NORTH DAKOTA
DEPARTMENT *of* HEALTH

HEALTH RESOURCES SECTION
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200
Fax: 701.328.1890
www.ndhealth.gov

TO: Long Term Care Facility Administrators and Director's of Nursing

FROM: BP. Bruce Pritschet, Director, Division of Health Facilities

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TOPIC: Follow-up Responses to Questions asked at Fall NDLTCA Regional Meeting during the North Dakota Department of Health, Health Resources Section Presentation

During the Fall 2013 NDLTCA Regional Meeting Presentations (September 18 – November 1, 2013) provided by Darleen Bartz, Bruce Pritschet, and/or Lucille Rostad, Health Resources Section, North Dakota Department of Health, several questions/issues surfaced which were brought back to the office with the indication that a follow-up memorandum clarifying the issues would be provided. The questions/issues are identified below, as well as the department's response to the questions.

Question 1: When the ePOC (electronic Plan of Correction) is implemented in North Dakota, when does the 10 calendar days the facility has to respond to with a plan of correction begin?

Response to Question 1: The facility has 10 calendar days after the survey has been released to them electronically (emailed) from the department to submit a Plan of Correction.

Question2: When a Skilled Nursing Facility increases or decreases bed capacity, how often can this occur during a year to be consistent with both state and federal requirements?

Response to Question 2: The most stringent requirement is to be followed which, in this instance is state law. NDCC 23-16-01. Moratorium on expansion of long-term care bed capacity. 1. "… A nursing facility may not … reconfigure licensed nursing facility bed capacity more than one time in a twelve month period."

Question 3: Can Curling irons with batteries be used for providing hair care for residents who are on oxygen?

Response to Question 3: Residents using oxygen while in the beauty shop is a concern. The site of the oxygen expulsion (nasal cannula) must be at least one foot away from the heating elements.

Curling irons, portable hair dryers, and bonnet-style hair dryers with the heating elements in the bonnet (or handle), including battery operated, cannot be used on residents using oxygen. A bonnet-style hair dryer with the heating element in the base is acceptable if the heating element is more than a foot from the oxygen expulsion site.

Question 4: Can candles be lit for religious ceremonies and birthdays in Basic Care and Skilled Nursing facilities?

Response to Question 4: NFPA data shows candles to be the number one cause of fires in dwellings.

However, the answer to this question is: Yes, with constant staff supervision, lit candles can be used consistent with the following guidance:

- Candles cannot be used in resident rooms.
- Candles may be used in other locations where they are placed in a substantial candle holder, **AND**
- Supervised (by staff or the religious leader) at all times while they are lit.
- Lit candles are not to be handled by residents due to the risk of fire and burns.
- Residents on oxygen should be separated from the burning candle by a minimum of 20 feet. Oxygen use should be restricted if the resident needs to be closer than 20 feet to a burning candle.

Resources: S & C 07-07, NFPA 99, Sections 8-3.1.11.2 (i), 8-6.2.1.1, 8-6.2.1.2, and 8-6.2.6; and discussion with CMS RO.

Question 5: Can Medication Assistant IIIs be used in Skilled Nursing Facilities?

Response to Question 5: Yes, as long as the individual holds active status on the Department's registry as a Certified Nurse Aide, and an active status on the North Dakota Board of Nursing Registry as a Medication Assistant III, and the Skilled Nursing Facility has verified the competency of the individual prior to allowing him or her to work in this capacity.
The requirements for supervision of a Medication Assistant III in the Skilled Nursing facility have been set forth by the North Dakota Board of Nursing as follows:

NDAC 54-07-05-04. Requirements for supervision. A licensed nurse who delegates medication administration to a medication assistant III must provide supervision as follows:

1. In a licensed nursing facility, the licensed nurse must be on the unit and available for immediate direction.

Question 6: What level of nursing supervision is needed for an individual who is in a certified nurse aide training program when providing cares to a resident in a facility prior to obtaining registry status?

Response to Question 6: The requirements found in NDAC Article 33-43 Nurse Aide Training, Competency Evaluation, and Registry provides a response to this question.

Individuals employed by nursing facilities pursuing registration as a certified nurse aide must complete a minimum of sixteen hours of classroom training in the following areas from a department-approved nurse aide training program prior to any hands-on contact with residents or patients. The areas are: (1) Communication and interpersonal skills; (2) Infection control; (3) Safety and emergency procedures, including the Heimlich maneuver; (4) Promoting residents' independence; and (5) Respecting residents' rights.

The regulations further state that an individual who is in a certified nurse aide training program "may not perform tasks for which competence has not been determined unless under the direct supervision of a licensed nurse."

After the first sixteen hours of training described above, the remainder of the seventy-five-hour-approved training and competency evaluation program must be completed within four months of the date of first employment in the facility as a nurse aide and must include at least sixteen hours of supervised practical training. Supervised practical skills training means manual skills training in a laboratory or other setting in which the nurse aide demonstrates knowledge while performing tasks on an individual while under the direct supervision of a licensed nurse under the general supervision of a qualified instructor. Other areas that are required to be addressed in the certified nurse aide training program include: (1) Basic nursing skills; (2) Personal care skills; (3) Mental health and social service needs; (4) Care of residents or clients with cognitive impairments; (5) Basic restorative services; and (6) Resident or patient rights.

Individuals in a nurse aide training program may not perform tasks for which competence has not been determined unless under the **direct supervision** of a licensed nurse. Direct supervision means that the responsible licensed nurse or licensed practitioner is physically present in the patient or client area and is available to assess, evaluate, and respond immediately. Once the individual has been determined competent to perform a task under the direct supervision of a licensed nurse, the individual can perform the task under the **general provision of supervision** by a licensed nurse.

An additional Basic Care Facility question which was asked following the Basic Care Networking Session at the December 2013 NDLTCA Fall Professional Development Meeting is responded to as follows:

Question 7: Can Hospice Services be provided in Basic Care Facilities?

Response to Question 7: To respond to this question, it is important to consider the definition of a basic care resident and also what hospice services entail.
As presented at the regional meetings, based on NDCC 23-09.3-08.1 and NDAC 33-03-24.1-01, 2, 5, 6, and 16 – the admission (and retention) criteria for a basic care resident is as follows:
The resident:

- May need assistance with activities of daily living which means that the resident is able to help with most of the activity, but cannot do it entirely alone. This includes eating, nutrition, dressing, personal hygiene, mobility, toileting, and behavior management.
- May need supervision of nutrition and medication management.
- Is capable of self preservation, with or without assistance, and
- Does not have a condition that requires continuous, twenty-four hour a day nursing or medical care.

When a resident no longer meets the criteria identified above, placement in another setting is indicated.

NDCC 23-17.4 defines a hospice patient as a "person diagnosed as terminally ill with a prognosis of an anticipated life expectancy of six months or less…" and further defines hospice services as "palliative and supportive medical, health, or other care provided to hospice patients and their families to meet the special needs arising out of the physical, emotional, spiritual, and social stresses experienced during the final stages of illness and during the dying and bereavement so that when and where possible the hospice patient may remain at home, with homelike inpatient (hospital or skilled nursing facility) care utilized only if and while it is necessary."

So, in response to the question identified above, if a basic care resident has been determined to be a hospice patient or terminally ill with a prognosis of 6 or fewer months to live, it can be expected that there will come a time when the resident is no longer able to "to help with most of the activity" but needs help from someone else for most or all of the activity, including eating, nutrition, dressing, personal hygiene, mobility, toileting, or behavior management. At that time, the resident no longer meets the definition of a basic care resident due to their declining condition. When the resident no longer meets the definition of a basic care resident due to declining status, the expectation is that the resident be transferred to a facility that provides a higher level of care such as a skilled nursing facility so that the needs of the resident can be met. It is expected that someone who is on hospice care or determined to be terminally ill with a prognosis of six months or less to live will decline to the point where basic care is no longer an appropriate or approved care-giving option.

There have been instances when a facility has contacted the department to request a waiver to the basic care requirements in order to allow someone who is receiving hospice or end of live care to stay in their facility beyond the time when they meet the definition of a basic care resident. This is reviewed on a case by case basis, based on the needs of the individual, staffing of the facility, ability of the facility to meet Life Safety Code standards with an individual who requires more care, and so forth. There have been specific instances when this has been allowed, but that determination is made on a case by case basis and is used rarely.

Also, a Basic Care Facility or Assisted Living Facility should not hold itself out to the public as able to provide end of life care or a hospice program without being licensed to provide that level of care. NDCC 23-17.4-02. Hospice program license required – states – "No person may establish, conduct, or maintain a hospice program, or advertise or present itself to the public as a hospice program, without first obtaining a hospice license from the department."

We hope this information is helpful and responds to your questions.