ____/____/____ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

_____PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	**Dose**	**Frequency**	**Route**	**(✓) If Self-Administered**
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral _____

Name of Contact Person _____

Agency _____

Social/Mental Health History: _____
_____
_____
_____
_____
_____
_____

3. AMBULATION/LOCOMOTION: ☐ No Problems ☐ Limited Ability ☐ Ambulatory w/ Aide or Device(s) ☐ Non-Ambulatory
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

4. UPPER EXTREMITIES: ☐ No Problems ☐ Limited Range of Motion ☐ Limited Strength ☐ Limited Eye-Hand Coordination
Specify affected joint(s) _____ ☐ Right ☐ Left ☐ Bilateral
☐ Other impairment, specify _____
_____
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

5. NUTRITION: ☐ Oral ☐ Tube (Type) _____ Height _____ Weight _____
Dietary Restrictions: _____
_____
_____
_____
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

6. RESPIRATION: ☐ Normal ☐ Well Established Tracheostomy ☐ Oxygen ☐ Shortness of Breath
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

7. SKIN: ☐ Normal ☐ Pressure Areas ☐ Decubiti ☐ Other _____
Skin Care Needs _____
_____
_____

8. BOWEL: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
☐ Ostomy: Type _____ Self-care: ☐ YES ☐ NO

9. BLADDER: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
Catheter: Type _____ Self-care: ☐ YES ☐ NO

10. ORIENTATION: ☐ Oriented ☐ Sometimes Disoriented ☐ Always Disoriented

11. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

12. VISION: ☐ Adequate for Daily Activities ☐ Limited (Sees Large Objects) ☐ Very Limited (Blind); Explain_____
Uses: ☐ Glasses ☐ Contact Lens ☐ Needs repair or replacement
Comments _____
_____

13. HEARING: ☐ Adequate for Daily Activities ☐ Hears Loud Sounds/Voices ☐ Very Limited (Deaf); Explain _____
☐ Uses Hearing Aid(s) ☐ Needs repair or replacement
Comments _____

14. SPEECH/COMMUNICATION METHOD: ☐ Normal ☐ Slurred ☐ Weak ☐ Other Impediment ☐ No Speech
☐ Gestures ☐ Sign Language ☐ Writing ☐ Foreign Language Only _____ ☐ Other ☐ None
☐ Assistive Device(s) (Type _____) Has device(s): ☐ Does not use ☐ Needs repair or replacement

CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0 -** INDEPENDENT, **1 -** SUPERVISION, **2 -** LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

ACTIVITIES OF DAILY LIVING (ADL) *DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:*	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	**PERFORMANCE CODE**
EATING								
TOILETING								
AMBULATION/LOCOMOTION								
BATHING								
DRESSING								
GROOMING/PERSONAL HYGIENE								
TRANSFERRING								

OTHER: (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)

ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

☐ Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

Name _____ Signature _____ Date _____

PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

☐ The resident may take therapeutic leave as needed.

Name _____ Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

RESIDENT INFORMATION: In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

DATE OF MOST RECENT EXAMINATION: Includes a yearly physical by the resident's attending physician.

ASSESSMENT:

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.

2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.

   - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.

   - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

TOP OF SECOND PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.

4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.

5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.

6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.

7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.

8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.

10. **ORIENTATION:** Check appropriate box.

11. **MEMORY:** Check appropriate box.

12. **VISION:** Check appropriate box. Expand on concerns in comments area.

13. **HEARING:** Check appropriate box. Expand on concerns in comments area.

14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

TOP OF THIRD PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

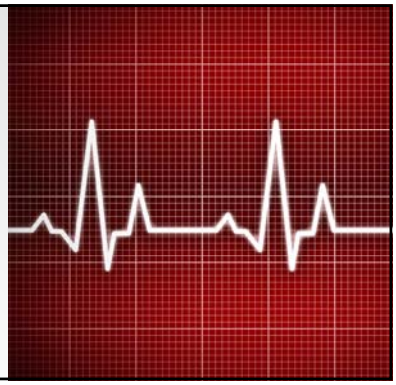
ACTIVITIES OF DAILY LIVING: Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

ASSESSOR CERTIFICATION: Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

PHYSICIAN AUTHORIZATION: The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.

Chapter 5: Monitoring Health Care

Monitoring Health Care



DIVISION OF HEALTH SERVICE REGULATION

ADULT CARE LICENSURE SECTION

Observations, Interviews and Record Reviews

Objectives

- Demonstrate knowledge of the rules pertaining to health care.
- Demonstrate the ability to monitor for compliance.

Fundamental Health Care Rules

- 10A NCAC 13F/G .0902(a)
- 10A NCAC 13F/G .0902(b)
- 10A NCAC 13F/G .0902(c)(1)(2)
- 10A NCAC 13F/G .0902(c)(3)(4)
- 10A NCAC 13F/G .0902(d)(1)(2)

- Review the FL-2
- Medication Administration Records
- DMA 3050-R (Adult Care Home Personal Care Physician Authorization and Care Plan)
- Progress Notes
- Hospital Records
- Home Health Notes
- Labs
- Therapy Notes
- Mental Health Provider Records
- LHPS Reviews

How to Monitor Health Care

Observations, Interviews and Record Reviews

- An adult care home shall provide care and services in accordance with the resident's care plan.

10A NCAC 13F/G .0902(a)

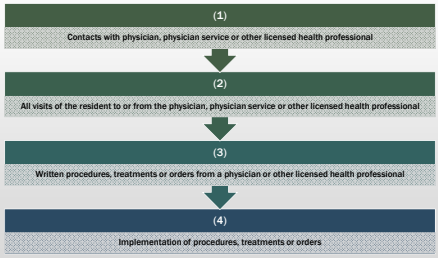
- The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

10A NCAC 13F/G .0902(b)

What are routine health care needs?

10A NCAC 13F/G .0902 (c)(1)(2)(3)(4)

(c) The facility **shall assure documentation** of the following in the resident's record:



10A NCAC 13F/G .0902(d)(1)(2)

(d) The following shall apply to the resident's physician or physician service:

(1) Resident or responsible person shall be allowed to choose a physician or physician service to attend the resident.

(2) The facility shall make arrangements that another physician is secured within 45 days when the resident is no longer able to remain under the care of their physician or physician service.

How is the monitoring visit conducted?

OBSERVATIONS, INTERVIEWS & RECORD REVIEWS

Entrance

- Conduct entrance conference with Administrator or Supervisor-In-Charge
- Explain Purpose of Visit
- Request Primary Contact Person
- Request Specific Information
- Approximate Length of Visit

Observations, Interviews & Record Reviews

- Tour Facility and Choose Resident Sample
- Observe Residents and Staff
- Record Review:
  - FL-2, MARs, DMA 3050-R, Progress Notes, Hospital Records, Home health Notes, LHPS Reviews, Therapy Notes and other services

Putting it All Together

- Observations:
  - What have you seen?
- Interviews:
  - What have you heard?
- Record Reviews?
  - What have you read?

Analysis:

Is there a problem?

What is causing the problem?

What impact does it have on the residents?

- Have you used all appropriate methods of investigation?
- Do you have all the necessary information?
- Is the sample sufficient and well chosen?
- What is the scope and severity of your findings?
- What is the impact to the resident(s)?

Exit

Appropriate Reports

Follow-Up

Practice Health Care Module

Health Care 10A NCAC 13F/G .0902 (b)
Census: 53

- You are in the facility on August 25, 2016 to monitor healthcare.
- Resident #23 is in your sample.
- You have reviewed 5 records and 3 records have problems with health care.
  - 2 were finger stick blood sugar checks
  - 1 lab not ordered
- Resident #23 had physician orders to check blood sugar twice a day and to call the physician if the value was less than 60 or greater than 350.
- Review of the resident's Medication Administration Records (MARs) for June and July revealed on 15 different days, the resident's blood sugar was not recorded.
- Three days in June on the 6th, 12th, and the 15th at 7:30am revealed blood sugars greater than 450.
- There was no documentation the physician had been notified.

A. Explain your investigation process. Start with the tour; pick a sample; who will that include? Record Reviews (what), Interviews (who)? Other contacts?

B. Is there deficient practice? How did you determine this?

C. Determine what the level of deficiency will be. How did you determine this?

D. Write the deficient practice statement.

RESIDENT REGISTER

The following resident information is to be completed and signed by the Administrator or Supervisor-in-Charge/Administrator-in-Charge and the resident or his/her responsible person within 72 hours of admission and kept in the resident's record in the home. Write "N/A" if the requested information is not applicable to the resident.

NAME OF HOME/FACILITY _____

A. IDENTIFYING INFORMATION

1. NAME_____
   (first) (middle) (last) (what resident prefers to be called)
2. DATE OF ADMISSION_____
   (month) (day) (year)
3. FORMER ADDRESS _____COUNTY:_____

   ADMITTED FROM: ☐ Own Residence ☐ Another's Residence

   A facility:_____
   (Name) (Address)
   Other:_____
4. BIRTHDATE_____ BIRTHPLACE_____ SS#_____
5. MEDICARE #_____MEDICAID #_____OTHER INSURANCE #'S_____
6. MARITAL STATUS ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated
7. GENDER ☐ Female ☐ Male
8. RACE ☐ Caucasian ☐ African-American ☐ Native-American ☐ Hispanic ☐ Other_____
9. FAMILY Father_____ Mother_____
   (include maiden name)

   CHILDREN_____

   SIBLINGS_____

   SPOUSE/PARTNER (Address if applicable)_____
10. RESPONSIBLE PERSON (if applicable)_____

    Address_____ Phone ( )_____

    Nature of Responsibility: ☐ Guardian ☐ Power of Attorney ☐ Payee
11. CONTACT PERSON (If responsible person is not designated)_____

    Address:_____ Phone ( )
12. PERSON IDENTIFIED BY THE RESIDENT TO RECEIVE A COPY OF THE DISCHARGE NOTICE

    Name _____

    Address_____ Phone ( )_____

B. RESOURCE INFORMATION

1. ATTENDING PHYSICIAN:_____

   Address_____

2. PREVIOUS PHYSICIAN_____

Address_____ Phone ( ) _____

PLANS MADE FOR PAYMENT OF: Personal Needs_____

Other_____

C. **PERSONAL INFORMATION**

1. ASSISTANCE REQUIRED FOR: (Check all that apply)

☐ Dressing	☐ Correspondence	☐ Mouth Care
☐ Bathing	☐ Getting In/Out of Bed	☐ Feeding
☐ Nail Care	☐ Toileting	☐ Positioning/Turning
☐ Shaving	☐ Hair/Grooming	☐ Scheduling Appointments
☐ Ambulation	☐ Skin Care	☐ Orientation to Time and Place

☐ (Other)_____

If different from information contained on the FL-2, home must contact resident's physician for clarification.

2. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

3. SPECIAL AIDS: (Check all that apply)

☐ Walker	☐ Hearing Aid	☐ Wheelchair
☐ Eyeglasses	☐ Dentures (Type)_____	☐ Other_____

4. PERSONAL HABITS: ☐ Smoking ☐ Alcohol ☐ Other_____

5. **KNOWN ALLERGIES OR SUBSTANCES NOT TO BE ADMINISTERED (Drug, Food, or Otherwise):**

---

6. FOOD PREFERENCES: If special diet, please describe:_____

_____

	FAVORITES	LEAST FAVORITES
Vegetable		
Fruit		
Meats		
Meat Substitutes		
Cereals and Breads		
Milk or Buttermilk		
Other Beverages		

7. COMMUNITY INVOLVEMENT

a. FAITH COMMUNITY_____ PASTOR_____

Address_____ Phone ( ) _____

b. CLUB, GROUP OR ORGANIZATIONAL MEMBERSHIPS_____

c. SPECIAL SKILLS OR TALENTS_____

d. PAST WORK AND VOLUNTEER SERVICE_____

e. HOBBIES_____

f. ACTIVITY INTERESTS: (Review *Listing of Suggested Activities with resident*).

	Favorites
Games	
Music	
Exercises	
Outdoor Activity	
Crafts	
Outings	
Social Activity	
Work Type/Volunteer Activity	
Intellectual Activity	

g. ACTIVITIES STRONGLY DISLIKED OR TO BE AVOIDED:_____
_____

If there is a question about a resident's ability to participate in an activity, the home must obtain a statement from the resident's physician regarding the resident's capabilities.

D. **REQUEST FOR ASSISTANCE**

Below are some areas in which the home can assist a resident upon the request of the resident or his/her responsible person. The administrator or supervisor-in-charge/administrator-in-charge must explain and complete each statement with the resident or his/her responsible person. The resident or his/her responsible person may subsequently change his/her mind and make a new request in writing at any time using Section H or some other notice. An equivalent signed record can be substituted for Section D.

1. I, as resident or the resident's responsible person, request that pertinent information be secured from the facility from which I just left. Signature:_____

2. I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time. Signature:_____

3. I, as resident or the resident's responsible person, request the use of lockable space for the security of personal valuables. I understand that I am entitled to one key at no charge and this space is accessible only to me and the administrator or supervisor-in-charge. Signature:_____

4. I, as resident or the resident's responsible person, request that the management of this home –
   a. Open my personal mail in my presence to read and explain the contents to me; and
   b. Assist in handling my mail that pertains to my financial or medical affairs.
   Signature:_____

E. **RECEIPT OF MATERIALS**

I, as resident or the resident's responsible person, acknowledge receipt of the following information which the management of the home reviewed with me:

- Home's resident contract specifying rates for the resident services and accommodations;
- House Rules which include policies on refunds, smoking, alcohol consumption, visitation, and reasons for discharge;

- Declaration of Residents' Rights;
- Home's grievance procedures for residents to present complaints and make suggestions as to the home's policies and services; and
- Home's willingness to comply with Title VI of Civil Rights Act.

Other:_____

_____

Signature_____

F. **SIGNATURES**

The resident or his/her responsible person should be asked to sign this form only after Sections A-E have been completed. The administrator or supervisor-in-charge/administrator-in-charge is to review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H. Section G is to be completed at the time the resident is discharged or transfers from the facility.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

G. **DISCHARGE/TRANSFER INFORMATION**

1. NOTICE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)
2. INITIATED BY: ☐ Administrator ☐ Other_____
Reason(s)_____
3. DATE OF DISCHARGE/TRANSFER_____
(Month) (Day) (Year)
To: ☐ Own Residence ☐ Another's Residence (Name)_____
☐ A Facility ☐ Other_____
4. NEW ADDRESS_____ Phone ( )
5. COPY OF THE DISCHARGE NOTICE HAS BEEN GIVEN TO THE PERSON IDENTIFIED BY THE RESIDENT IN SECTION A, #12 OF THIS FORM AS REQUIRED BY GENERAL STATUTE 131D-4.8? ☐ **Yes** (required)

I acknowledge the above information to be complete and accurate.

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator-in-Charge) (Date)

H. **REVIEW/REVISION**

The space below may be used to revise the information contained on the form.

Changes:_____

_____

(Resident or Resident's Responsible Person) (Date)

(Administrator or Supervisor-in-Charge/Administrator –in-Charge) (Date)

Surveyor's Initials: _____

ADULT CARE LICENSURE RESIDENT RECORD REVIEW

Resident: _____ **Date:** _____ **Facility:** _____

Diagnoses: _____ **Date of Birth:** _____

_____ **Date of Adm:** _____

_____

Check appropriate:
☐POA
☐Guardian
☐Resp. Person

Name: _____

Address: _____

_____

FL-2 Date:

ambulation:
☐ non-amb
☐ semi-amb
☐ ambulatory

disorientation
☐ constant
☐ intermittent
☐ oriented
☐ no info

assistive device:
☐ none
☐ cane
☐ walker
☐ w/c
☐ other:
_____
_____

bladder:
☐continent
☐incontinent
☐int catheter
☐ext catheter

bowel:
☐continent
☐incontinent
☐colostomy

TB Testing

2-Step / Chest X-Ray

STEP 1

given:

read as: on:

STEP 2

given:

read as: on:

Diet Order

Date	Diet Order
	supplements: ☐Y ☐N
	thickener: ☐Y ☐N

Health Care

Date	Orders / TX:	Date	Referral / FU:
	☐BS: ☐B/P: ☐HR: ☐WT: ☐O_2: ☐TED: ☐ROM: ☐DSG:		☐PT/OT/SLP: ☐HH: ☐POD: ☐MD: ☐LAB:

Medication Review

Quarterly: ☐Y ☐N
Complete: ☐Y ☐N

Date of Review: _____

Last date: _____

recommendations:
☐none
☐yes:
_____
_____

follow-up:
☐none
☐yes:_____
_____
_____
_____

LHPS Review

Quarterly: ☐Y ☐N
Complete: ☐Y ☐N

Date Task Ordered:	Tasks:	Phys.Assess.

Date of Review: _____

recommendations:
☐none
☐yes:_____
follow-up:_____
_____

Mental Health

☐Seen by MH

Provider: _____
Provider Number: _____

Facility Addressed ☐Y ☐N

Interventions:_____
_____
_____
_____
_____

Assessment & Care Plan

Assessment Date

☐MD signed
☐ Annual
☐ Significant Δ

☐72-hour: (Res. Reg)
_____

CP Date

ADLs

	eating
	toileting
	ambulation
	bathing
	dressing
	grooming
	transfer

Restraints

☐ Order: _____
☐ Assessment_____
☐ Consent:_____

Special Care Units

☐Disclosure
☐Pre-screening
☐Diagnosis
☐Resident Profile – 30 days

Weight Management

Significant Δ: ☐Y ☐N
MD Notified: ☐Y ☐N

Notes:

_____
_____
_____

_____ _____
_____ _____
_____ _____

Resident's Name_____ **Surveyor's Initials: _____**

Notes:

OPTIONAL FORM

LABS

Name of Resident:	Date of order:	Lab Order (PT INR, H&H, UA, etc)	Lab, Home Health Notified Of Order: (date)	Date Drawn:	Results to MD: (Lab or facility)	New Orders: Yes/no	Initials of staff completing form:

OPTIONAL FORM

MEDICAL APPOINTMENTS

NAME OF RESIDENT	NAME OF PHYSICIAN, LAB, HOSPITAL, ETC.	DATE AND TIME OF APPOINTMENT	PAPER WORK SENT WITH RESIDENT	INITIALS OF STAFF
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		
		Date: Time:		

This Check list has been developed as a tool to evaluate and monitor areas pertaining to the Health Care rule in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based. Items on the checklist that are recommendations that may prevent problems from developing do not have a licensure regulation referenced.

10A NCAC 13F/G .0902 HEALTH CARE

(a) An adult care home shall provide care and services in accordance with the resident's care plan.
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.
(c) The facility shall assure documentation of the following in the resident's record:

(1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care.
(2) all visits of the resident to or from the resident's physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware.
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule

(d) The follow shall apply to the resident's physician or physician service

(1) The resident or the resident's responsible person shall be allowed to chooses a physician or physician service to attend the resident.
(2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

	Yes	No	Comments
1. The facility provides care and services in accordance with the resident's care [;am 10A NCAC 13F/G .0902(a)			
2. The facility assures referral and follow up to meet the routine health care needs of the resident 10A NCAC 13F/G .0902(b)			
3. The facility assures referral and follow up to meet the acute health care needs of the resident 10A NCAC 13F/G .0902(b)			

	Yes	No	Comments
4. The facility documents the following in the residents record: 10A NCAC 13F/G .0902(c) • Facility contact with the resident's physician, physician service or other licensed health professional regarding resident care • Facility contacts with the resident's physician, physician service or other licensed health professional when illness/ accidents occur • Documentation of all visits of the resident to or from the resident's physician, physician service, or other licensed health professional of which the facility is aware • Documentation of written procedures, treatments or orders from a physician or other licensed health professional • Implementation of procedures			
5. The follow shall apply to the resident's physician or physician service: 10A NCAC 13F/G .0902(d) • The resident or the resident's responsible person was allowed to choose a physician or physician service to attend the resident • If the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan			
6. There is a system in place to assure care plans are current and reflect the resident care needs			
7. There is a system in place to identify residents requiring lab work			

	Yes	No	Comments
8. There is a system in place to assure residents lab work is drawn			
9. There is a system in place to assure follow up appointments are kept			
10. There is a system in place to receive and carry out new orders			
11. There is a system in place to assure treatments are done as ordered.			
12. There is a system in place to assure FSBS are done as ordered			
13. There is a system in place to assure weights are done as ordered.			

INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

RESIDENT INFORMATION: In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

DATE OF MOST RECENT EXAMINATION: Includes a yearly physical by the resident's attending physician.

ASSESSMENT:

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.

2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.

   - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.

   - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

TOP OF SECOND PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.

4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.

5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.

6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.

7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.

8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **BLADDER:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.

10. **ORIENTATION:** Check appropriate box.

11. **MEMORY:** Check appropriate box.

12. **VISION:** Check appropriate box. Expand on concerns in comments area.

13. **HEARING:** Check appropriate box. Expand on concerns in comments area.

14. **SPEECH/COMMUNICATION METHOD:** Check appropriate box.

TOP OF THIRD PAGE: RESIDENT_____: Place name as on Medicaid ID card in this blank.

CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

ACTIVITIES OF DAILY LIVING: Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

ASSESSOR CERTIFICATION: Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

PHYSICIAN AUTHORIZATION: The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.

ADULT CARE HOME
PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

RESIDENT INFORMATION

(Please Print or Type)

RESIDENT _____ SEX (M/F) ___ DOB ___/___/___ MEDICAID ID NO. _____

FACILITY _____

ADDRESS _____

_____PHONE _____ PROVIDER NUMBER _____

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

Name	Dose	Frequency	Route	(✓) If Self-Administered
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral _____

Name of Contact Person _____

Agency _____

Social/Mental Health History: _____

Resident _____

3. AMBULATION/LOCOMOTION: ☐ No Problems ☐ Limited Ability ☐ Ambulatory w/ Aide or Device(s) ☐ Non-Ambulatory
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

4. UPPER EXTREMITIES: ☐ No Problems ☐ Limited Range of Motion ☐ Limited Strength ☐ Limited Eye-Hand Coordination
Specify affected joint(s) _____ ☐ Right ☐ Left ☐ Bilateral
☐ Other impairment, specify _____
_____
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

5. NUTRITION: ☐ Oral ☐ Tube (Type) _____ Height _____ Weight _____
Dietary Restrictions: _____
_____
_____
_____
Device(s) Needed _____
Has device(s): ☐ Does not use ☐ Needs repair or replacement

6. RESPIRATION: ☐ Normal ☐ Well Established Tracheostomy ☐ Oxygen ☐ Shortness of Breath
Device(s) Needed _____ Has device(s): ☐ Does not use ☐ Needs repair or replacement

7. SKIN: ☐ Normal ☐ Pressure Areas ☐ Decubiti ☐ Other _____
Skin Care Needs _____
_____
_____

8. BOWEL: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
☐ Ostomy: Type _____ Self-care: ☐ YES ☐ NO

9. BLADDER: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
Catheter: Type _____ Self-care: ☐ YES ☐ NO

10. ORIENTATION: ☐ Oriented ☐ Sometimes Disoriented ☐ Always Disoriented

11. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

12. VISION: ☐ Adequate for Daily Activities ☐ Limited (Sees Large Objects) ☐ Very Limited (Blind); Explain_____
Uses: ☐ Glasses ☐ Contact Lens ☐ Needs repair or replacement
Comments _____
_____

13. HEARING: ☐ Adequate for Daily Activities ☐ Hears Loud Sounds/Voices ☐ Very Limited (Deaf); Explain _____
☐ Uses Hearing Aid(s) ☐ Needs repair or replacement
Comments _____

14. SPEECH/COMMUNICATION METHOD: ☐ Normal ☐ Slurred ☐ Weak ☐ Other Impediment ☐ No Speech
☐ Gestures ☐ Sign Language ☐ Writing ☐ Foreign Language Only _____ ☐ Other ☐ None
☐ Assistive Device(s) (Type _____) Has device(s): ☐ Does not use ☐ Needs repair or replacement

CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0** - INDEPENDENT, **1** - SUPERVISION, **2** - LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

ACTIVITIES OF DAILY LIVING (ADL) *DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:*	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	PERFORMANCE CODE
EATING								
TOILETING								
AMBULATION/LOCOMOTION								
BATHING								
DRESSING								
GROOMING/PERSONAL HYGIENE								
TRANSFERRING								

OTHER: (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)

ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

☐ Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

Name _____ Signature _____ Date _____

PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

☐ The resident may take therapeutic leave as needed.

Name _____ Signature _____ Date _____

Chapter 6: Licensed Health Professional Support (LHPS)

LICENSED HEALTH PROFESSIONAL SUPPORT

Division of Health Service Regulation
Adult Care Licensure Section

HISTORY

- Senate Bill 864 (1996 Session of the General Assembly)
- Allows unlicensed personnel to perform specific heavy care tasks with Registered Nurse (RN) oversight.

Objectives

- Learn the rules related to licensed health professional support (LHPS).
- Assess the quality of LHPS services provided to residents through observation, interview and record review.
- Improve the quality of LHPS services through effective interventions.

Fundamental LHPS Rules

- 10A NCAC 13F .0903
  - On-site review and evaluation of the residents' health status, care plan and care provided related to a particular task.
- 10A NCAC 13F. 0504
  - Training and skill validation of staff to ensure they are competent to perform the tasks.

28 LHPS Tasks
10A NCAC 13 F/G .0903

1. Applying and removing ace bandages, ted hose, binders and braces/splints
2. Feeding techniques
3. Bowel/Bladder training programs
4. Enemas, suppositories
5. Urinary catheter
6. Chest physiotherapy or postural drainage
7. Clean dressing changes*
8. Finger stick blood samples
9. Colostomy or ileostomy
10. Pressure ulcers*
11. Inhalation by machine
12. Forcing and restricting fluids
13. Intake and output records
14. Medication administration through feeding tube
15. Medication administration through injection
16. Oxygen administration and monitoring
17. Care of residents that are physically restrained
18. Oral suctioning
19. Care of tracheostomy
20. Administering and monitoring tube feedings
21. CPAP and BIPAP
22. Heat Therapy
23. Application and removal of prosthetic devices
24. Ambulation using assistive devices requiring physical assistance
25. Range of motion exercises
26. Physical or Occupational Therapy
27. Transferring semi-ambulatory or non-ambulatory residents
28. Nurse aide II tasks

GS 131D-2.2(a)

Adult Care Homes shall <u>not</u> care for individuals with:

- Ventilator
- Continuous nursing care
- Medical Doctor (MD) certification that placement s no longer appropriate for the resident
- Facility cannot meet residents needs
- Other medical and functional care needs as determined by the Medical Care Commission

Rule Update
10A NCAC 13F/G .0504(c)

- A Physician may certify staff on a **TEMPORARY** basis.
- Prevents unnecessary relocation of an admitted resident.

LHPS Reviews

10A NCAC 13F/G .0903(c)

Who can perform LHPS Reviews?

- Registered Nurse (RN)
- Occupational and/or Physical Therapist

LHPS Reviews

When are reviews to be completed?

- Within the first 30 days of admission.
- Within 30 days from the date the resident develops the need for the task.
- At least QUARTERLY thereafter.

LHPS Reviews

Where are reviews to be completed?

- Onsite
- Reviews kept in the facility

LHPS Reviews

What does the review include?

- Physical assessment of the resident
- Evaluation of care provided
- Recommended changes
- Documentation
- LHPS Recommendations

LHPS Recommendations

- Completed with each review.
- Documentation of the facility response.
- Notification to the physician or appropriate health professional.

LHPS Reviews

10A NCAC 13F .0504

Who can validate LHPS skills?

- RN
  - All tasks
- Physical Therapist/Occupational Therapist
  - (17) and (22) through (27)
- Pharmacist
  - (8)
- Respiratory Therapist
  - (6), (11), (16), (18), (19) and (21)

Competency Validation

- Unlicensed staff must be trained and validated in the specific tasks outlined in the rule. *Paragraphs (a) and (b).*

Example: Training on diabetes provided prior to staff administering the insulin.

- Ongoing competency.

LHPS Reviews

10A NCAC 13F .0504(a)

When are competency validations performed?

- PRIOR to the performance of the task.
- Documented and available.

Monitoring Tips

Competency Validation…

- Are competency validations completed before performing the task?
- Are return demonstrations done?
- Staff knowledgeable in performing tasks?
- Are staff proficient?

Did the RNs documentation include…

- Indication of staff competency
- Physical assessment of resident
- Response to care provided
- Recommendations if necessary

Monitoring the LHPS…

- Observations, interviews, record reviews
- Analysis

Conclusion

- Assure Safety and Accountability
- Identify Residents (Tracking System)
- Identify Staff that need training and competency validation.
- Refer to the LHPS Rule

OPTIONAL FORM

LICENSED HEALTH PROFESSIONAL SUPPORT REVIEW AND EVALUATION OF RESIDENT

Resident's Name:_____ Date of Evaluation_____

Facility Name:_____ Date of Last Evaluation_____

Review of Health Status and Care Provided—Physical Assessment as related to Diagnoses/Current Condition and Progress to Care Provided:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

_____
_____
_____

LHPS Personal Care Task Provided	Staff Competency	Validated
_____	yes___	no____
_____	yes___	no____
_____	yes___	no____
	yes___	no____

Signature/title_____

As on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

Optional Form

LICENSED HEALTH PROFESSIONAL SUPPORT

INITIAL EVALUATION & QUARTERLY REVIEW OF RESIDENTS

RESIDENT: _____ DATE OF BIRTH: _____ ROOM: _____

DATE OF EVALUATION: _____ DATE OF LAST EVALUATION: _____

PRIMARY DIAGNOIS: _____ OTHER Dx.: _____

HEIGHT: _____WEIGHT: _____PULSE RATE: _____TEMP.: _____RESPRIATION: _____BP: _____

Personal care tasks currently present: (check all that apply)

❑ Applying and removing ace bandages, ted hose, binders, and braces and splints	❑ Feeding techniques for residents with swallowing problems	❑ Bowel or bladder training programs to regain continence	❑ Enemas, suppositories and vaginal douches
❑ Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter	❑ Chest physiotherapy or postural drainage	❑ Clean dressing changes excluding packing wounds & application of prescribed enzymatic debriding agents	❑ Collecting and testing of fingerstick blood samples
❑ Care of well-established colostomy or ileostomy	❑ Care for pressure ulcers up to and including a Stage II pressure ulcer	❑ Inhalation medication by machine	❑ Forcing and restricting fluids
❑ Maintaining accurate intake and output data	❑ Medication administration through a well established gastrostomy feeding tube	❑ Medication administration through injections	❑ Oxygen administration and monitoring
❑ Care of residents who are physically restrained and the use of care practices as alternatives to restraints	❑ Care of well-established tracheostomy	❑ Administering and monitoring of tube feedings through a well-established gastrostomy tube	❑ Monitoring of continuous positive air pressure devices (CPAP and BIPAP)
❑ Application and removal of prosthetic devices	❑ Ambulation using assistive devices that requires physical assistance	❑ Range of motion exercises	❑ Any other prescribed physical or occupational therapy
❑ Transferring semi-ambulatory or non-ambulatory residents	❑ Application of prescribed heat therapy	❑ Tasks performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under the act in 21 NCAC 36	❑ Oral Suctioning

Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care:

_____
_____
_____
_____
_____
_____
_____
_____

Changes and follow up recommended to meet the Resident's Needs:

_____
_____
_____

LHPS Personal Care Task Provided	**Staff Competency Validated**
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____

Signature/Title _____ Date: _____

Note: The facility shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring, but not limited to, one or more of the above tasks.

EXAMPLE: paranoid schizophrenia NIDDM

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name **Date of Evaluation _04/10/2015**
Mr. Very Pleasant Resident____ Date of Last Evaluation _01/05/2015

Review of Health Status and Care Provided--Physical Assessment as related to Diagnoses/Current condition

Recieves Risperdol Consta 37.5mg. injections every 2 weeks. Dosage was increased from 25mg. last month. Shots given by ACT team nurse. Resident compliant with injection appointments and lab work. Even though he states he does not believe he needs these injections. Resident is alert and oriented X3. Resident still has delusions about his deceased mother visiting him. Reports the frequency of the voices is decreasing. Resident is easily re-directed when he becomes agitated. No outbursts observed by staff this quarter.
Resident has gained 3 lbs this quarter (Jan, Feb, Mar 2015) Weight today 220lbs. Resident and staff report non-compliant with NCS diet.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue to encourage compliance with NCS diet, healthy snacking. Monitor for additional weight gain. Report changes in behavior and additional weight gain to MD.

LHPS Personal Care Task Provided	Staff Competency Validated	
Injection	YES X	NO

Signature/title __Mrs. Good Nurse RN_____

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

EXAMPLE: Resident with diagnosis of diabetes and lung disease

LICENSED HEALTH PROFESSIONAL SUPPORT
REVIEW AND EVALUATION OF RESIDENT

Resident's Name **Date of Evaluation _02/22/2016**
Mr. Pleasant Resident____ Date of Last Evaluation _10/1/2015

Review of Health Status and Care Provided--Physical Assessment as related to Diagnoses/Current condition

Finger sticks ordered BID and recorded on the MAR at 7:30am and 4:30pm. FSBS range from 98-150. No skin problems noted , good circulation in feet, nails clean and trimmed. Insulin injection daily controls blood sugar. Staff and Resident reveal compliance with NCS diet. No visual or dental complaints.

No complaints of shortness of breath, lungs clear, no wheezes noted. Nail beds pink, gets Nebulizer treatment at 8:00am and 8:00pm. Resident is not using prn inhalers.

Recommended Changes in Caring for the Resident to meet the Resident's Needs:

Continue FSBS checks as ordered.

LHPS Personal Care Task Provided	Staff Competency Validated	
FSBS	YES X	NO
Injection	YES X	NO
Nebulizer	YES X	NO

Signature/title Mrs. Good Nurse RN

.

An on-site review and evaluation is to be completed within the first 30 days of admission for new residents or within 30 days from the date the resident develops the need for one or more of the LHPS personal care task. Reviews and evaluations are to be completed at least quarterly thereafter.

Optional Form

LICENSED HEALTH PROFESSIONAL SUPPORT

INITIAL EVALUATION & QUARTERLY REVIEW OF RESIDENTS

RESIDENT: _____ DATE OF BIRTH: _____ ROOM: _____

DATE OF EVALUATION: _____ DATE OF LAST EVALUATION: _____

PRIMARY DIAGNOIS: _____ OTHER Dx.: _____

HEIGHT: _____WEIGHT: _____PULSE RATE: _____TEMP.: _____RESPRIATION: _____BP: _____

Personal care tasks currently present: (check all that apply)

❑ Applying and removing ace bandages, ted hose, binders, and braces and splints	❑ Feeding techniques for residents with swallowing problems	❑ Bowel or bladder training programs to regain continence	❑ Enemas, suppositories and vaginal douches
❑ Positioning and emptying of the urinary catheter bag & cleaning around the urinary catheter	❑ Chest physiotherapy or postural drainage	❑ Clean dressing changes excluding packing wounds & application of prescribed enzymatic debriding agents	❑ Collecting and testing of fingerstick blood samples
❑ Care of well-established colostomy or ileostomy	❑ Care for pressure ulcers up to and including a Stage II pressure ulcer	❑ Inhalation medication by machine	❑ Forcing and restricting fluids
❑ Maintaining accurate intake and output data	❑ Medication administration through a well established gastrostomy feeding tube	❑ Medication administration through injections	❑ Oxygen administration and monitoring
❑ Care of residents who are physically restrained and the use of care practices as alternatives to restraints	❑ Care of well-established tracheostomy	❑ Administering and monitoring of tube feedings through a well-established gastrostomy tube	❑ Monitoring of continuous positive air pressure devices (CPAP and BIPAP)
❑ Application and removal of prosthetic devices	❑ Ambulation using assistive devices that requires physical assistance	❑ Range of motion exercises	❑ Any other prescribed physical or occupational therapy
❑ Transferring semi-ambulatory or non-ambulatory residents	❑ Application of prescribed heat therapy	❑ Tasks performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under the act in 21 NCAC 36	❑ Oral Suctioning

Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care:

_____
_____
_____
_____
_____
_____
_____
_____

Changes and follow up recommended to meet the Resident's Needs:

_____
_____
_____

LHPS Personal Care Task Provided	**Staff Competency Validated**
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____
_____	**yes** _____ **no** _____

Signature/Title _____ Date: _____

Note: The facility shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring, but not limited to, one or more of the above tasks.

OPTIONAL

LHPS Review Tracking

YEAR __________

1. LHPS on-site review and evaluation of resident's health status, care plan and care provided is required within 30 days admission or order for task & quarterly thereafter for the following residents'
2. Check for new admissions and new care order that require LHPS review

DATES REVIEW DONE

Resident Name	Date Adm or Task Ordered	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec

OPTIIONAL

Licensed Health Professional Support (LHPS) Quality Assurance Tool

Facility Name: _____ Date: _____

Resident Name	LHPS task(s)	Assigned Care Givers	Care Giver Skill Validation	LHPS Review quarterly

Skills/Competency Evaluation
(Licensed Health Professional Support)

Optional Form

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
1. Applying and removing ace bandages, Ted hose, binders, and braces, and splints					
2. Feeding techniques for residents with swallowing problems					
3. Bowel or bladder training programs to regain continence					
4. Enemas, suppositories, breaking up of fecal impactions and vaginal douches					
5. Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter					
6. Chest physiotherapy or postural drainage					
7. Clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents					
8. Collecting and testing of fingerstick blood samples					
9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)					
10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater					
11. Inhalation medication by machine					
12. Forcing and restricting fluids					
13. Maintaining accurate intake and output date					
14. Medication administration through a well established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established.)					
15. Medication administration through injection (sub q only)					
16. Oxygen administration and monitoring					
17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints					
18. Oral suctioning					
19. Care of well established tracheostomy, not to include indo-tracheal suctioning					

Skill/ Competency	Perf. Date	Satisfactory Completion Date	Inst. Initials/ Signature	Needs Training	Inst. Initials/ Signature
20. Administering and monitoring of tube feedings through a well established gastrostomy tube (see description in Subparagraph (14))					
21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)					
22. Application of prescribed heat therapy					
23. Application and removal of prosthetic devices except as used in early postoperative treatment for shaping of the extremity					
24. Ambulation using assistive devices that requires physical assistance					
25. Range of motion exercises					
26. Any other prescribed physical or occupational therapy					
27. Transferring semi-ambulatory or non-ambulatory residents					
28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36					

Additional Tasks List Below					

Instructor's Initials Name & Title Instructor's Initials Name & Title

_____

_____

EMPLOYEE SIGNATURE _____ **DATE:** _____

SUPERVISOR'S SIGNATURE: _____ **DATE:** _____

OPTIONAL

Tracking Tool

(Administrator/designee's use)

10A NCAC 13F/G .0903 Licensed Health Professional Support

(a) An adult care home shall assure than an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following

(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the onsite review and evaluation of the residents' health status, care plan and care provided as required in Paragraph(a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter

FACILITY:_____

RESIDENT:_____

Administrator/Designated Staff
Signature (completing check sheet)_____ **Date:**_____

Date referred to RN:_____ **Date referred to OT or PT:**_____

Name of RN:_____ **Name of PT/OT:**_____

CHECK ALL TASKS REQUIRED

[] applying and removing ace bandages, ted hose, binders, braces and splints
[] feeding techniques for residents with swallowing difficulties
[] bowel or bladder training programs to regain continence
[] enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches
[] positioning & emptying of the urinary catheter bag and cleaning around the urinary catheter
[] chest physiotherapy or postural drainage
[] clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents
[] collecting and testing of fingerstick blood samples
[] care of well-established colostomy or ileostomyi
[] care for pressure ulcers up to and including Stage II pressure ulcer
[] inhalation medication by machine
[] forcing and restricting fluids
[] maintaining accurate intake and output data
[] medication administration through gastrostomy feeding tube
[] medication administration through injections (subcutaneous, excluding anticoagulants)
[] oxygen administration and monitoring
[] restraints
[] oral suctioning
[] tracheostomy care (not to include endotracheal suctioning)
[] tube feedings through established gastrostomy tube
[] CPAP or BiPap
[] heat therapy
[] application or removal of prosthetic devices
[] ambulation using assistive devices that require physical assistance
[] transferring semi-ambulatory or non-ambulatory residents

Optional Form

Staff Validation by LHPS Tracking Tool
YEAR _____

1. *LHPSs must validate the competencies of LPNs and non-licensed personnel for tasks listed on the **Residents Identified for Licensed Health Professional Support** form prior to the staff providing the care.*
2. *Check for new staff and new care orders that require staff validation by LHPS before the staff can perform the task.*

Task Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	10	20	21	22	23	24	25
Date Validated ⇒ Staff Name ⇓																									

TEMPORARY LICENSED HEALTH PROFESSIONAL SUPPORT TASK PHYSICIAN'S CERTIFICATION

Resident's Name_____

Facility_____

I certify that the **NON-*LICENSED*** facility staff may be competency validated by an appropriate licensed health professional, according to Rule 10A NCAC 13F .0504 or 13G .0504, to perform **(*please specify task below*)**

_____

on a **temporary** basis for: _____ one day

_____ up to seven days

_____ up to thirty days

MD Signature_____Date_____

This check list has been developed as a tool to evaluate and monitor areas pertaining to Licensed Health Professional Support in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based. Items on the checklist that are recommendations may prevent problems from developing but do not have a licensure regulation referenced.

10A NCAC 13F/G .0903 Licensed Health Professional Support

	Yes	***No***	***Comments***
1. The facility has an appropriate LHPS that participates in the on-site review and evaluation of resident's health status, care plan and care provided requiring one or more of the 28 personal care task(s) outlined in rule **10 A NCAC 13 F/G .0903 (a)(b)**			
2. The evaluation is on site and hands on **10A NCAC 13F/G .0903 (c)**			
3. The evaluation is completed within the first 30 days of admission or within 30 days of developing the task **10A NCAC 13F/G .0903(c)**			
4. The evaluation is performed at least quarterly thereafter **10A NCAC 13 F/G .0903 (c)**			
5. The evaluation contains the following: **10A NCAC 13F/G .0903 (c)(1)(2)(3)(4)** • Performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of the Rule			

	Yes	***No***	***Comments***
• Evaluating the resident's progress to care being provided • Recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and • Documenting the activities in Subparagraphs (1) through (3) outlined above.			
6. Action is taken in response to the LHPS review **10A NCAC 13F/G .0903 (d)**			
7. Documentation of the facility response to the recommendation is available for review **10A NCAC 13F/G .0903 (d)**			
8. The physician or appropriate health profession is informed of the recommendations when necessary **10A NCAC 13F/G .0903 (d)**			
9. There is a system in place to identify residents' requiring the LHPS review			
10. There is a system in place to notify the LHPS nurse of the new task or a new admission with a task			
11. There is a system in place to assure the reviews are completed timely.			
12. There is a system in place to assure the reviews contained the required information			

	Yes	***No***	***COMMENTS***
13. There is a system in place to ensure the LHPS nurse has a copy of the rules and understand the requirements.			
14. System to verify license of RN performing LHPS			

LICENSED HEALTH PROFESSIONAL SUPPORT
10A NCAC 13 F/G .0903
LHPS reviews for the following tasks may include, but are not limited to the following:

1. Applying and removing ace bandages, ted hose, binders, and braces and splints
    a. Assessment
        i. Site of application of ace bandages, binders, braces and splints (note any swelling)
        ii. Ted Hose smooth and not wrinkled, time applied, time removed?
        iii. Condition of skin under splints, TEDS, braces, and binders(note irritation/blisters/reddened/painful areas)
        iv. If splint, note circulation in extremities
        v. Appliance clean/condition
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

2. Feeding Techniques for residents with swallowing problems
    a. Assessment
        i. Type of technique identified (e.g. chin tuck, double swallow, etc.)
        ii. Lung sounds
        iii. Appetite
        iv. Staff assisting with feeding?
        v. Diet served as ordered (e.g. puree, thickened liquids) medication served with thickened liquids?
        vi. Alternate foods and fluids frequently?
        vii. Feeding with tip of spoon?
        viii. Spoon only half filled?
        ix. Straw use or non-use?
        x. Weight
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

3. Bowel or Bladder training programs to regain continence
    a. Assessment
        i. How often and amount fluids offered
        ii. How often toileted
        iii. How often incontinent
        iv. If bowel program,
            1. Response to suppositories, enemas, etc.
            2. How often incontinent?
            3. Dietary recommendations (e.g. encourage fluids)
        v. Condition of skin under briefs?

b. Evaluate the resident's progress to the care provided
c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
d. Documentation of a, b and c

4. Enemas, suppositories, break-up and removal of fecal impactions and vaginal douches
    a. Assessment
        i. Why enemas, suppositories given?
        ii. Results of enemas, suppositories, and frequency given
        iii. How often fecal impactions removed?
        iv. Resident tolerance of procedure
        v. Vaginal douches—why given, effectiveness, and resident tolerance
        vi. Observations of vaginal discharge, perineal skin or anal condition
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c

5. Positioning and emptying of urinary catheter bag and cleaning around the urinary catheter
    a. Assessment
        i. When catheter last changed?
        ii. Description of urine in bag and tubing (color, amount, exudates?)
        iii. Leakage around catheter?
        iv. Frequency of staff cleaning
        v. Positioning of drainage bag
        vi. Any treatments for UTI's?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

6. Chest physiotherapy or postural drainage
    a. Assessment
        i. Lung sounds
        ii. Description of secretions and amount
        iii. Coughing/Shortness of breath?
        iv. Frequency of procedure
        v. Resident assessment of effectiveness of procedure
        vi. Hospitalizations or infections?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

7. Clean dressing changes, excluding packing wound and application of prescribed enzymatic debriding agents
    a. Assessment
        i. Site and type of dressing
        ii. Frequency of change
        iii. Description of wound
        iv. Positioning of resident required?
        v. Pressure reducing devices used?
        vi. Home Health involved?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

8. Collecting and testing of finger stick blood samples.
    a. Assessment
        i. Blood sugar ranges
        ii. Skin assessment (open or irritated areas/ circulation in feet)
        iii. Nail assessment (particularly toenails)
        iv. Dietary compliance
        v. Resident understanding of disease
        vi. Dental problems?
        vii. Visual problems?
        viii. Frequency of sliding scale administration if indicated
        ix. Complaints of peripheral neuropathy?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

9. Care of well established colostomy or ileostomy (having a healed surgical site without sutures or drainage)
    a. Assessment
        i. Description of stoma
        ii. Description of skin around stoma
        iii. Description of fecal material in bag
        iv. Frequency of appliance change
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

10. Care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater
    a. Assessment

i. Site of ulcer
ii. When first discovered?
iii. Description of ulcer
iv. Home health involvement?
v. Dressings and/or frequency of change
vi. Pressure reducing devices?
vii. Positioning and turning requirement?
viii. Resident response to treatments

b. Evaluate the resident's progress to the care provided
c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
d. Documentation of a, b, and c.

11. Inhalation by machine
    a. Assessment
        i. Assessment of Lungs
        ii. Frequency of Nebulizer treatments
        iii. Resident response to the treatments
        iv. Equipment clean and in good working order?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

12. Forcing and restricting fluids
    a. Assessment
        i. Required amount of fluids to be forced or restricted
        ii. Resident compliance with order?
        iii. Recorded amounts forced or restricted?
        iv. Weights if indicated
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c

13. Maintaining accurate intake and output records
    a. Assessment
        i. Reason for measuring intake and output (e.g. dialysis, CHF)
        ii. Review of intake and output record
        iii. Diet compliance if indicated(e.g. NAS)
        iv. Resident understanding and compliance with measuring intake and output?
        v. Weights if indicated
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

d. Documentation of a, b, and c.

14. Medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established)
    a. Assessment
        i. Assessment of skin around tube placement
        ii. Abdominal assessment to include bowel sounds
        iii. Resident tolerance of procedure
        iv. Frequency of medication administration (if applicable)
        v. Amount of water used to flush tubing
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

15. Medication administration through injection (Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin)
    a. Assessment
        i. Assessment of injection sites
        ii. Frequency of injections
        iii. Response to injection (e.g. Haldol injection---resident behaviors)
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b and c.

16. Oxygen administration and monitoring
    a. Assessment
        i. Type of oxygen delivery (e.g. tank, concentrator, portable tank, or combinations)
        ii. Rate of oxygen flow (as ordered)
        iii. Frequency of administration (self-administration/staff?)
        iv. Lung assessment
        v. Resident's response (i.e. able to ambulate to and from DR without SOB)
        vi. Resident compliant with treatment?
        vii. Condition/maintenance of equipment
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

17. The care of residents who are physically restrained and the use of care practices as alternatives to restraints
    a. Assessment
        i. Date of restraint order
        ii. Type of restraint used (least restrictive)
        iii. Frequency of use
        iv. Applied correctly?
        v. How often checked and released
        vi. Reason for restraint
        vii. Skin assessment
        viii. Resident response to restraint
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

18. Oral suctioning
    a. Assessment
        i. Reason for suctioning
        ii. Frequency of suctioning
        iii. Lung assessment
        iv. Assessment of mouth
        v. Resident response to suctioning
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

19. Care of well-established tracheostomy, not to include endotracheal suctioning
    a. Assessment
        i. Assessment of stoma and skin surrounding stoma
        ii. Description and frequency of care involved
        iii. Assessment of secretions
        iv. Lung assessment
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

20. Administering and monitoring of tube feedings through a well-established gastrostomy tube
    a. Assessment
        i. Assessment of site and skin around site
        ii. Abdominal assessment

iii. Residuals noted?
iv. Lung assessment
v. Description of type of tube feeding (e.g. Bolus or continuous and type of formula used)
vi. Mouth care provided and assessment of oral mucosa
vii. Resident response to procedure
viii. Weights

b. Evaluate the resident's progress to the care provided
c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
d. Documentation of a, b, and c.

21. The monitoring of continuous positive air pressure devices (CPAP and BIPAP)
    a. Assessment
        i. Type of device used (CPAP or BIPAP)
        ii. Self administer or staff assisted?
        iii. Resident compliance with order?
        iv. Resident response to treatment
        v. Equipment clean and in good working order?
    b. Evaluate the resident's progress to the care provide
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

22. Application of prescribed heat therapy
    a. Assessment
        i. Type and frequency of application
        ii. Site of application
        iii. Assessment of skin after prescribed heat therapy
        iv. Resident response to treatment
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

23. Application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity
    a. Assessment
        i. Type of prosthetic
        ii. Resident compliant with use of prosthetic?
        iii. Assessment of stump
        iv. Length of time worn
        v. Any problems with prosthesis?
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident

d. Documentation of a, b, and c.

24. Ambulation using assistive devices that requires physical assistance
    a. Assessment
        i. Type of assistive device required (slide board, walker, waist belt)
        ii. Type of help required in use of assistive device (e.g. 1 person stand by assist)
        iii. Frequency of staff assistance required
        iv. Resident response to ambulation (e.g. resident able to ambulate approximately 500 feet with 1 person stand by assist)
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

25. Range of motion exercises
    a. Assessment
        i. Frequency of ROM exercises
        ii. Active, Assistive or Passive ROM
        iii. What extremities involved?
        iv. Evaluation of movement of affected area
        v. Assessment of any contracture
        vi. Response to ROM exercises
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b and c.

26. Any prescribed physical or occupation therapy
    a. Assessment
        i. Type of therapy prescribed
        ii. Frequency of therapy
        iii. Therapy provided by PT or OT?
        iv. Resident response to therapy (e.g. able to ambulate to DR with stand by assist only)
    b. Evaluate the resident's progress to the care provided
    c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
    d. Documentation of a, b, and c.

27. Transferring semi-ambulatory or non-ambulatory residents
    a. Assessment
        i. Type of transfer (e.g. Hoyer lift, bed to chair, etc.)
        ii. Number of people required for transfer
        iii. Resident tolerance, response to transfers
    b. Evaluate the resident's progress to the care provided

c. Recommendations for changes in the care of the resident based on the assessment and evaluation of progress of the resident
d. Documentation of a, b, and c.

28. Nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.
    a. www.ncbon.com/

Chapter 7: Staff Training and Competency

Staff Training & Competency

Adult Care Licensure Section
Division of Health Service Regulation

Lack of staff NEGATIVELY impacts care.

"This is why we lift on three"…

When we monitor staffing…

- Determine:
  - Staffing
  - Staff Qualifications
- This causes the facility to:
  - Focus on adequate staffing and qualifications of the staff.
  - Tracks and updates staff qualifications.

Agenda

- When to Monitor
- Targeted Sample
- Observations, Interviews & Record Reviews
- Staffing Terms

- .0400 Staff Qualifications
- .0500 Staff Orientation, Training and Competency
- .0600 Staffing

- Other Staff Qualifications
- Test for Tuberculosis (TB)

- .1300 Special Care Unit

When to Monitor?

- Annual
- Complaint
- Resident Care NOT Being Provided
- Lack of Staff
- Frequent Staff Turnover

Plan and Prepare

- Review DSS Facility File
- Review Annual Monitoring Plan
- Look for related Complaints/Problems
- Review Perpetual Staff Log
- Plan a Targeted Sample of Staff Record Reviews
- Review Incident and Accident Reports

Targeted Sample for Qualifications

- Variety of Staff:
  - Administrators, Supervisors-in-Charge (SIC), Medication Aides, Activity Director, Food Service, Housekeeping
- New Hires:
  - Including aides hired in the last six months and long-term employees.

Observation, Interviews & Record Reviews

- Observation:
  - Administrator Certificate posted?
  - Staff on Duty?
  - Staff observations?
    - Record names and times
- Interview:
  - Private and Confidential
  - During Tour and after Record Review
  - Have staff describe duties
- Record Reviews:
  - Facility Personnel Records
  - Scheduling/Time Records
  - Match Job Description to Tasks
  - Training Records

Questions to Ask

Staff

- How were you oriented to the facility?
- What was taught during orientation?
- What is the chain of command?
- Who did you receive your training from?
- Tell me about Resident Rights?
- Tel me about your training on oxygen, restraints and pressure ulcers?

Residents

- How do you get your needs met?
  - What about 3rd shift?
- How do you get along with staff?
- How do the staff treat you?
- Do you have any concerns about staff that I haven asked about?

Staffing Terms Used

Adult Care Home

- Administrator
- Administrator-In-Charge
- Medication Staff
- Activity Director
- Food Service Supervisor

Family Care Home

- Administrator
- Supervisor-In-Charge
- Medication Staff
- Activity Director

.0400 Staff Qualifications – Adult Care Home

- Administrator
  - Certified by DHSR
- Administrator-In-Charge
  - 21 years or older
  - High School Graduate or passed G.E.D. program
  - 6 months training/experience or (LHP, LNHA, CALA)
  - 12 hours a year of C.E.
- Medication Staff (Medication Aides)
  - Must complete clinical skills validation
  - Pass written exam 90 days from the above
  - 6 hours of CE annually
- Activity Director
  - High School Graduate or passed G.E.D. program
  - Must complete within 9 months from hire the basic activity director course
- Food Service Supervisor
  - Should be experienced in food service and willing to accept consultation from a registered dietician.

.0400 Staff Qualifications – Family Care Home

- Administrator
  - 18 years or older
  - High School Graduate or passed G.E.D. program
  - Pass written exam
  - 30 days on-the-job training program
  - Relevant past education, training and experience
  - 15 hours a year of C.E.
- Qualifications of Supervisor-In-Charge
  - High School Graduate or passed G.E.D. program
  - 12 hours a year of C.E.
- Medication Staff (Medication Aides)
  - Must complete clinical skills validation
  - Pass written exam 90 days from the above
  - 6 hours of CE annually
- Activity Director
  - High School Graduate or passed G.E.D. program
  - Must complete within 9 months from hire the basic activity director course

.0500 Staff Orientation, Training and Competency – Adult Care Homes

- Personal Care Training
  - Complete an 80-hour program
  - Complete the above within 6 months after hire
  - Exempt staff: LHP, Nurse Aide Registry
- Medication Administration
  - Pass written exam
  - RN or Registered Pharmacist must complete clinical skills validation
- Licensed Health Professional Support Tasks
  - Employee must be validated for personal care tasks (.0903)
  - Completed by RN, Pharmacist, OT/PT/RT
- Food Service Orientation
  - Complete food service orientation program within 30 days of hire

.0500 Staff Orientation, Training and Competency – Family Care Homes

- Personal Care Training
  - Complete an 25-hour or 80-hour program*
  - Complete the above within 6 months after hire
  - Exempt staff: LHP, Nurse Aide Registry
- Medication Administration
  - Pass written exam
  - RN or Registered Pharmacist must complete clinical skills validation
- Licensed Health Professional Support Tasks
  - Employee must be validated for personal care tasks (.0903)
  - Completed by RN, Pharmacist, OT/PT/RT

. 0600 Staffing – Adult Care & Family Care Homes

- Capacity
  - Administrator or Designee
  - Personal Care & Other Staff
  - Personal Care Aide Supervisors
- Must staff to the capacity of the home or to the resident census.
- 10A NCAC 13F .0606 Staffing Chart (Adult Care Homes 21 or more residents)

Staffing Chart Adult Care Homes

- 10A NCAC 13F .0606 Staffing Chart (Adult Care Homes 21 or more residents)

- http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20f/10a%20ncac%2013f%20.0606.pdf

Other Staff Qualifications

- Job Description
- Residents' Rights
- Health Care Personnel Registry
- Criminal Background Check
- Controlled Substance Screen
- 2 Step TB Test
- Current CPR

Epidemiology Health (Tuberculosis) Rule

- **10A NCAC 13G .0702 TUBERCULOSIS TEST AND MEDICAL EXAMINATION**

(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

https://www2.ncdhhs.gov/dhsr/acls/pdf/memo/tbrulememo072012.pdf

.1300 Special Care Unit

- .1302 Special Care Unit Disclosure

- Staff present in the unit at all times in sufficient number to meet the needs of residents.
- Care Coordinator on duty 8 hours a day/5 days week
- Administrator
  - 20 hours of dementia specific training
- All Staff
  - 6 hours of training within 1 week of hire
- Personal Care Staff
  - 20 hours of training within 6 months of hire
    - does not include initial 6 hours
  - 12 hours of C.E. annually – 6 hours dementia specific

Adequate staff can POSITIVELY impact care.

Perpetual Staff Log

For_____

Facility Name

Complete for all staff once and update every routine monitoring visit for new staff or expiring items. Note: Mark N/A if does not apply. Delete employees who terminate. **Bolded** areas must be rechecked and updated, so write those in pencil. File inside specific agency facility file.

Staff Names ⇒ Items and references ⇓					
Type Position					
Hire Date					
Date Health Care Personnel Registry Ck (code #) G.S. 131E-256 10A NCAC 13G .0406 & .1206 10A NCAC 13F .0407 & .1205					
Date Criminal Hx Ck G.S. 131D-40 10A NCAC 13G .0406 10A NCAC 13F .0407					
Date TB 2-step started/completed 10A NCAC 13G .0405 10A NCAC 13F .0406					
Date Drug Testing prior to employment G.S. 131D-45					
CPR (q24 mos.) last date taken 10A NCAC 13G .0507 10A NCAC 13F .0507 (Need one on duty /shift)					
Personal Care Staff Trng & Comp.(W/I 6mos hire) or qualified exemption 10A NCAC 13G .0501 10A NCAC 13F .0501					
Competency Validation for LHPS Personal Care task prior to doing task 10A NCAC 13G .0504 10A NCAC 13F .0504					
Adm. of 7 or more bed facility currently Certified 10A NCAC 13F .0401					
FCH Adm. Approval letter/cert from DHSR for facility 10A NCAC 13G .0401					
FCH Adm. 15 hr CE annually 10A NCAC 13G .0401					

Notes:

Perpetual Staff Log

For_____

Facility Name

Staff Names ⇒ Items and references ⇓					
Medication Staff					
Med Staff & Med Staff Supervisors Date Med Admin Clinical Skills Checklist completed 10A NCAC 13G .0403/.0503 10A NCAC 13F .0403/.0503					
Med Staff & Med Staff Supervisors (employment prior to 10/01/13 OR exempt from required medication training) Date Passed Med Test (W/I 90 days of Validation date) 10A NCAC 13G .0403/.0503 10A NCAC 13F .0403/ .0503					
Med Staff & Med Staff Supervisors hired after 10/01/13 & NOT exempt from required medication training Date 5/10/15 Hour Training Completed GS 131D-4.5B (b)					
Med Staff & Med Staff Supervisors hired after 10/01/13 & NOT exempt from required medication training Date Passed Med Test (W/I 60 days of Validation date) GS 131D-4.5B (b)					
Med Staff & Med Staff Supervisors 6 hours Med CE/yr 10A NCAC 13G .0403 10A NCAC 13F .0403					
Med Staff and Med Staff Supervisors Date Annual Infection Control Training GS 131D-4.5B (a)					
Special Care Unit Staff					
SCU training New employees 20 hr. W/I six months 10A NCAC 13F.1309					

Notes:

OPTIONAL

This checklist has been developed as a tool to evaluate and monitor areas pertaining to the Health Care rule regarding Special Care Units for Alzheimer and Related Disorders in Adult Care and Family Care Homes. Licensure regulations for adult and family care homes have been referenced for the items that are specifically rule based.

SECTION .1300 SPECIAL CARE UNITS FOR ALZHEIMER AND RELATED DISORDERS

13F.1304 Special Care Units Building Requirements	Yes	No	Comments
1. Plans for new or renovated construction or conversion of existing building areas have been submitted to the Construction Section of DHSR for review and approval? • *Were plans submitted and approved prior to construction beginning?* • *Were residents in existing facilities given appropriate notice of room change or relocation during renovation/construction?*			
2. Is the SCU separated from rest of facility by closed doors? (2)			
3. Are exit doors locked with special locking devices? (3) (See attachment * 1003.3.1.8.5 regarding locking devices) If additional information needed regarding the locking devices, call The Construction Section @ 919-855-3923.			
4. If no, is there a system of security monitoring? (4) • *What system does the facility have in place to monitor the unlocked doors?* • *Does the facility provide 24/7 visual supervision?*			
5. Do other residents, staff, visitors have to routinely pass through the SCU to reach other areas of the building? (5)			
6. Is there a staff work area? (6)			

7. Is there a nourishment station for preparation and provision of snacks? (6) • *Are food and drinks for snacks available for independent residents and provided for all dependent residents?*			
8. Is there lockable space for medication storage? (6)			
9. Is there storage space for residents' records? (6)			
10. Is living and dining space provided within the unit? (7) (30 sq. ft. per resident)			
11. Is there direct access from the unit to a secured outside area? (8)			
12. Is there a toilet/lavatory within the unit for every 5 residents? (9)			
13. Is there a tub and shower within the unit? (10)			
14. Is there minimization of potentially distracting, mechanical noises (eg., loud ice machines, window air conditioners, intercoms and alarm systems)? (11) • *Does the SCU environment promote a calming, relaxed atmosphere, or does it provide excessive stimulation?*			

13F.1305 **Policies and Procedures**	Yes	No	Comments
Do the policies and procedures address:			
1. In the facility's philosophy, a mission statement and objectives regarding the special population to be served that includes -safe, secure , familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications ?(1)(a) -a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each residents' abilities? (1)(b) • *Does the facility's activity program involve community services, group and individual (one on one) activities?* -individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning? (1)(c) • *Does the facility obtain personal information about each resident's interests and capabilities, and then develop an individualized plan of care and activities based upon this information?* -methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance? (1)(d) • *Does the facility have appropriate space for a variety of activities, including indoor and outdoor activities?*	___ ___ ___ ___	___ ___ ___ ___	

2. The process and criteria for admission to and discharge from the unit? (2)			
3. A description of the special care services offered in the unit? (3)			
4. Resident assessment and care planning, including opportunity for family involvement? Implementation of the care plan, including responding to changes in the resident's condition? (4)			
5. Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior? (5)			
6. Staffing in the unit? (6)			
7. Staff training based on special care needs of the residents? (7)			
8. Physical environment and design features that address the needs of the residents? (8)			
9. Activity plans based on personal preferences and needs of the residents? (9)			
10. Opportunity for involvement of families in resident care and the availability of family support programs? (10)			
11. Additional costs and fees for the special care provided? (11)			

13F.1306 Admission to the Special Care Unit	Yes	No	Comments
1. Does a physician specify a diagnosis on the FL-2 that meets the conditions of the specific group of residents to be served? (1)			
2. Is there a documented pre-admission screening by the facility to evaluate the appropriateness of the individual's placement in the special care unit? (2)			
3. Are family members seeking admission of a resident to the special care unit provided disclosure information required by G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter ? Is this disclosure documented in the resident's record? (3)	___ ___	___ ___	
13F.1307 Special Care Unit Resident Profile and Care Plan	Yes	No	Comments
1. Did the facility develop a written profile within 30 days of admission? (1)			
2. Does the facility review and update the profile **quarterly?** (1)			
3. Does the profile contain assessment data that describes the resident's: -behavioral patterns? (1) -self-help abilities? (1) -level of daily living skills? (1) -special management needs? (1) -physical abilities and disabilities? (1) -degree of cognitive impairment? (1)			

4. Does the facility develop and revise the resident's care plan (13F.0802) based on the resident profile? (2)			
5. Does the care plan specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities? (2)			
13F.1308 **Special Care Unit Staffing**	Yes	No	Comments
1. Is staff present in the unit at all times in sufficient number to meet the needs of the residents? (a) (NOTE: At no time shall there be less than one staff person who meets the orientation and training requirements in Rule .1309 of this section, for up to eight residents on 1ST and 2ND shifts and one hour of staff time for each additional resident; and one staff person for up to 10 residents on 3RD shift and .8 hours of staff time for each additional resident.)			
2. Is there a care coordinator on duty in the unit at least 8 hours a day, five days a week? (b) (NOTE: The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.)			
3. In units of 16 or more residents and any units that are freestanding facilities, is there a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule? (c)			

13F.1309 Special Care Unit Staff Orientation and Training	Yes	No	Comments
1. Prior to establishing a SCU, does the administrator document receipt of at least 20 hours of training specific to the population to be served for each SCU to be operated? (1)			
2. Does the administrator have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement? (1)			
3. Has each employee assigned to perform duties in the SCU completed 6 hours of orientation on the nature and needs of the residents within the first week of employment? (2)			
4. Has staff responsible for personal care and supervision within the unit completed 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule, within 6 months of employment? (3)			
5. Has staff responsible for personal care and supervision within the unit completed at least 12 hours of continuing education annually, with 6 hours being dementia specific? (4)			

13F.1310 Other Applicable Rule for Special Care Units

In addition to specific rules pertaining to special care units for residents in this Section, such units shall also meet all other applicable requirements governing the operation of adult care homes as set forth in this Subchapter.

OPTIONAL

This check list has been developed as a quality assurance tool to evaluate and monitor rules in Adult Care and Family Care Homes when Residents are demonstrating behavior issues. Licensure regulations for adult and family care homes have been referenced for the items that are rule based specific to behavior issues. All other licensure rules also apply, but this can be a ready reference for specific rules related to behavior issues. ***Items on the checklist that are recommendations that may prevent problems from developing do not have a licensure regulation referenced.***

10A NCAC 13F/G Behavior Specific Rules

10 A NCAC 13 F/G .00305(h)(4) Physical Environment	Yes	No	Comments
In a home that has at least one resident who has been determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents is equipped with a sounding device that is activated when the door is opened?	____	____	
Is the sound at a sufficient volume to be heard by staff?	____	____	
If a central system of remote sounding devices is provided, is the control panel for the system located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel?	____	____	
10 A NCAC 13 F/G .0703(e) Tuberculosis Test, Medical Examination and Immunizations	Yes	No	Comments
(e)The facility has made arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated?	____	____	

10 A NCAC 13 F/G .0801 (C)(1)(D) Resident Assessment	Yes	No	Comments
An assessment of a resident has been completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule (D) Significant change can include: deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic. (K) And, new onset of impaired decision-making. • *What is the date the resident was admitted to the facility?* • *Does the facility have a copy of the discharge summary from a previous psychiatric facility?* • *Does the facility have copies of progress notes from a physician, psychiatrist, MH provider that address the resident's progress/lack of progress toward behavior goals?*			
Assessment Tool: **Care Plan Form DMA 3050-R** Has the facility utilized the DMA 3050-R to assess a resident's mood and behavior? Have they identified mood and behavior indicators such as: • Constant pacing and restlessness • Increased confusion, disorientation • Refusing medications • Refusing meals • Refusing bathing, neglecting grooming, deterioration in personal hygiene • Increased anger, frustration • Increased loudness or tone of voice • Destructive behavior, throwing objects			

• Verbal or physical threats toward staff or other residents • Sexually inappropriate behaviors • Delusions, hallucinations • Self-injurious behaviors • Talk or attempts of suicide • Sleep pattern disturbance • Changes in mood, indicated by increased crying, withdraw from normal activities, loss of appetite, flat/sad affect, making negative statements, increase in anxious complaints or concerns, etc.			

10 NCAC 13F/G .0802 (a)(b)(f) Resident Care Plan	Yes	No	Comments
A care plan has been developed for each resident in conjunction with the resident assessment to be completed <u>within 30 days</u> following admission according to Rule .0801 of this Section The care plan is an individualized, written program of personal care for each resident?(a) • *Keyword: "Individualized" Is the care plan truly a reflection of the resident, including their psychosocial well-being state, cognitive status, physical functioning/ADL's, mood and behavior?* • *Did the facility use the DMA 3050-R or a comparable facility form containing a minimum of the same information?*			
The care plan has been revised as needed based on further assessments of the resident according to Rule .0801 of this Section. (b) The facility has also assured that an assessment of a resident who has experienced a significant change is completed within 10 days following the significant change. (c)			
The care plan for each resident who is under			

the care of a provider of mental health, developmental disabilities or substance abuse services includes resident specific instructions regarding how to contact that provider, including an emergency contact when significant behavioral changes described in Rule .0801(c)(1)(D) of this Subchapter are identified, the facility has referred the resident to a provider of mental health, developmental disabilities or substance abuse services in accordance with Rule .0801(d) of this Subchapter? (f) • *Where is the number listed to contact the resident's MH service provider? In the chart? At the nurses station?* • *Is there a MH provider contact number for after-hours? A crisis hotline?* • *Have the staff been informed of how to find these numbers? Are the numbers accessible to the staff?* • *Has the staff been trained in the case of an emergency (resident-to-resident altercation, violent behavior, etc.) on how to protect the other residents until the situation is resolved?*

10 NCAC 13F/G .0902 (b) Health Care	Yes	No	Comments

The facility has assured referral and follow-up to meet the routine and acute health care needs of the resident? • *What is the facility's system for monitoring and tracking appointments?* • *How does the facility reschedule cancelled/postponed appointments and document these schedule changes?* • *What is the facility's system for implementing the new orders, if any, after the appointment?*			

10A NCAC 13F.1212 (f)(g) 10A NCAC 13G.1213 (f)(g) Reporting of Accidents and Incidents	Yes	No	Comments
When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority. If a physical assault by a resident has occurred, or if there has been a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility has immediately: - sought the assistance of the local law enforcement authority? (1) -provided additional supervision of the threatening resident to protect others from harm? (2) -sought any needed emergency medical treatment? (3)	____ ____ ____ ____	____ ____ ____ ____	

-made a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident? (4) -cooperated with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment? (5)	____ ____	____ ____	

Division of Health Service Regulation
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, NC 27699-2708
(919) 855-3765

REPORT OF ADMINISTRATOR QUALIFICATIONS
FOR FAMILY CARE HOMES

Name of Facility_____County_____

Applicant's Name_____ Phone ( )_____

E-mail Address _____ Fax ( )_____

Mailing Address _____
Street City State Zip

Birth Date _____ S.S. #_____Driver's License # _____

You are asked to voluntarily provide your social security number here and where subsequently requested in this document with the understanding that it will be used only as an identification number for internal record keeping and data processing.

Are you or your spouse an official or employee of the Department of Health and Human Services or of any county department of social services, or a member of the Social Services Commission, any county board of social services, or of any board of county commissioners? [ ] Yes [ ]No

EDUCATION
Circle Highest Grade Completed 1 2 3 4 5 6 7 8 9 10 11 12 G.E.D.
College 1 2 3 4 Grad School 1 2 3 4 Other_____

Send documentation of education such as copy of diploma or transcript of hours completed.

WORK HISTORY

Employer: Address:

Job Title: Supervisor:

Date Employed: # You Supervised:

Date Separated: Reason for Leaving

Duties:

Employer: Address:

Job Title: Supervisor:

Date Employed: # You Supervised:

Date Separated: Reason for Leaving

Duties:

Employer: Address:

Job Title: Supervisor:

Date Employed: # You Supervised:

Date Separated: Reason for Leaving

Duties:

Employer: Address:

Job Title: Supervisor:

Date Employed: # You Supervised:

Date Separated: Reason for Leaving

Duties:

If you have completed the 30-day on-the-job training program (AIT) required by rule, list name of facility and dates of training. Provide the 3 AIT forms to be requested from this office and completed by trainer. If requesting AIT exemption, send letter describing your long term care management/supervisory experience.
Facility: Dates of training:

Have you ever been convicted of any criminal or driving offense(s) other than a minor traffic violation:
[ ] Yes [ ] No. Please provide a criminal background report from the county clerk of court.

Please give the full name, mailing address, and phone number of three references who have knowledge of your background and qualifications related to the field of adult care, one of which must be a current or former employer. **(Include copies of these references)**

1.

2.

3.

NOTE: Application is not complete without a copy of administrator's exam results, proof of education, reference letters, criminal background report, documentation of a 2-step TB test (2 TB skin tests within no more than 12 months of each other) and the 3 AIT forms or exemption approval. If you seek exemption from the AIT (Administrator-in-training), submit a letter stating what your long term care or health care management or supervisory training/experience has been, including dates, duties and location.

I certify that I have given true, accurate and complete information on this form to the best of my knowledge. I authorize investigation of statements made in this report and understand that false information may be grounds for disqualification.

Signature Date

MEDICATION AIDE QUALIFICATIONS CHECKLIST

NCDHHS, Division of Health Service Regulation, Adult Care Licensure Section

Facility Name/Location _____ Survey Date(s)_____

Name of Staff Person	*Title of Staff Person*	*Date of Hire*	*Medication Training or Verification Yes or No & Date*	*Clinical Skills Checklist?* ***YES or NO***	*If Yes, Date Completed*	*Pass Med Test****?*** ***YES or NO***	*If Yes, Date Passed*

Notes:

PERSONNEL RECORD REVIEW

Facility Name: _____ Date of Survey: _____

Staff Selection: (*For Staff Qualifications Review ONLY or Reporting to HCPR – Give clean copy to facility and Team Leader)*

A._____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

K. _____

L. _____

M. _____

N. _____

O. _____

Adult Care Licensure Section
Staff Qualifications Review

Facility: ______________________________________ **Date:** _________________ **Surveyor Name:** _____________________________

Record Review: (Based on your interviews and observations, choose a sample of employment records of 1 staff per shift for record review. If SCU **and** HA then; 1 staff per shift for both units.)

Staff Data:	**Date Completed**	**Date Completed (N/A) if not applicable**
Name: ___________________________ Identifier #:___________ Hire Date:_____________ Position: ________________	TB test: Step 1 _________ Step 2 _________ Criminal bkgrd: ________ Drug Screen: __________ HCPR status: __________	PCS training (80/25 hrs.): __________ (If applicable): SCU Training: 20 Hrs.:_______ 6 Hrs.: _________ Med Aide: Employment Verification:__________ CPR Completed: _________ Medication Training: 5 hr. _______ 10 hr. _______ OR 15 hr. _______ Diabetic Care:_________ Medication Clinical skills: ___________ Test (w/in 60 days any validation after 9/30): __________ LHPS Validation: _______ Restraint Usage:_______ Infection Control Training:____________
Name: ___________________________ Identifier #:___________ Hire Date:_____________ Position: ________________	TB test: Step 1 _________ Step 2 _________ Criminal bkgrd: ________ Drug Screen: __________ HCPR status: __________	PCS training (80/25 hrs.): __________ (If applicable): SCU Training: 20 Hrs.:_______ 6 Hrs.: _________ Med Aide: Employment Verification:__________ CPR Completed: _________ Medication Training: 5 hr. _______ 10 hr. _______ OR 15 hr. _______ Diabetic Care:_________ Medication Clinical skills: ___________ Test (w/in 60 days any validation after 9/30): __________ LHPS Validation: _______ Restraint Usage:_______ Infection Control Training:____________
Name: ___________________________ Identifier #:___________ Hire Date:_____________ Position: ________________	TB test: Step 1 _________ Step 2 _________ Criminal bkgrd: ________ Drug Screen: __________ HCPR status: __________	PCS training (80/25 hrs.): __________ (If applicable): SCU Training: 20 Hrs.:_______ 6 Hrs.: _________ Med Aide: Employment Verification:__________ CPR Completed: _________ Medication Training: 5 hr. _______ 10 hr. _______ OR 15 hr. _______ Diabetic Care:_________ Medication Clinical skills: ___________ Test (w/in 60 days any validation after 9/30): __________ LHPS Validation: _______ Restraint Usage:_______ Infection Control Training:____________

Adult Care Licensure Section
Staff Qualifications Review

Facility: _____ Date: _____ Surveyor Name: _____

Chapter 8: Food Service

Quality Without Question Focus on Food Service

Division of Health Service Regulation
Adult Care Licensure Section

Objectives

- Participants will understand how to use observation, interview and record review to assess the quality of food services provided to residents.
- Participants will understand rules and regulations for nutrition and food service.
- Participants will understand food procurement and kitchen management.
- Participants will understand and know what defines a therapeutic diet.

Test your knowledge

Pre-test Exercise

10A NCAC 13F .0405 Qualifications of Food Service Supervisor.

Regulatory Reference

(a) The food service supervisor shall be experienced in food service and willing to accept consultation from registered dietitian.

10A NCAC 13F .0509 Food Service Orientation

Regulatory Reference

The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent with 30 days of hire for those staff hired on or after July 1, 2004. Registered Dietitians are exempt from this orientation.

Survey Process

Determining Non-Compliance
???Systems Failure???

5 W's

- What – the facility failed to do. What was the impact on the resident?
- Who – were the staff or resident(s) involved?
- Where – it occurred.
- When – the problem occurred and how long it lasted.
- Why – did it occur

Meet the Kitchen Staff

- Introduce yourself and let staff know why you are there.
- Develop a rapport with kitchen staff.
- Try to put staff at ease.

TOURING THE KITCHEN

Information Gathering

- What are you cooking today?
- Can I see your diet list?
- Can I see your regular and therapeutic menus?
- Do you have any residents who need feeding assistance or eat in their rooms?
- Do you have any residents who require thickened liquids?
- Do you have any residents on supplements?
- Ask for copy of sanitation report
- Compare sanitation report to what you observe in kitchen and dining room.

Why did we ask questions?

- We need a sample of residents.
- The sample is based on the current facility census.
- We want residents on therapeutic diets, thickened liquids, and residents who require feeding assistance.
- We want the most challenging residents.

OBSERVE and INTERVIEW

Observations
source, date, time and location

Interviews
source, date, time and location

What is the Cook Doing?

- **While we are checking out the kitchen we still have one eye on the cook/dietary staff!**
  - Are they frying/baking/broiling?
  - What types of seasoning are being used?
  - Do they have no added salt or no added sweet products to prepare meals as stated on the menus?
  - Did staff wash there hands?
  - Is staff hair covered?

10A NCAC 13F/G.904 Nutrition and Food Service

- **Food Procurement and Safety**
- **(a)(1)** The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination
- **(a)(2)** All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination

Sanitation Inspection

10A NCAC 13F.0306 House keeping and Furnishing

(a)(4) Adult Care Homes shall have a NC Division on Environment Health approved sanitation classification at all times in facilities with 12 beds or less a NC Division of Environmental Health sanitation score of 85 or above at all times in facilities with 13 beds or more

10A NCAC 13G.0315 Housekeeping and Furnishing

(a) (4) The family care hone shall have a NC Division of Environmental Health approved sanitation classification at all times in facilities.

Test your knowledge

Monitoring Activity
Inspection Reports

10A NCAC 13F/G.0904 Nutrition and Food Service

Food Preparation and Service

(b) (1)Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service.

Ensure all equipment is working properly

Leaking refrigerators/freezers

Leaking sinks/dishwasher

Refrigerators/freezers should have thermometers

Dishwasher

Dishwasher should be equipped with wash, rinse, and sanitizer. If sanitizer is not available, dishwasher should be equipped with a booster of 170˚F

3 Compartment Sink

Applies to facilities greater than 12 beds

- 1st Compartment – Wash water
- 2nd Compartment – Rinse water
- 3rd Compartment – Sanitize
  - Chlorine – 50 PPM
  - Iodophor products – 12.5 PPM (Iodine - not commonly used)
  - Quaternary ammonium products – 200 PPM (sanitizing solution requires a test strip)

Refrigeration Units

Leftovers should be appropriately stored, labeled, and dated.

There should be no spoiled, outdated food in refrigerators.

Refrigeration Units

Refrigerated units should be at a temperature not to exceed 45˚F

Raw meat/fresh eggs are not stored over ready to eat foods in the refrigerator

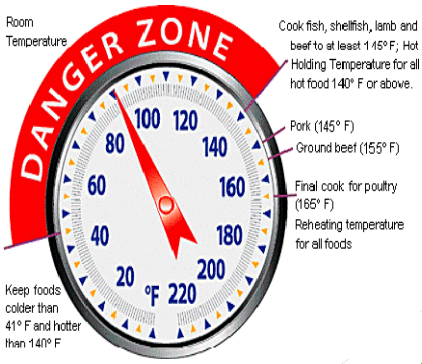
Thawing Foods

Food should be thawed using the following techniques:

- Under potable running water of a temperature of 70˚F
- Or through part of the conventional cooking process

Thawing Foods

- In a microwave oven only when food will be immediately transferred to conventional cooking equipment as part of a continuous cooking process or when the entire, uninterrupted cooking process takes place in the microwave oven
- May be thawed in the refrigerator



Additional Regulatory reference

10A NCAC 13F .0311 Other Requirements

(a) The building and all fire safety, electrical, mechanical , and plumbing equipment in an adult care home shall be maintained in a safe and operating conditions.

10A NCAC 13G .0317 Building Service Equipment

(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operation conditions.

Food Supply

10a NCAC 13 F/G .0904 Nutrition and Food Service

(a) (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets

3-Day Supply of Perishable Food

- Perishable food is usually foods that require refrigeration.
- If your menu calls for milk, orange juice, butter, eggs etc. ensure you have enough of each item to cover all residents for 3 days

DRY STORAGE

5-Day Supply of Non-Perishable Food

- Non-perishable food is usually food that does not require refrigeration
- Examples: canned fruit, vegetables, cake mixes, cereal, etc.

10A NCAC 13G .0904 Nutrition and Food Service

FOOD REQUIREMENTS

- (d) (2) Foods and beverages that are **appropriate to residents diets** shall be offered or made available to all residents as **snacks** between each meal for a **total of three snacks** per day and shown on the menu as snacks.
- (d)(3) Milk One cup at least twice a day
  - Two servings of fruit
  - Three servings Vegetables
  - One whole egg at least three times a week at breakfast
  - Two to Three ounces of pure cooked meat at least two times a day
  - Cereals/Breads at least 6 servings a day

Observation of Meal Service

source, date, time and location

Observation of Meal Service

What are we writing?

- Document start and end times of meal service.
- How long it takes to plate the meal until it reaches the resident.
- What the resident actually received.
- How staff interacts with residents.

10A NCAC 13F .0904 FOOD REQUIREMENTS

- (d) (3) (h) WATER AND OTHER BEVERAGES

Water shall be served to each resident at each meal, in addition to other beverages.

Milk
Whole, Low Fat, Skim or Buttermilk

Example:

Milk: 1 cup (8 ounces) twice a day the facility has 20 residents

20 (residents) x 16 oz./day = 320 ounces

*There are 128 ounces in 1 gallon of milk
*320 ÷ 128 = 2.5 gallons of milk needed/day
*If you need a 3-day supply you will need 2.5 (gallons) x 3 (days) = 7.5 gallons of milk

10A NCAC 13F/G .0904 Nutrition and Food Service

- (b) (2)Table service shall include a napkin and non-disposable place setting consisting of a least a knife, fork, spoon, plate and beverage containers.
- Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident

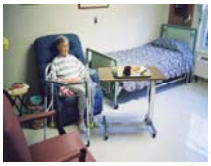
10A NCAC 13F/G .0904
Nutrition and Food Service
Feeding Assistance

(f1)Sufficient staff shall be available for individual feeding assistance as needed.

(f2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

10A NCAC 13F .0904 Nutrition and Food Service

(b)(4) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.



Before / After Meal Service

- Interview staff, residents, and family members (if available)
- We are trying to get the whole picture
- We will never know if we do not ask the questions

Menus

What kind of diets does the facility provide?

10A NCAC 13G/F .0904(c)(2)

*Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff

Menus should not be in the Administrator's office on a shelf!

Regular menus **do not** have to be signed by a Registered Dietician

Substitutions
10A NCAC 13F/G .0904 (c)(3)

Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.

Substitutions must:

- Stay in the same food group
- Examples:
  - Only citrus fruit or juice is a substitute for citrus fruit or juice
  - Orange juice - substitute - grapefruit juice
  - Collard greens - substitute - turnip greens
  - Oatmeal - substitute - grits

Therapeutic Diets

A therapeutic diet is a meal plan that controls the intake of certain foods or nutrients.

It is part of the treatment of a medical condition prescribed by a physician and planned by a dietician.

Therapeutic diets are modified for (1) nutrients, (2) texture, and/or (3) food allergies/ food intolerances.

10A NCAC 13F .0904 Nutrition and Food Service

- **(e)(1):** All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician
- Where applicable, therapeutic diet orders shall be specific to calorie, gram or consistency unless there are written orders which include the definition of any therapeutic diet identified in facility's therapeutic menu
- Approved by a registered dietitian

10A NCAC 13F .0904 Nutrition and Food Service

- **(e)(3)** The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff
- Diet list must be current, list each resident, and the therapeutic diet as prescribed by the physician

10A NCAC 13F/G .0904 Nutrition and Food Service

(e)(4)All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

A therapeutic diet is the same as a medication order

Common reasons therapeutic diets may be ordered

To balance amounts of carbohydrates, fat and protein.

To decrease the amount of a nutrient such as sodium, sugar, potassium.

To exclude foods due to allergies or food intolerance (gluten).

To provide texture modifications due to problems with chewing and/or swallowing

Overview of the general therapeutic diets

Carbohydrate Controlled-CC
No concentrated sweets diet -NCS
Calorie Controlled Diabetic-1200,1500
No added salt diet -NAS
Low sodium diet-LS
Low fat diet-LF
Low cholesterol diet -LC
Renal diet

Therapeutic Diet Examples

- **No Added Salt (NAS):** 3-4g sodium
- **Diabetic Diets:**
  - No Concentrated Sweets (NCS)
  - No Added Sugar
  - Carbohydrate Controlled
  - Calorie ADA Diet

No Added Salt (NAS)

- Used to manage high blood pressure and fluid retention
- Use of table salt is restricted and salt may be limited in cooking
- Typically provides between 3-4 grams of sodium daily (3000-4000 mg)
- Follow menu and corresponding recipes

No Added Salt (NAS) diet

- Is a regular diet with no salt packet on the tray. Food is seasoned as regular food.
- Adding salt is avoided, smoked meats, processed foods and pickled foods are avoided.
- Patients with the following conditions will most likely need to follow a low-sodium/salt restricted diet: Hypertension, Heart disease, Edema, Kidney disease

No Added Salt (NAS)

- **Tips on Reducing Salt:**
  - Choose low or reduced sodium and no salt added foods
  - Use fresh or frozen fruits and vegetables
  - Rinse canned vegetables
  - Use spices instead of salt
  - Use canned soups prudently

Calorie controlled diet (ADA)

- These diets control calories, carbohydrates, protein, and fat intake in balanced amounts to meet nutritional needs, control blood sugar levels, and control weight.
- Portion control is used with these diets.

- Most commonly used calorie levels are: 1,200, 1,500, 1,800 and 2,000.

No Concentrated Sweets (NCS)

- Is considered a liberalized diet for diabetics when their weight and blood sugar levels are under control.
- It includes regular foods without the addition of sugar.
- Calories are not counted as in ADA calorie controlled diets.

No Concentrated Sweets (NCS)

- **NCS Diets eliminate:**
  - Sugar
  - Corn Syrup
  - High Fructose Syrup
  - Honey
  - Molasses
  - Maple Syrup

- **Tip:** Use canned fruit packed in juice/water

Controlled Carbohydrate Diet

- **Tips:**
  - Portion control is key
  - Follow menus closely
  - Use correct measurements
  - Follow recipe

Low fat/low cholesterol diet

- In low cholesterol diets, intake of foods high in saturated fats must be avoided. These foods include beef, pork, eggs and cheese, among other items. This type of diet is necessary for maintaining heart health in patients with heart disease.
- Is used to reduce fat levels and/or treat medical conditions that interfere with how the body uses fat such as diseases of the liver, gallbladder, or pancreas.

Low Fat / Low Cholesterol Diet

Residents with arteriosclerosis or problems with cholesterol:

- Total Fats: 25-30% of total calories
  - Saturated fats: <7% of total calories
  - Monounsaturated: <10% of total calories
  - Polyunsaturated: <10% of total calories
- Cholesterol: <200 mg daily

Low Fat / Low Cholesterol Diet

- **Tips:**
  - Choose lean meats with fat trimmed (turkey, fish, poultry without skin)
  - Skim or 1% milk
  - Cheese labeled with ≤ 2-6 grams of fat per ounce
  - Unsaturated vegetable oils (olive, corn, safflower, canola)

Low Fat / Low Cholesterol Diet

- **Additional Tips:**
  - Limit margarine and butter
  - Low fat dressings
  - Fresh, frozen, dried fruits and vegetables
  - Whole grain instead of white flour
  - Avoid fried foods

Renal Diet

- Designed for individuals who have chronic renal failure (kidney disease) or End Stage Renal Disease (ESRD) and may be on dialysis
- Follow menu and corresponding recipes

Renal Diet

- **Typically restricts:**
  - Protein
  - Sodium
  - Potassium
  - Phosphorous
  - Fluids may be restricted on an individual basis

Renal Diet

Tips:

- Follow the Menu
- If a resident is on fluid restriction, ensure staff is knowledgeable of restriction and how to document appropriately
- If a resident goes out to dialysis ensure that lunch and appropriate snacks are sent
- Lunch menus must be signed by a Registered Dietician

Texture modifications

Mechanical Soft Diets

- To achieve correct consistency use knife, blender, food processor or meat grinder
- Types of consistency: chopped or ground
- No raw fruits or vegetables allowed

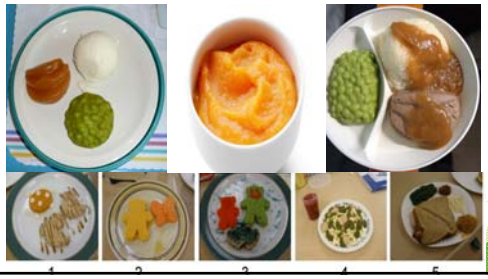
Mechanically Altered (Soft) diets

- Soft diets consist of food that is easily chewed and digested.
- Soft diets are used typically in the following situations:
- With patients who have digestive or chewing difficulty, with poor dental conditions, missing teeth, no teeth, or a condition known as dysphasia.

Pureed diet

- Changes the regular textured diet by pureeing it to a smooth liquid consistency.
- Indicated poor dentition in which chewing is inadequate or swallowing difficulties.
- Foods should be pureed separately. Avoid nuts, seeds, raw vegetables, and raw fruits.
- Is nutritionally adequate when offering all food groups.
- All food groups should be served i.e.: breads- the menu should give instruction on how it should be prepared.

Puree foods should hold its consistency



Liquid Diets

Clear liquid diet

- Examples are juices without pulp, broth, and Jell-O.
- Is often used as the first step to restarting oral feeding after surgery or an abdominal procedure.
- People with severe diarrhea.
- Should not be used for an extended period as it does not provide enough calories and nutrients.

Full liquid diet

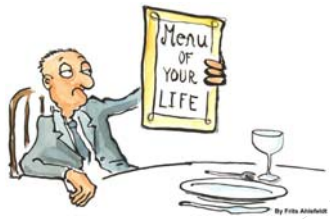
- Examples of food allowed are ice cream, pudding, thinned hot cereal, custard, strained cream soups, and juices with pulp.
- Used as the second step to clear liquids are tolerated.
- Should not be used for extended periods.

Clear Liquid Diet

- Clear liquid diet will supply fluid and energy
- Primarily used before and after tests or surgery
- Items should be liquid at room temperature and clear
- Examples: apple juice, broth, popsicles, tea and gelatin

10A NCAC 13F/G .0904 Nutrition and Food Service

- (c)(7)The facility shall have a matching therapeutic diet menu for all physician ordered therapeutic diets for guidance for food service staff



Combination Diets

- "We Do Right" Adult Care Home has individual menus for NAS, NCS, and LF/LC
- Send this information to each resident's physician asking physician to choose a diet for their residents

Combination Diets cont….

- According to your menus, residents on NCS diets should get 2% milk, NAS diets should get whole milk and LF/LC diets should get skim milk
- Facility should contact RD and get a new menu for a combination diet or
- Contact physician to let him know your facility does not offer combination diets

Thickeners

- Used when residents have swallowing disorders
- Dysphagia occurs when there is a problem with any part of the swallowing process
- Types of consistency: nectar, honey or pudding
- Ordered by the Physician and should include the type of consistency.

Thickeners

- Ice should never be used with thickened liquids because it changes consistency of beverage
- If a resident is on thickened liquids, we expect to see thickened liquids on medication cart for medication administration.

General Aspiration Precautions

- Resident should sit upright when eating (45˚)
- Each portion should be <1 teaspoon
- Place food well into mouth
- Resident should swallow several times after each portion is served

Record Review

- Pull charts for sampled residents
- What are we looking for?
- Current FL-2 Form: signed by physician, resident diagnoses, current diet orders
- Current Care Plan: signed by physician, Activities of Daily Living, etc.
- Information pertinent to resident and diet

Pulling it all Together

- Compare current physician diet order with facility's diet list and menus with what was actually served to resident
- **All Four Must Match!**

Test your knowledge

Monitoring Activity

FOOD SERVICE MONITORING WORKSHEET –Assigned Surveyor

Time Served: _____ **Time Finished:** _____

Facility Name: _____ **Date:** _____ **Surveyor Initials:** _____ **B L D (Circle One)**

Resident Name	Diet Order		Therapeutic Diet Menu Available		On Modified Diet List		Thickened Liquids		Supplement Order (how often)		Feeding Assistance Required		Meal Observation (Food Served on Plate)
	Date	Diet Type	Y	N	Y	N	Y	N	Y	N	Y	N	
1.													
2.													
3.													
4.													
5.													

DHSR/AC 4614 (Rev. 11/16) NCDHHS

Therapeutic Diet List for Butterfields Assisted Living

- **NO CONCENTRATED SWEETS**
  Carolyn A., Jewel C., Homer G.
  Myrtle W., Annie C., Ann M.
- **MECHANICAL SOFT**
  John G., Simon L.
  Lyle B., Janet P.
- **PUREED**
  Foster C., Margaret M.
  Geneva H., Grant T.
- **RENAL**
  April B.
- **2200 CALORIE ADA**
  May G.

10A NCAC 13F/G .0703
Tuberculosis Test, Medical Examination and Immunizations

- (c) (4) If the information on the FL-2 or MR-2 is not clear or insufficient , the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.

THINGS TO CONSIDER

Quality of life is of major importance to long-term care residents.

Liberalization of diets may result in a better nutrition outcome for residents and an improved quality of life.

Texture-modified diets such as puree, mechanical soft, and thickened liquids should not be liberalized.

Use of liberalized diets simplifies food preparation, tray delivery, and use of foods during activities in a long-term care facility.

Writing the Corrective Action for Non-Compliance

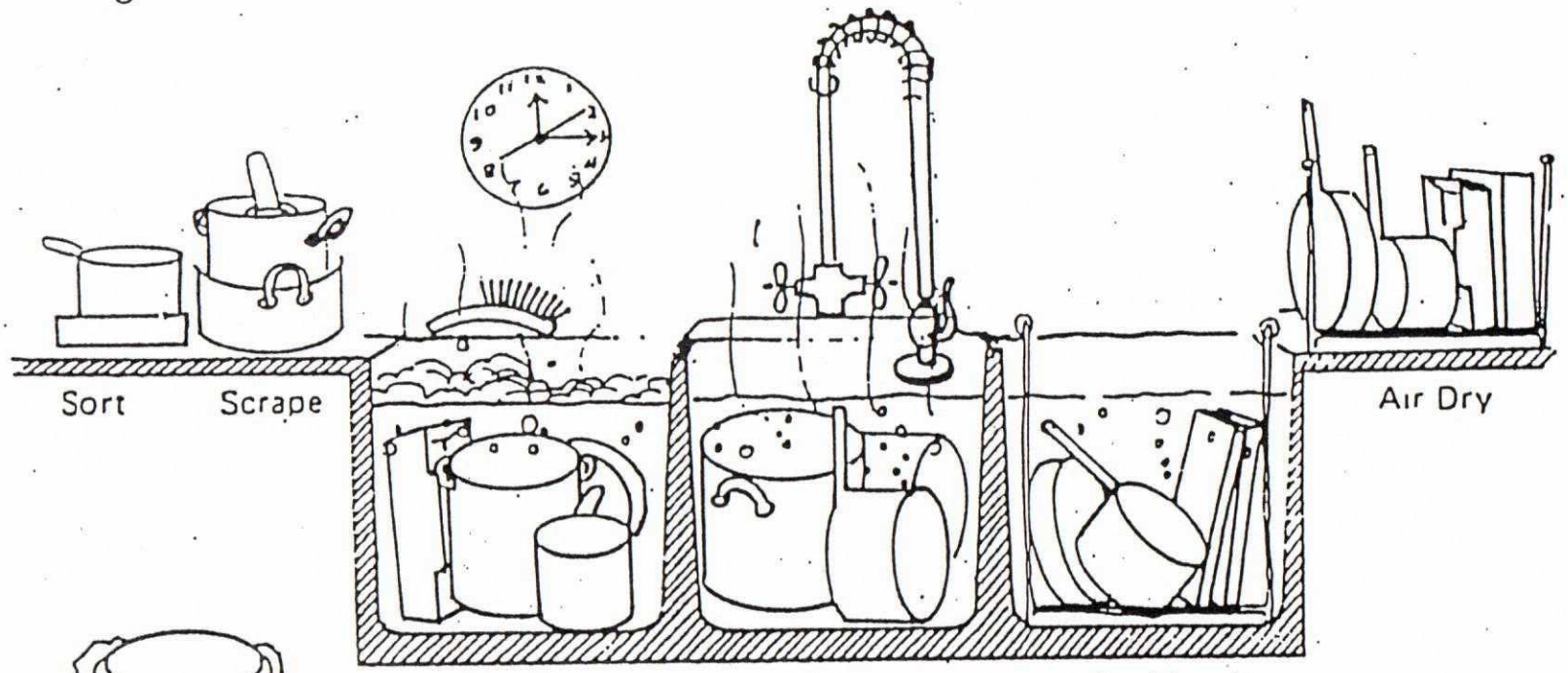
- Regulatory Reference
- Practice Statement
- Findings includes sources of Evidence
- Observations
- Interviews
- Record Reviews
- "Tell The Story"
- Examples
  - .0904(a)(1)
  - .0904(a)(2)

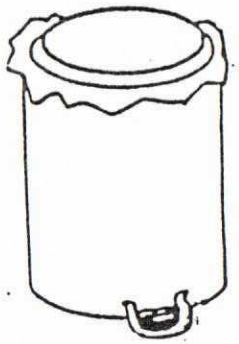
Bottom Line

We are ALL here for the residents, to ensure they get adequate care and services

QUESTIONS

Exhibit 10.6 A three-compartment sink for manual washing, rinsing, and chemical sanitizing





WASH
with a good detergent
in hot water
120°F

RINSE
in clean
hot water
120°F

SANITIZE
1 minute in 50 ppm
chlorine solution or
approved equivalent
between 75°F and 120°F

OR in 170°F hot water (not with clorox) for 30 seconds

SANITIZATION STANDARDS

CLOROX		WATER
1/3 CUP	TO	5 GALLONS
3 TABLESPOONS	TO	3 GALLONS
1 TABLESPOON	TO	1 GALLON

(For dish machines, follow manufacture's recommendations.)

MENU SUBSTITUTION FORM

.0904 (c)(3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.

DATE: _____

DATE SUBSTITUTION MADE: _____

MEAL SUBSTITUTION SERVED: breakfast/lunch/supper
(Circle one)

DAY: _____ CYCLE: _____

SUBSTITUTION MADE BY: _____

_____ was served in place of _____

_____ was served in place of _____

_____ was served in place of _____

_____ was served in place of _____

_____ was served in place of _____

_____ was served in place of _____

FOOD SERVICE MONITORING WORKSHEET –Assigned Surveyor

Time Served: _____ Time Finished: _____

Facility Name: _____ Date: _____ Surveyor Initials: _____ B L D (Circle One)

Resident Name	Diet Order		Therapeutic Diet Menu Available		On Modified Diet List		Thickened Liquids		Supplement Order (how often)		Feeding Assistance Required		Meal Observation (Food Served on Plate)
	Date	Diet Type	Y	N	Y	N	Y	N	Y	N	Y	N	
1.													
2.													
3.													
4.													
5.													

FOOD SERVICE MONITORING WORKSHEET

Sanitation Score: _____ Date: _____

Facility Name: _____ Date: _____ Time: _____ Surveyor Initials: _____

Observation/Interview (Resident Staff Other)	Date	Time

Best Practices in Food Service

- **INSIDE THE KITCHEN:**
  - Who is responsible for ensuring all equipment is properly working?
  - Who is responsible for ensuring all equipment has had routine service?
  - How often will this be monitored?

- **HOT FOODS HOT AND COLD FOOD COLD**
  - What system is in place to ensure that all food served to residents is at the appropriate temperature?
  - Do you keep food temperature logs?
  - Who is responsible for the temperature logs?
  - Who checks to ensure the temperature logs are being documented?

- **TEMPERATURE CONTROL BEFORE FEEDING ASSISTANCE IS PROVIDED**
  - Who is responsible for ensuring that the meal is served at the proper temperatures for residents who receive feeding assistance?
  - Who is responsible for ensuring the resident requiring feeding assistance is offered his/her meal in a timely manner?

- **MENUS:**
  - What system/training has been put in place to ensure staff are able to read and follow menus?
  - Are all kitchen staff trained to read menus?
  - Who is responsible for documenting substitutions?
  - Who is responsible for ensuring the substitution is an adequate substitution?
  - Who is responsible for ensuring substitutions are being documented?
  - Who is responsible for ensuring the facility has therapeutic menus for all therapeutic diet orders in your facility?

- Who is responsible for updating menus when a new diet order comes into the facility?
- Who is responsible for ensuring your regular menus meet the requirement?
- Who is responsible for ensuring diet orders have been clarified?
- Who is responsible for informing the kitchen staff of new diet orders?

- **DIET LIST:**
  - Who is responsible for ensuring the diet list is current?
  - Who is responsible for ensuring if the diet order changes the diet list changes to reflect the subsequent order?
  - Who double checks the diet list for accuracy?

- **THICKENED LIQUIDS AND SUPPLEMENTS**
  - Who is responsible for preparing thickened liquids?
  - What training has been provided to ensure staff are preparing thickened liquids accurately?
  - Who is responsible for providing supplements?
  - Who is responsible for documenting supplements were administered?

- **FEEDING ASSISTANCE:**
  - Who is responsible for providing feeding assistance?
  - Has staff been properly trained on providing feeding assistance?
  - Who is responsible for ensuring there is an adequate amount of staff to provide feeding assistance to all of your residents?

- If you have to ask the question, then you know we are going to ask the question
- It is OK to put monitoring and tracking systems in place

Food Establishment Inspection Report

Score: 95.5

Establishment Name: [redacted]
Location Address: [redacted]
City: [redacted] **State:** [redacted]
Zip: [redacted] **County:** [redacted]
Permittee: [redacted]
Telephone: 0000000000
Wastewater System: ☒ Municipal/Community ☐ On-Site System
Water Supply: ☒ Municipal/Community ☐ On-Site Supply

Establishment ID: 04051160010
☒ Inspection ☐ Re-Inspection
Date: 12/05/2016 **Status Code:** A
Time In: 1:15 PM **Time Out:** 2:45 PM
Category#: 4
FDA Establishment Type: Institutional Food Service
No. of Risk Factor/Intervention Violations: 2
No. of Repeat Risk Factor/Intervention Violations: 0

Foodborne Illness Risk Factors and Public Health Interventions

Risk factors: Contributing factors that increase the chance of developing foodborne illness.
Public Health Interventions: Control measures to prevent foodborne illness or injury

Compliance Status					OUT	CDI	R	VR
Supervision .2652								
1	☒ IN	☐ OUT	☐ N/A	PIC present, Demonstration - Certification by accredited program and perform duties	☐ 2 ☐ 0			
Employee Health .2652								
2	☒ IN	☐ OUT		Management, employees knowledge; responsibilities & reporting	☐ 3 ☐ 1.5 ☐ 0			
3	☒ IN	☐ OUT		Proper use of reporting, restriction & exclusion	☐ 3 ☐ 1.5 ☐ 0			
Good Hygienic Practices .2652,.2653								
4	☐ IN	☒ OUT		Proper eating, tasting, drinking, or tobacco use	☐ 2 ☒ 1 ☐ 0	X		
5	☒ IN	☐ OUT		No discharge from eyes, nose, and mouth	☐ 1 ☐ 0.5 ☐ 0			
Preventing Contamination by Hands .2652,.2653,.2655,.2656								
6	☒ IN	☐ OUT		Hands clean & properly washed	☐ 4 ☐ 2 ☐ 0			
7	☒ IN	☐ OUT	☐ N/A	☐ N/O No bare hand contact with RTE foods or a pre-approved alternate procedure properly allowed	☐ 3 ☐ 1.5 ☐ 0			
8	☒ IN	☐ OUT		Handwashing sinks supplied & accessible	☐ 2 ☐ 1 ☐ 0			
Approved Source .2653,.2655								
9	☒ IN	☐ OUT		Food obtained from approved source	☐ 2 ☐ 1 ☐ 0			
10	☐ IN	☐ OUT	☒ N/O	Food received at proper temperature	☐ 2 ☐ 1 ☐ 0			
11	☒ IN	☐ OUT		Food in good condition, safe & unadulterated	☐ 2 ☐ 1 ☐ 0			
12	☒ IN	☐ OUT	☐ N/A	☐ N/O Required records available: shellstock tags, parasite destruction	☐ 2 ☐ 1 ☐ 0			
Protection from Contamination .2653,.2654								
13	☒ IN	☐ OUT	☐ N/A	☐ N/O Food separated & protected	☐ 3 ☐ 1.5 ☐ 0			
14	☐ IN	☒ OUT		Food-contact surfaces: cleaned & sanitized	☐ 3 ☒ 1.5 ☐ 0			X
15	☒ IN	☐ OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food	☐ 2 ☐ 1 ☐ 0			
Potentially Hazardous Food Time/Temperature .2653								
16	☐ IN	☐ OUT	☐ N/A	☒ N/O Proper cooking time & temperatures	☐ 3 ☐ 1.5 ☐ 0			
17	☒ IN	☐ OUT	☐ N/A	☐ N/O Proper reheating procedures for hot holding	☐ 3 ☐ 1.5 ☐ 0			
18	☒ IN	☐ OUT	☐ N/A	☐ N/O Proper cooling time & temperatures	☐ 3 ☐ 1.5 ☐ 0			
19	☐ IN	☐ OUT	☐ N/A	☒ N/O Proper hot holding temperatures	☐ 3 ☐ 1.5 ☐ 0			
20	☒ IN	☐ OUT	☐ N/A	☐ N/O Proper cold holding temperatures	☐ 3 ☐ 1.5 ☐ 0			
21	☒ IN	☐ OUT	☐ N/A	☐ N/O Proper date marking & disposition	☐ 3 ☐ 1.5 ☐ 0			
22	☐ IN	☐ OUT	☒ N/A	☐ N/O Time as a public health control: procedures & records	☐ 2 ☐ 1 ☐ 0			
Consumer Advisory .2653								
23	☐ IN	☐ OUT	☒ N/A	Consumer advisory provided for raw or undercooked foods	☐ 1 ☐ 0.5 ☐ 0			
Highly Susceptible Populations .2653								
24	☒ IN	☐ OUT	☐ N/A	Pasteurized foods used, prohibited foods not offered	☐ 3 ☐ 1.5 ☐ 0			
Chemical .2653,.2657								
25	☐ IN	☐ OUT	☒ N/A	Food additives: approved & properly used	☐ 1 ☐ 0.5 ☐ 0			
26	☒ IN	☐ OUT	☐ N/A	Toxic substances properly identified, stored, & used	☐ 2 ☐ 1 ☐ 0			
Conformance with Approved Procedures .2653,.2654,.2658								
27	☒ IN	☐ OUT	☐ N/A	Compliance with variance, specialized process, reduced oxygen packaging criteria or HACCP plan	☐ 2 ☐ 1 ☐ 0			

Good Retail Practices

Good Retail Practices: Preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Compliance Status					OUT	CDI	R	VR
Safe Food and Water .2653,.2655,.2658								
28	☒ IN	☐ OUT	☐ N/A	Pasteurized eggs used where required	☐ 1 ☐ 0.5 ☐ 0			
29	☒ IN	☐ OUT		Water and ice from approved source	☐ 2 ☐ 1 ☐ 0			
30	☐ IN	☐ OUT	☒ N/A	Variance obtained for specialized processing methods	☐ 1 ☐ 0.5 ☐ 0			
Food Temperature Control .2653,.2654								
31	☒ IN	☐ OUT		Proper cooling methods used; adequate equipment for temperature control	☐ 1 ☐ 0.5 ☐ 0			
32	☒ IN	☐ OUT	☐ N/A	☐ N/O Plant food properly cooked for hot holding	☐ 1 ☐ 0.5 ☐ 0			
33	☒ IN	☐ OUT	☐ N/A	☐ N/O Approved thawing methods used	☐ 1 ☐ 0.5 ☐ 0			
34	☒ IN	☐ OUT		Thermometers provided & accurate	☐ 1 ☐ 0.5 ☐ 0			
Food Identification .2653								
35	☒ IN	☐ OUT		Food properly labeled; original container	☐ 2 ☐ 1 ☐ 0			
Prevention of Food Contamination .2652,.2653,.2654,.2656,.2657								
36	☒ IN	☐ OUT		Insects & rodents not present; no unauthorized animals	☐ 2 ☐ 1 ☐ 0			
37	☒ IN	☐ OUT		Contamination prevented during food preparation, storage & display	☐ 2 ☐ 1 ☐ 0			
38	☒ IN	☐ OUT		Personal cleanliness	☐ 1 ☐ 0.5 ☐ 0			
39	☒ IN	☐ OUT		Wiping cloths: properly used & stored	☐ 1 ☐ 0.5 ☐ 0			
40	☒ IN	☐ OUT	☐ N/A	Washing fruits & vegetables	☐ 1 ☐ 0.5 ☐ 0			
Proper Use of Utensils .2653,.2654								
41	☒ IN	☐ OUT		In-use utensils: properly stored	☐ 1 ☐ 0.5 ☐ 0			
42	☒ IN	☐ OUT		Utensils, equipment & linens: properly stored, dried, & handled	☐ 1 ☐ 0.5 ☐ 0			
43	☒ IN	☐ OUT		Single-use & single-service articles: properly stored & used	☐ 1 ☐ 0.5 ☐ 0			
44	☒ IN	☐ OUT		Gloves used properly	☐ 1 ☐ 0.5 ☐ 0			
Utensils and Equipment .2653,.2654,.2663								
45	☐ IN	☒ OUT		Equipment, food & non-food-contact surfaces approved, cleanable, properly designed, constructed & used	☐ 2 ☒ 1 ☐ 0		X	
46	☐ IN	☒ OUT		Warewashing facilities: installed, maintained & used, test strips	☐ 1 ☒ 0.5 ☐ 0			
47	☒ IN	☐ OUT		Non-food contact surfaces clean	☐ 1 ☐ 0.5 ☐ 0			
Physical Facilities .2654,.2655,.2656								
48	☒ IN	☐ OUT	☐ N/A	Hot & cold water available; adequate pressure	☐ 2 ☐ 1 ☐ 0			
49	☒ IN	☐ OUT		Plumbing installed; proper backflow devices	☐ 2 ☐ 1 ☐ 0			
50	☒ IN	☐ OUT	☐ N/A	Sewage & waste water properly disposed	☐ 2 ☐ 1 ☐ 0			
51	☒ IN	☐ OUT		Toilet facilities: properly constructed, supplied, & cleaned	☐ 1 ☐ 0.5 ☐ 0			
52	☒ IN	☐ OUT		Garbage & refuse properly disposed; facilities maintained	☐ 1 ☐ 0.5 ☐ 0			
53	☐ IN	☒ OUT		Physical facilities installed, maintained & clean	☐ 1 ☒ 0.5 ☐ 0			
54	☒ IN	☐ OUT		Meets ventilation & lighting requirements: designated areas used	☐ 1 ☐ 0.5 ☐ 0			
					TOTAL DEDUCTIONS:	4.5		

Comment Addendum to Food Establishment Inspection Report

Establishment Name: [redacted]
Location Address: [redacted]
City: [redacted] State: [redacted]
County: [redacted] Zip: [redacted]

Wastewater System: ☒ Municipal/Community ☐ On-Site System
Water Supply: ☒ Municipal/Community ☐ On-Site Supply

Permittee: [redacted]
Telephone: 0000000000

Establishment ID: 04051160010
☐ Routine Inspection ☐ Re-Inspection
☐ Complaint Date: 12/05/2016
☐ Verification Status Code: A
☐ Name Change Category#: 4
☐ Status Change
☐ Pre-Opening Visit
☐ Other

Temperature Observations

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
Stew (reheating) (steamer)	85 °F	milk/cheese/tomatos (walk in cooler)	41 °F		

Observations and Corrective Actions

Item Number	Violations cited in this report must be corrected within the time frames below, or as stated in sections 8-405.11 of the food code.
4	2-401.11; Core; Do not sit or store employee drinks on prep tables or in areas that would contaminate food contact areas. Employee drinks must also always have lids and straws. The one sitting on the prep table did have lid and straw, but it was stored in the wrong location.; Corrected During Inspection
14	4-501.114; Priority; Dish machine is not sanitizing. Facility is calling repair person so that it can be quickly repaired. Until machine is repaired, dishes must be sanitized by hand in 3 compartment sink or by use of spray bottle once dishes come out of dish machine. Machine was repaired and working properly by end of inspection. Line was not pushed in machine far enough and had to be re-primed!; Verificat Required
45	4-501.11; Core;Repair freezer that is dripping condensate and forming ice on some food boxes. Condensate or ice is a potential sou or contamination of food.; Repeat
46	4-302.14; Priority Foundation; Make sure sanitizer test strips are kept on site for sanitizers that are being used. Needs chlorine test strips for dishmachine and quaternary ammo. test strips for dish sink.
53	6-201.11; Core; Repair ceilings in kitchen that are in poor repair from water damage.
	General Comments Follow-Up 12/06/2016

Person in Charge (Print & Sign): [redacted] **Verification Required Date:** 12/15/2016

Regulatory Authority (Print & Sign): [redacted] **REHS ID:** [redacted]

REHS Contact Phone Number: [redacted]

FOOD SERVICE MONITORING ACTIVITY

LUNCH TIME OBSERVED at Butterfields Assisted Living, Cricket, N.C.

Directions for Activity: Compare the meal observed to the resident's FL-2 to the Therapeutic Diet List, and to the Menu. Use the food service monitoring tool to document observations and record findings from record review. Determine if the facility is out of compliance with rule areas and write, if any the deficiency/deficiencies for this food service monitoring visit.

Assume food portions are appropriate.

1. Resident Margaret M. has one white scoop, one brownish white scoop, and one greenish white scoop of food. She also has a dessert bowl with yellow pudding and is served a cup of coffee and water. Interview with staff reveals the food was fried fish, mashed potatoes and coleslaw.

2. Resident April B. has fried fish, mashed potatoes, coleslaw, 4 hushpuppies, a bowl of pears, and two glasses, which appear to be water. Interview reveals that one glass of liquid is Sprite and the other glass is water.

3. Simon L. has baked fish, baked potato, coleslaw, roll, a dish of lemon pie, and a glass of tea and a glass of water.

4. May G. has a serving of fried fish, baked potato, coleslaw, 6 hushpuppies, a dish of Lemon Pudding, a glass of tea and a glass of water. Interview with staff reveals that the Tea is Sugar Free.

5. Myrtle has a serving of fried fish, baked potato, coleslaw, 6 hushpuppies, a dish of lemon pie, a glass of milk and a glass of water.

MODIFIED DIET LIST FOR BUTTERFIELDS MANOR

1500 CALORIE ADA

CAROLYN A.
MYRTLE W.

1800 CALORIE ADA

JEWEL C.
ANNIE C.
HOMER G.
ANN M.

2200 CALORIE ADA

MAY G.

LOWFAT LOW CHOLESTEROL

MARGARET M.
THEODORE I.

RENAL

APRIL B.

PUREED

FOSTER C.
GRANT T.
GENEVA H.

MECHANICAL SOFT

JOHN G.
LYLE B.
SIMON L.
JANET P.

BUTTERFIELDS ASSISTED LIVING

	Portion Size	REGULAR	NO ADDED SALT (3-4 GM)	MECHANICAL SOFT	PUREED	RENAL	NO CONCENTRATED SWEETS
BREAKFAST	6 oz 1 1 2 1 1 8 oz	Orange juice Egg scrambled Bacon Pancakes Margarine Syrup Milk Coffee	Orange juice Egg scrambled Pancakes LS Margarine Syrup Milk Coffee	Orange juice Egg scrambled Pancakes Margarine Syrup Milk Coffee	Orange juice Pureed Egg, scrambled Pureed Bacon Pancakes Margarine Syrup Milk Coffee	Apple juice LS Egg scrambled Pancakes 2 LS Margarine Syrup 2 Milk Coffee	Orange juice Egg scrambled Bacon Pancakes Margarine SF Syrup Milk Coffee
LUNCH	3oz 1 med ½ c 4-6 1sl	Fried Fish Baked potato Coleslaw Hushpuppies Lemon Pie Coffee, tea, milk	LS Fried Fish Baked potato Coleslaw Hushpuppies Lemon Pie Coffee, tea, milk	Baked Fish Bake potato Coleslaw Roll Lemon Pie Coffee, tea, milk	Pureed Fried Fish Mashed potato Pureed Coleslaw Roll Lemon Pudding Coffee, tea, milk	Fried Fish 1 oz. Noodles ½ c Coleslaw Hushpuppies 4 Pears ½ c Sprite Koolaid	Fried Fish Baked potato Coleslaw Hushpuppies SF Lemon Pudding Coffee, tea, milk
DINNER	3 oz ½ c ½ c 1 ½ c 1 8 oz	Cubed beef steak Mashed potatoes Mixed vegetables Roll Sliced oranges Margarine Milk Coffee, tea	Cubed beef steak Mashed potatoes Mixed vegetables Roll Sliced oranges LS Margarine Milk Coffee, tea	Chopped Cubed beef steak Mashed potatoes Mixed vegetables Roll Sliced oranges Margarine Milk Coffee, tea	Pureed cube steak Mashed potatoes Pureed Mixed vegetables Roll Pureed pears Margarine Milk Coffee, tea	Cubed beef 1 oz Rice ½ c Cauliflower ½ c Roll Pineapple ½ c Margarine Tea, Ginger-ale	Cubed beef steak Mashed potatoes Mixed vegetables Roll Sliced oranges Margarine Milk Coffee, tea

NOTE: BACON CAN BE PUREED WITH EGGS **SF (sugar-free) pudding should be made w/skim milk**
Water should be served with each meal

Used by permission with revisions from Patsy Holley, R.D.

FL-2 (86)

INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
B.	April		9/28/24	F	1-2-08

5. COUNTY AND MEDICAID NUMBER	6. FACILITY	ADDRESS	7. Provider NUMBER 99999
02 245-00-7000	Butterfields	Cricket, N.C.	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bowers	Frances W. (daughter) 3 No Lane , Upton, NC 28806

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
____HOME ____X DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER ____HOSPITAL	____HOME __X_ X DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER	13. DATE APPROVED/DENIED	____ SNF ____ HOME ____ ICF ____ DOMICILIARY (REST HOME) X ____ OTHER

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **Dementia**	5.
2. **End Stage Renal Disease (ESRD)**	6.
	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY		CONTINENT		CONTINENT
x	INTERMITTENTLY		SEMI-AMBULATORY	x	INCONTINENT	x	INCONTINENT
INAPPROPRIATE BEHAVIOR			NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	**FUNCTIONAL LIMITATIONS**			EXTERNAL CATHETER	**RESPIRATION**	
	VERBALLY ABUSIVE		SIGHT	**COMMUNICATION OF NEEDS**		x	NORMAL
	INJURIOUS TO SELF		HEARING		VERBALLY		TRACHEOSTOMY
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.
	OTHER:	**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
PERSONAL CARE ASSISTANCE		x	PASSIVE	x	NORMAL		DIET Renal
x	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL
	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON
x	DRESSING		RE-SOCIALIZATION				PARENTERAL
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		**NEUROLOGICAL**					GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL				WEIGHT 108##
			FREQUENCY				HEIGHT 5"2"

17. SPECIAL CARE FACTORS		FREQUENCY	SPECIAL CARE FACTORS		FREQUENCY
	BLOOD PRESSURE	**weekly**		BOWEL AND BLADDER PROGRAM	
	DIABETIC URINE TESTING			RESTORATIVE FEEDING PROGRAM	
	PT (BY LICENSED PT)			SPEECH THERAPY	
	RANGE OF MOTION EXERCISES			RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1 Aruceot 5 mg 1 po daily	7.
2 Atiivan .5 mg q 6 hr prn anxiety	8.
3. **Ambien 5 mg 1 po hs prn sleep**	9.
4. **Hemodialysis Mon Wed Fri**	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION: PPD negative 1/1/98

21. PHYSICIAN'S SIGNATURE	22. DATE

372-124 (12-92)

EDS – DMA COPY

FL-2 (86)

INSTRUCTIONS ON REVERSE SIDE

NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
M.	Margaret		7/02/17	F	1-08-08

5. COUNTY AND MEDICAID NUMBER	6. FACILITY	ADDRESS	7. Provider NUMBER 99999
02 245-00-7000	Butterfields	Cricket, N.C.	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bowers	Frances W. (daughter) 3 No Lane , Upton, NC 28806

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
____HOME _____X DOMICILIARY _____ SNF (REST HOME) _____ ICF _____ OTHER _____HOSPITAL _____	____HOME __X_X DOMICILIARY _____ SNF (REST HOME) _____ ICF _____ OTHER _____	13. DATE APPROVED/DENIED	_____ SNF _____ HOME _____ ICF _____ DOMICILIARY (REST HOME) X _____ OTHER _____

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **COPD**	5.
2. **Hypercholesterolemia**	6.
3. Parkinson's	7.
4.	8.

16. PATIENT INFORMATION

	DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY	x	CONTINENT	x	CONTINENT	
	INTERMITTENTLY		SEMI-AMBULATORY		INCONTINENT		INCONTINENT	
	INAPPROPRIATE BEHAVIOR		NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY	
	WANDERER		**FUNCTIONAL LIMITATIONS**		EXTERNAL CATHETER		**RESPIRATION**	
	VERBALLY ABUSIVE		SIGHT		**COMMUNICATION OF NEEDS**	x	NORMAL	
	INJURIOUS TO SELF		HEARING		VERBALLY		TRACHEOSTOMY	
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:	
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.	
	OTHER:		**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
	PERSONAL CARE ASSISTANCE	x	PASSIVE	x	NORMAL		DIET Pureed	
	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL	
x	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON	
	DRESSING		RE-SOCIALIZATION				PARENTERAL	
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC	
	PHYSICIAN VISITS		**NEUROLOGICAL**				GASTROSTOMY	
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT	
	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS	
	OVER 180 DAYS		PETIT MAL				WEIGHT 147#	
			FREQUENCY				HEIGHT 5"5""	

	17. SPECIAL CARE FACTORS	FREQUENCY		SPECIAL CARE FACTORS	FREQUENCY
	BLOOD PRESSURE	**weekly**		BOWEL AND BLADDER PROGRAM	
	DIABETIC URINE TESTING			RESTORATIVE FEEDING PROGRAM	
	PT (BY LICENSED PT)			SPEECH THERAPY	
	RANGE OF MOTION EXERCISES			RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1 Atrovent MDI 2 puffs qid	7.
2 Albuterol MOI 2 puffs qid	8.
3. **Lopid 600 mg 1 tid**	9.
4. **Sinemet 50/200 mg 1 daily**	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE

372-124 (12-92)

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FL-2 (86)

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NORTH CAROLINA MEDICAID PROGRAM
LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
G.	May		5/14/27	F	1-1-08

5. COUNTY AND MEDICAID NUMBER	6. FACILITY	ADDRESS	7. Provider NUMBER 99999
02 245-00-7000	Butterfields	Cricket, N.C.	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bowers	Marvin G. (son) 15 No Lane, Upton, NC 28806

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER / 13. DATE APPROVED/DENIED	14. DISCHARGE PLAN
____HOME _____X DOMICILIARY _____ SNF (REST HOME) _____ ICF _____ OTHER _____HOSPITAL _____	____HOME __X_X DOMICILIARY _____ SNF (REST HOME) _____ ICF _____ OTHER _____		_____ SNF _____ HOME _____ ICF _____ DOMICILIARY (REST HOME) X _____ OTHER _____

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **Essential Hypertension (HTN)**	5.
2. **Weight Loss**	6.
3. Borderline Diabetic	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY	x	CONTINENT	x	CONTINENT
	INTERMITTENTLY		SEMI-AMBULATORY		INCONTINENT		INCONTINENT
INAPPROPRIATE BEHAVIOR			NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	**FUNCTIONAL LIMITATIONS**			EXTERNAL CATHETER	**RESPIRATION**	
	VERBALLY ABUSIVE		SIGHT	**COMMUNICATION OF NEEDS**		x	NORMAL
	INJURIOUS TO SELF		HEARING		VERBALLY		TRACHEOSTOMY
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.
	OTHER:	**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
PERSONAL CARE ASSISTANCE		x	PASSIVE	x	NORMAL		DIET 2200 Calorie ADA
	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL
	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON
	DRESSING		RE-SOCIALIZATION				PARENTERAL
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		**NEUROLOGICAL**					GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL				WEIGHT 97#
			FREQUENCY				HEIGHT 5'

17. SPECIAL CARE FACTORS		FREQUENCY		SPECIAL CARE FACTORS	FREQUENCY
	BLOOD PRESSURE	**weekly**		BOWEL AND BLADDER PROGRAM	
	DIABETIC URINE TESTING	Fingerstick BS ac breakfast		RESTORATIVE FEEDING PROGRAM	
	PT (BY LICENSED PT)			SPEECH THERAPY	
	RANGE OF MOTION EXERCISES			RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1. Weigh weekly	7.
2. HCTZ 25 mg 1 po Q am	8.
3. **Glucerna Shake 1 can po tid**	9.
4. **Diabeta 5 mg 1 po bid**	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE

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LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME FIRST MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
W. Myrtle	2-17-24	F	1-1-08

5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. Provider NUMBER 99999
02 245-00-7000	Butterfields Cricket, N.C.	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bowers	Jay W.(husband) 3 No Lane, Upton, NC 28806

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
____HOME ____X DOMICILIARY (REST HOME) ____ SNF ____ OTHER ____ ICF ____HOSPITAL	____HOME __X__X DOMICILIARY (REST HOME) ____ SNF ____ OTHER ____ ICF	13. DATE APPROVED/DENIED	____ SNF ____ HOME ____ ICF ____ DOMICILIARY (REST HOME) X ____ OTHER

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **Blind**	5.
2. **Insulin Dependent Diabetes**	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY	x	CONTINENT	x	CONTINENT
	INTERMITTENTLY		SEMI-AMBULATORY		INCONTINENT		INCONTINENT
INAPPROPRIATE BEHAVIOR			NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	**FUNCTIONAL LIMITATIONS**			EXTERNAL CATHETER	**RESPIRATION**	
	VERBALLY ABUSIVE	x	SIGHT	**COMMUNICATION OF NEEDS**		x	NORMAL
	INJURIOUS TO SELF		HEARING		VERBALLY		TRACHEOSTOMY
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.
	OTHER:	**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
PERSONAL CARE ASSISTANCE		x	PASSIVE	x	NORMAL		DIET No Concentrated Sweets
	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL
	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON
	DRESSING		RE-SOCIALIZATION				PARENTERAL
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		**NEUROLOGICAL**					GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL				WEIGHT 164#
			FREQUENCY				HEIGHT 5"1"

17. SPECIAL CARE FACTORS		FREQUENCY		SPECIAL CARE FACTORS		FREQUENCY
	BLOOD PRESSURE	**weekly**		BOWEL AND BLADDER PROGRAM		
	DIABETIC URINE TESTING			RESTORATIVE FEEDING PROGRAM		
	PT (BY LICENSED PT)			SPEECH THERAPY		
	RANGE OF MOTION EXERCISES			RESTRAINTS		

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1 Novolin N 70/30 25 uq am	7.
2 Novolin R sliding scale	8.
3. **150-200= 2 units**	9.
4. **201-250=4 units**	10.
5. **251-300=6 units**	11.
6. 301-350 = 8 units, > 350 call MD	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE

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LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
L.	Simon		12/12/28	F	1-10-03

5. COUNTY AND MEDICAID NUMBER	6. FACILITY	ADDRESS	7. Provider NUMBER 99999
02 245-00-7000	Butterfields	Cricket, N.C.	

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Bowers	Madge L. (wife) 9 No Lane, Upton, NC 28806

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NUMBER	14. DISCHARGE PLAN
____HOME ____X DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER ____HOSPITAL	____HOME __X__X DOMICILIARY (REST HOME) ____ SNF ____ ICF ____ OTHER	13. DATE APPROVED/DENIED	____ SNF ____ HOME ____ ICF ____ DOMICILIARY (REST HOME) X ____ OTHER

15. ADMITTING DIAGNOSES – PRIMARY, SECONDARY, DATES OF ONSET

1. **Hyporthyroidism**	5.
2. **Weight Loss**	6.
3.	7.
4.	8.

16. PATIENT INFORMATION

DISORIENTED		AMBULATORY STATUS		BLADDER		BOWEL	
	CONSTANTLY	x	AMBULATORY	x	CONTINENT	x	CONTINENT
	INTERMITTENTLY		SEMI-AMBULATORY		INCONTINENT		INCONTINENT
INAPPROPRIATE BEHAVIOR			NON-AMBULATORY		INDWELLING CATHETER		COLOSTOMY
	WANDERER	**FUNCTIONAL LIMITATIONS**			EXTERNAL CATHETER	**RESPIRATION**	
	VERBALLY ABUSIVE		SIGHT	**COMMUNICATION OF NEEDS**		x	NORMAL
	INJURIOUS TO SELF		HEARING		VERBALLY		TRACHEOSTOMY
	INJURIOUS TO OTHERS		SPEECH		NON-VERBALLY		OTHER:
	INJURIOUS TO PROPERTY		CONTRACTURES		DOES NOT COMMUNICATE		O2 PRN CONT.
	OTHER:	**ACTIVITIES/SOCIAL**		**SKIN**		**NUTRITION STATUS**	
PERSONAL CARE ASSISTANCE		x	PASSIVE	x	NORMAL		DIET Mechanical Soft
	BATHING		ACTIVE		OTHER:		SUPPLEMENTAL
	FEEDING		GROUP PARTICIPATION		DECUBITI – DESCRIBE:		SPOON
	DRESSING		RE-SOCIALIZATION				PARENTERAL
	TOTAL CARE		FAMILY SUPPORTIVE				NASOGASTRIC
PHYSICIAN VISITS		**NEUROLOGICAL**					GASTROSTOMY
	30 DAYS		CONVULSIONS/SEIZURES				INTAKE AND OUTPUT
	60 DAYS		GRAND MAL		**DRESSINGS:**		FORCE FLUIDS
	OVER 180 DAYS		PETIT MAL				WEIGHT 143#
			FREQUENCY				HEIGHT 5"8"

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE	**weekly**	BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS / NAME & STRENGTHS, DOSAGE & ROUTE

1 Synthroid 112 mg 1 po q am	7.
2 Check Pulse, hold if BP > 85	8.
3.	9.
4.	10.
5.	11.
6.	12.

19. X-RAY AND LABORATORY FINDINGS / DATE

20. ADDITIONAL INFORMATION:

21. PHYSICIAN'S SIGNATURE	22. DATE

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POST TEST FOR FOOD SERVICE ORIENTATION

Circle the best answer for each question.

1. Sanitation of kitchen surfaces is different than "clean" in that it means it has been treated to kill what? A. harmful bacteria B. rodents C. flies D. animals

2. Kitchen equipment such as blenders and meat slicers should be sanitized: A. once a month B. once a week C. once a day D. after each use

3. Dishes can be sanitized by using: A. soap and water B. a fan to air dry C. water temperatures of 170 degrees or sanitizing chemicals such as bleach D. a drying rag.

4. Food can be stored on the floor as long as it is in dry storage area and the floor is clean. True or False

5. What is the appropriate temperature for refrigerators? A. 50 degrees or below B. 0 degrees C. 45 degrees or below D. 32 degrees or below

6. Which food may contain harmful bacteria? A. raw chicken B. fresh eggs C. raw meat D. all of these may contain harmful bacteria

7. Cross-contamination occurs *only* when *hands* are not washed after handling raw meat or poultry. True or False

8. An acceptable way to thaw hamburger would be to: A. let it sit on the counter B. in a sink full of water C. in a pan in the bottom of the refrigerator D. outside on a hot day.

9. Your hands should be washed after which of the following: A. touching raw meat, poultry or seafood B. after a trip to the restroom C. after touching garbage or other unclean surfaces. D. All of these

10. After hot foods have been prepared and are ready to be served, they should be held at what temperature to ensure bacteria do not grow rapidly? A. 0 degrees Fahrenheit
B. at least 140 degrees Fahrenheit C. 35 degrees Fahrenheit D. 500 degrees Fahrenheit

11. You should **not** work in food service if you have which of the following? A. a cold or the "flu" B. an infected wound C. both A and B D. a bad hair day

12. Therapeutic diets are made up by chefs. True or False

13. What appliance is needed to prepare pureed diets? A. oven B. sharp knife
C. a blender or food processor D. toaster

14. Which diet provides meats chopped or ground for residents who have problems chewing?
A. No Concentrated Sweets B. Renal C. No Added Salt
D. Mechanical Soft

15. Which diet limits sweets such as regular cakes, pies, candy and regular sodas and drinks?
A. Renal B. No Concentrated Sweets C. Puree D. No Added Salt

16. Which diets may require that foods be prepared separately from regular foods because of salt? A. Renal and 2-gram Sodium B. puree and mechanical soft C. Finger Foods
D. Dysphagia

17. A Low Fat/Low Cholesterol menu may call for low-fat preparation methods, such as baking instead of frying. True or False

18 Which diet is used for residents with swallowing problems? A. No concentrated Sweets B. Dysphagia C. Low Cholesterol Low Fat D. No Added Salt

19. What equipment is needed to prepare thickened liquids using a powdered thickener? A. measuring cups B. measuring spoons C. microwave D. both A and B

20. Where can you find directions for how much thickener should be added to a 4-ounce beverage to achieve nectar thickness? A. on the label of the canister or packet of thickener
B. the menus C. the recipe book D. the phone book

21. A teaspoon of thickener will work in *any amount* of beverage. True or False

22. Therapeutic diet menus are the same in all facilities. True or False

23. It's OK to pick *any* day from the menus for meal preparation? True or False

24. When making substitutions on therapeutic diets, what is an easy way to know what other foods can be substituted? A. look at a different day under the same therapeutic menu column. B. ask the residents C. just use your imagination D. pick something the same color

25. There is no need to follow recipes when preparing therapeutic diets. True or False

26. You can order residents around only if they are not doing what you want them to do. True or False

27. It is the cook's responsibility to provide alternative foods if a resident refuses the meal served and to honor each resident's food preferences. True or False

28. Loud music of your liking should only be played occasionally in the dining room. True or False

29. You can tease residents just like you would your own friends. True or False

30. You should always be helpful to residents except when you are not feeling well or too busy. True or False

I have read the Food Service Orientation Manual and completed the Post Test.

_____ _____

Signature of person who completed food service orientation Date

I verify that the person whose signature is above received the Food Service Orientation Manual and completed the Post Test.

_____ _____

Signature of Administrator or Administrator/Supervisor-in-Charge Date

The Post Test with signatures is to be maintained in the facility.

Answers to Post Test

1. A
2. D
3. C
4. False
5. C
6. D
7. False
8. C
9. D
10. B
11. C
12. False
13. C
14. D
15. B
16. A
17. True
18. B
19. D
20. A
21. False
22. False
23. False
24. A
25. False
26. False
27. True
28. False
29. False
30. False

Pretest

1. What is the best time of day to monitor a facility for food service?

2. What should you do if a resident stops you in the hall on your way in a facility to monitor and wants to talk to you?

3. If you only have 10 minutes before a meal to gather information. What is the most important?

4. What do you look for at a table setting?

5. What is the best way to determine facility compliance with food service rules? Interview, observation, or records?

6. You have just observed a meal. Phrase a question to a cook to determine if he/she is using modified menus to serve the diabetic residents.

7. How do you determine what was served for yesterday's evening meal? Who do you interview first? second? third?

8. A resident is to receive thickened liquids honey consistency. What do you look for at meal time? When do you interview the cook about it? How do you phrase the question?

9. Which of the following columns on the menu is the same as a 4 gram Sodium diet: NAS, No Table Salt, or Limited Sodium?

10. A resident has an order for a Puree diet. Should they have bread?

11. What should pureed food look like?

12. A resident has a Renal diet order. A list of foods to avoid and foods to use are on the wall. Is this all the facility needs for guidance? Explain.

13. How do you determine if the fruit served to diabetic residents at lunch was unsweetened?

14. What should you do if you see ground beef sitting in the kitchen sink?

PROTEIN

Here is a sample list of high-protein substitutes.
7 Grams of Protein Equals 1 Ounce

Eggs

Egg, Whole (X-Large)	1oz Protein
Egg, Whites Only (X-Large)	3 Whites = 1oz Protein
Egg Substitutes	1/4c. = 1oz Protein

Dairy

Cheeses, Regular (American, Swiss, Monterey, Cheddar)	1/4c. = 1oz = 1oz Protein
Cheeses, Soft (Ricotta, Mozzarella, Cottage Cheese)	1/4c. = 1oz = 1oz Protein
Cheeses, Grated (Parmesan, Romano)	2Tbsp. = 1/8c. = 1oz Prot.

Other

Beans or Peas, Dried (cooked, lentils, pinto, navy, split, etc.)	1/2c. = 1oz Protein
Nut Butters (Peanut)	2Tbsp. = 1/8c. = 1oz Prot.

Purees

The proper texture is ---

** fluffy, like whipped potatoes
** pudding like, moist food uniform in texture, which clumps together

Purees should—

- Taste good and be appealing to the eye
- Hold its shape at room temperature without weeping
- Have no lumps, no pieces, and no strings
- Be held and served at appropriate temperatures

Non-Commercial Thickening and Thinning Agents

1. Instant mashed potatoes, real whipped potatoes better
2. Cooked vegetables, such as carrots and potatoes
3. Cooked fruits, such as pears and peaches, applesauce
4. Blended or ready to eat adult oatmeal, cream of wheat, cream of rice, and grits
5. Flour, cornstarch, tapioca, and eggs if cooked after adding
6. Breadcrumbs, use ¼ cup per four ounce serving
7. Instant pudding, whipped topping, canned pudding, and marshmallow cream
8. Liquid non-dairy creamer, cheese, sour cream, dry milk powder, blended cottage cheese, cream cheese, and plain yogurt
9. Gelatin in cold foods, use no more than 1 TBSP per 4-ounce portion. Do not allow to chill.

Commercial Thickeners

1. Follow instructions on each product label to prevent clumping
2. Designed to thicken all foods and liquids

Puree Production

1. Use a food processor or blender.
2. Use all standard practices of sanitation to prevent bacteria growth.
3. If foods have skins or seeds, strain before thickening.
4. Serve all foods as listed on the Puree Menu.

Meat and Entrees

1. Addition of stock, broth, gravy, or au jus, preferred over water.
2. If milk added, heat milk before adding to solids.

Breads

1. Serve as listed on the Puree Menu. May be pureed with entrée if listed as pureed on the menu. Serving size must then be adjusted.
2. If bread is served in a slurry, 1 TBSP thickener in 4 ounces liquid or 1 TBSP gelatin may be dissolved in 2 cups liquid. Do not chill. Allow to soften 15 minutes before service.

RESIDENTS WITH POOR APPETITES

I. Environmental factors that have been proven to be effective:

A. Dining in the dining area versus the resident's room

B. The dining area:

1. The quieter the area, the better the residents will eat.
2. Alert and oriented residents in separate area.
3. The more vocal residents in separate area.
4. Staff should use calm and quiet voices and not distract residents.
5. Classical music on low volume.
6. Candles (not lit) on the table.
7. Table arrangements made and placed on tables by residents. Use holiday themes and have residents make during activity times.
8. A large clock on the wall ideally chosen by residents.
9. **Feeding assistance provided if needed. An assessment may need to occur to determine how the resident can remain independent in feeding.**

II. Dietary Factors:

A. Double portions

B. Snacks between meals

C. Snacks for game prizes for limited groups

D. Finger food snacks are often better than others.

E. Whole milk and other dairy products for residents that are not lactose intolerant or who do not have renal insufficiency.

III. Exercise:

Residents should exercise before meals or anytime during the day.

IV. Attitude of Staff

A. Give staff autonomy. Do not beg, threaten, or bribe residents to eat.

B. Let residents know you are there for them.

V. Supplements ordered by the physician.

A. Multivitamin with Iron and Zinc Sulfate

B. A supplement powder: Example--PROMOD--1 scoop is ordered one, two, or three times per day which is 5 grams protein. Can be stirred in soup, shakes, juices. This supplement is especially good for residents who are at high risk for skin breakdown. Not Recommended for residents on a protein controlled diet.

C. Other complete supplements. REMEMBER: Sugar free supplements are available for diabetics.

D. Administration must be documented. Facility is responsible for purchasing.

FOODSERVICE

RESOURCE®

ThickenUp®

DIRECTIONS: While stirring briskly, SLOWLY add RESOURCE ThickenUp to hot or cold liquid. Stir until completely dissolved. Product will set up within 15 seconds. NOTE: Product can be prepared using a blender at low speed for 5 to 10 seconds. **Do not overmix.**

DESIRED CONSISTENCY
(Prepared Serving Size = 4 fl. oz.)

Nectar	1 Tbsp.
Honey	1 1/2 Tbsp.
Pudding	2 Tbsp.

THIS CANISTER IS SOLD BY WEIGHT, NOT VOLUME. SOME SETTLING MAY OCCUR DURING SHIPPING AND HANDLING.

VITAMIN A CONTENT

	IU
ASPARAGUS, BOILED, 1/2 CUP	746
BEETS, CANNED, 1/2 CUP SLICES	0
BROCCOLI BOILED 1/2 CUP	1,099*
BRUSSEL SPROUTS, BOILED, 1/2 CUP	561
CABBAGE, BOILED 1/2 CUP	64
CARROTS, CANNED 1/2 CUP	10,050*
COLLARDS, BOILED 1/2 CUP	5,084*
CUCUMBER, RAW, 1/2 CUP SLICES	23
GREEN BEANS, CANNED 1/2 CUP	237
GREEN PEAS, CANNED 1/2 CUP	653
GREEN PEAS AND CARROTS, 1/2 CUP	5,352*
KALE, BOILED, 1/2 CUP	4,810*
LIMA BEANS, COOKED 1/2 CUP	0
MUSTARD GREENS, BOILED, 1/2 CUP CHOPPED	2,122*
OKRA, BOILED, 1/2 CUP SLICES	460
PUMPKIN, CANNED, 1/2 CUP	26,908*
PUMPKIN PIE MIX, 1/2 CUP	11,203*
POTATO, IRISH, BAKED, 1 MED	0
SPINACH, BOILED, 1/2 CUP	7,380*
SQUASH, YELLOW CROOKNECK, BOILED, 1/2 CUP	259
SQUASH, BUTTERNUT, MASHED, 1/2 CUP	7,141*
SWEET POTATO, MASHED 1/2 CUP	27,968*
TOMATO, RED, 1	1,394
TOMATOES, CANNED, RED, BOILED, 1/2 CUP	1,623*
TURNIP GREENS, BOILED, 1/2 CUP	3,959*

* APPROPRIATE CHOICES FOR MEETING MENU REQUIREMENT: "THREE SERVINGS OF DARK GREEN LEAFY OR DEEP YELLOW VEGETABLES PER WEEK"

Weekly Menu Planning Worksheet: Regular Diet

DHSR ACLS 3/10

Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐	Milk 8oz. ☐☐ Fruit ½ cup ☐☐ Protein 2-3oz. ☐☐ Vegetable ½ cup ☐☐☐ Bread/Starch ☐☐☐☐☐☐
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Breakfast	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**
Snack	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**
Lunch	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
Snack	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**
Dinner	**Dinner**	**Dinner**	**Dinner**	**Dinner**	**Dinner**	**Dinner**
Snack	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**	**Snack**

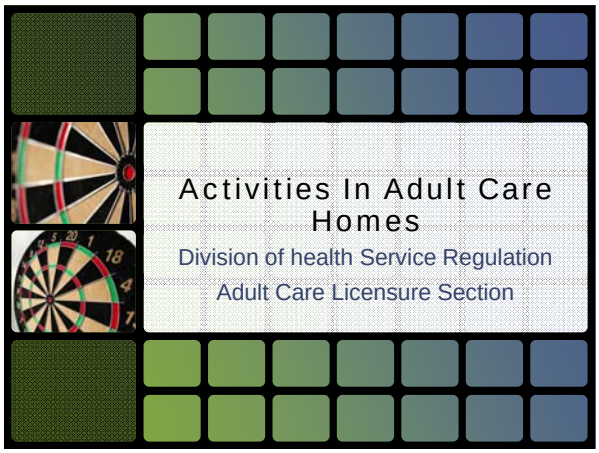
***Serve 1 egg at least 3 times/week at breakfast ☐☐☐ ***Serve deep leafy green or yellow vegetables 3 times/week ☐☐☐

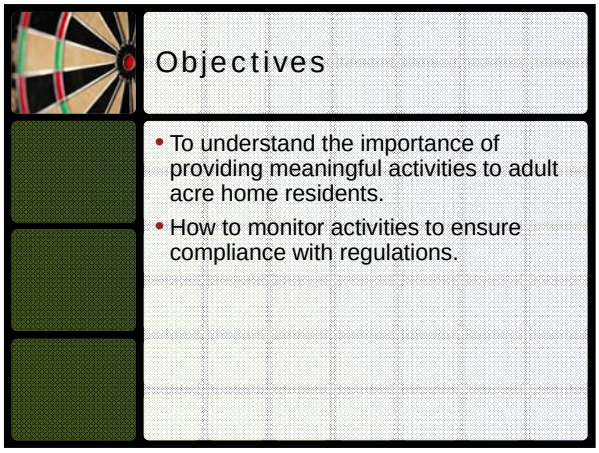
☐Yes ☐No Fruits, vegetables, protein, and milk requirements are met through meals only?

☐Yes ☐No Protein substitute used no more than 3 times per week?

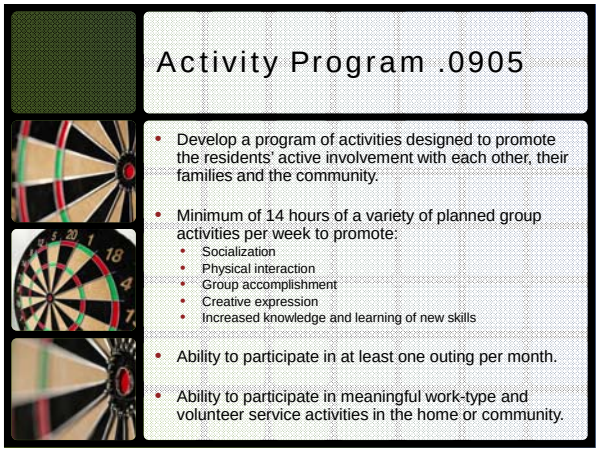
☐Yes ☐No At least 8oz. of water is served with each meal, plus beverage of choice?

Chapter 9: Activities


Activities In Adult Care Homes
Division of health Service Regulation
Adult Care Licensure Section

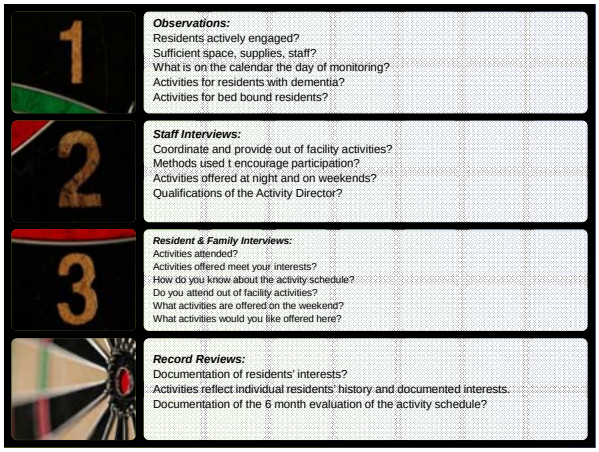

Objectives
• To understand the importance of providing meaningful activities to adult acre home residents.
• How to monitor activities to ensure compliance with regulations.

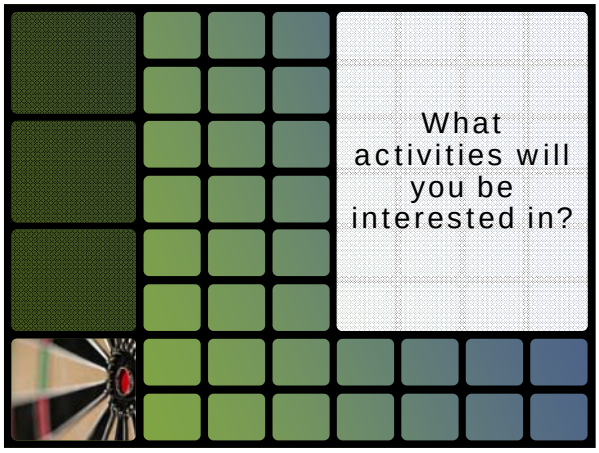

Rule Areas
Activity Program
Activity Programming
Activity Director Qualifications
10A NCAC 13F/G .0905
10A NCAC 13F/G .0404


Activity Program .0905
Develop a program of activities designed to promote the residents' active involvement with each other, their families and the community.
Minimum of 14 hours of a variety of planned group activities per week to promote:
Socialization
Physical interaction
Group accomplishment
Creative expression
Increased knowledge and learning of new skills
Ability to participate in at least one outing per month.
Ability to participate in meaningful work-type and volunteer service activities in the home or community.


Activity Director .0404
Qualifications
At least a high school graduate, GED or alternative exam.
Complete an activity course within 9 months of employment.
Responsibilities
Record information on resident's interests and capabilities.
Develop individual and group activities.
Prepare monthly calendars.
Evaluate the program every 6 months.
Involve community resources.
Assure adequate supplies and supervision.
Encourage resident participation.


Observations, Interviews, Record Reviews
MONITORING ACTIVITIES


1
2
3
Observations:
Residents actively engaged?
Sufficient space, supplies, staff?
What is on the calendar the day of monitoring?
Activities for residents with dementia?
Activities for bed bound residents?
Staff Interviews:
Coordinate and provide out of facility activities?
Methods used t encourage participation?
Activities offered at night and on weekends?
Qualifications of the Activity Director?
Resident & Family Interviews:
Activities attended?
Activities offered meet your interests?
How do you know about the activity schedule?
Do you attend out of facility activities?
What activities are offered on the weekend?
What activities would you like offered here?
Record Reviews:
Documentation of residents' interests?
Activities reflect individual residents' history and documented interests.
Documentation of the 6 month evaluation of the activity schedule?


What activities will you be interested in?

ACTIVITIES OBSERVATION SURVEY FORM

DATE_____ **FACILITY** _____

SURVEYOR _____ **TIMES:**_____

Activities: *(observe for the following)*

	Does observation trigger follow up?	Concerns/Issues/Positive Comments
Is there an Activity Schedule posted?	Y N	
Is there at least 14 hours of scheduled activities a week?	Y N	
Are activities observed to be carried out as scheduled?	Y N	
Do staff encourage residents to participate in the activities?	Y N	
Activity supplies available for current activity?	Y N	

_____

_____

_____

_____

_____

_____

_____

_____

_____

Licensure of a FCH

Licensure of a Family Care Home

Division of Health Service Regulation - Adult Care Licensure Section

Initial Contact for Licensing a FCH

10A NCAC 13G

G.S. 131D

- Initial contact for licensing a family care home (FCH) should be made with the adult services section of the local county department of social services.
- An adult home specialist with that agency will provide licensing information to the applicant and collect the necessary licensure materials from the applicant to be sent to the N.C. Division of Health Service Regulation to complete the licensure process.

4 Steps…

1. Apply for a License: County Department of Social Services
2. Obtain Construction Approval: Construction Section
3. Compilation of Records: County Department of Social Services
4. Obtain a License: Adult Care Licensure Section

1. Apply for a License: County DSS

I. Applicant contacts Adult Home Specialist (AHS).

II. AHS Specialist responds to all questions regarding license applications.
   I. General review of licensure rules/process
   II. Referral to local zoning board for approval
   III. Referral to ACLS to request application packet and rule book

III. Applicant completes and submits Initial License Application to ACH Specialist.

Continued… County DSS

IV. Applicant submits the Administrator information to ACH Specialist.*
   I. Report of Administrator Qualifications
   II. Documentation of 30-day On-the-Job Training or Administrator In-Training Exemption
   III. Local Criminal Background Check
   IV. 3 Reference Letters
   V. TB Screening
   VI. Documentation of Passing State Administered Rules Exam
   VII. Documentation of Completion of High School or GED Program

Continued… County DSS

V. ACLS Receives Application Material from the AHS
   V. ACLS sends letter to applicant requesting certain records and policies and procedures for review.

2. Obtain Construction Approval: Construction Section

I. AHS Completes Initial Assessment of Proposed Structure.
   I. AHS verifies approval of local zoning office*
II. AHS May Consult with Construction Section
III. Existing Structures
   I. AHS submits cover letter or transmittal form to ACLS.*
IV. New Construction
   I. Applicant submits cover letter or transmittal form to ACLS.*
V. Construction Section Review
VI. Construction Approval
   I. Applicant Contacts AHS

3. Compilation of Records: County DSS

The Adult Home Specialist Reviews Operational Plans & Policies:

I. Personnel Requirements for Administrator
II. Policy & Procedures
III. Staff Personnel Records
IV. Civil Rights Compliance

V. AHS submits to ACLS:
   I. Initial License Application
   II. Documentation of Administrator Approval
   III. Applicant Submits Licensure Fee

4. Obtain a License: ACLS

I. Reviews Application Material
II. AHS Makes On-site Visit
III. ACLS Completes Review – On-site Visit
IV. Submits License to Applicant and DSS
V. Initial License for 6 Months
VI. Licenses Renewed Annually

Licensure Contacts:

- Administrator Qualification Inquires
  - FCH: Doug Barrick 919-855-3778
    doug.barrick@dhhs.nc.gov
  - ACH: Scott Ashley 919-855-3781
    scott.ashley@dhhs.nc.gov
- Construction Section
  - 919-855-3893
- Policy & Procedure Review
  - Tameka Riggsbee 919-855-3792
    tameka.riggsbee@dhhs.nc.gov
  - Nicky Lee 919-855-4662
    Veronica.lee@dhhs.nc.gov

Sample FCH Licensure Letter

Human Services

TEL FAX

Human Services

October 14th, 2016

Mr. or Ms. _____
Adult Care Licensure Section
Division of Health Service Regulation
2708 Mail Service Center
Raleigh NC 27699

Dear _____:

I am writing the Adult Care Licensure Section to confirm the intent of Mr. or Ms. _____ to license another family care home in _____ County. The facility will be named _____, which is located at _____.

Mr. or Ms. _____ hopes to be licensed for 6 ambulatory residents; the contact number for the facility at this time is _____ until further notice.

_____, _____ County Adult Home Specialist, will be working with her in this endeavor. _____ can be contacted at _____.

Sincerely,

_____
Adult Services _____
Adult and Community Services
_____ County Human Services
Phone: _____
FAX: _____

Resident Rights & Long Term Care Ombudsman Program

Resident Rights Prezi Link

http://prezi.com/wio4ttcxo_pu/?utm_campaign=share&utm_medium=copy&rc=ex0share

NORTH CAROLINA
ADULT CARE HOME BILL OF RIGHTS

(condensed version)

EVERY RESIDENT SHALL HAVE THE FOLLOWING RIGHTS:

1. To be treated with respect, consideration, dignity and full recognition of his or her individuality and right to privacy.
2. To receive care and services which are adequate, appropriate and in compliance with relevant federal and State laws and rules and regulations.
3. To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.
4. To be free of mental and physical abuse, neglect and exploitation.
5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
6. To have his or her personal and medical record kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom disclosure may be made except as required by applicable state or federal statute or regulation or by third party contact.
7. To receive a reasonable response to his or her requests from the facility administrator and staff.
8. To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own initiative at any reasonable hour.
9. To have access at any reasonable hour to a telephone where he or she may speak privately.
10. To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationery and postage.
11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion and retaliation.
12. To have and use his or her own possessions where reasonable and have an accessible lockable space provided for security of personal valuables. This space shall be accessible only to the residents and the administrator or supervisor in charge.
13. To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.
14. To be notified when the facility is issued a provisional license by the North Carolina Department of Health and Human Services and the basis on which the provisional license was issued. The resident's responsible family member or guardian shall also be notified.
15. To have freedom to participate by choice in accessible community activities and in social, political, medical and religious resources and to have freedom to refuse such participation.
16. To receive upon admission to the facility a copy of this section.
17. To not be transferred or discharged from a facility except for medical reasons, their own or other residents' welfare, or nonpayment. Except in cases of immediate jeopardy to health or safety, residents shall be given at least 30 days advance notice of the transfer or discharge and their right to appeal.

The Ombudsman is an advocate for those who live in long term care facilities.
For more information on residents' rights, call the
Regional Long Term Care Ombudsman.

Telephone: **(336) 294-4950 or (336) 761-2111**

North Carolina Department of Health and Human Services • Division of Aging

County Oversight/ ACLS Support

County Oversight/ACLS Support Prezi Link

http://prezi.com/ihxn_94ey2rw/?utm_campaign=share&utm_medium=copy&rc=ex0share

YEAR:

******** County Annual Tracking Form

Facility License Number	Facility Name	Personal Care & Supervision (date monitored)	Nurtition & Meals (date monitored)	Health Care & Medications (date monitored)
		Rule: .0901	Rule: .0904	Rules: .0902 & .1004

Staffing (date monitored)
Rules: Sections .0400 & .0500

********* County Report For Fiscal Year 20****

Substantiated Violations of Resident Rights

County:		
Nature of Residents Right Violation	**Number of Substantiated Violations**	**Number Referred to DHHS**
G. S. 131 D-21 #1		
G. S. 131 D-21 #2		
G. S. 131 D-21 #3		
G. S. 131 D-21 #4		
G. S. 131 D-21 #5		
G. S. 131 D-21 #6		
G. S. 131 D-21 #7		
G. S. 131 D-21 #8		
G. S. 131 D-21 #9		
G. S. 131 D-21 #10		
G. S. 131 D-21 #11		
G. S. 131 D-21 #12		
G. S. 131 D-21 #13		
G. S. 131 D-21 #14		
G. S. 131 D-21 #15		
G. S. 131 D-21 #16		
G. S. 131 D-21 #17		
Total	0	0