Long Term Care
NEWSLETTER
Indiana State Department of Health

ISDH Long Term Care
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Roundtable Questions and Answers

The Indiana State Department of Health (ISDH) has monthly meetings with representatives of the three long term care provider associations - Hoosier Owners and Providers for the Elderly (HOPE), Indiana Association for Homes and Services for the Aged (IAHSA), and Indiana Health Care Association (IHCA). One meeting each quarter is set aside as a "Roundtable" for reviewing provider questions about specific regulatory requirements. These Roundtable Meetings generally occur in February, May, August, and November. At these meetings, each question is reviewed and discussed by participants to clarify any issues. Following the meeting, answers to the questions are reduced to writing and published in the Division of Long Term Care Newsletters. Previous roundtable questions may be found in newsletters posted on the ISDH Web site.

The ISDH will continue to publish roundtable questions and answers in our newsletters. So that the questions do not get mixed in with other newsletter items and to assist you tracking these questions, a separate newsletter edition will be devoted to roundtable questions. A Roundtable Meeting was held on February 15, 2008. The questions and answers from that meeting are below.

Roundtable Questions and Answers
February 15, 2008 Provider/ISDH Roundtable Meeting

Question 1 [February 2008]: A complaint was called in by a staff member who had just been terminated because she had not provided care to an assigned resident throughout the duration of the night shift. Following the shift, the resident was observed to have a newly developed dusky red, mushy heel. The director of nursing began an investigation to ensure care was provided (per the plan of care) during the night. The aide then admitted that she had not provided the necessary care. As a defense, the aide stated that there was not enough staff to complete necessary care but this was not found to be the case by the facility. The aide was therefore terminated and the nurse in charge was also counseled for not ensuring the aides were completing their duties as assigned.

Initially, the surveyors stated that there would be a deficiency because of the facility not reporting the incident as neglect, which begs the question as to whether facilities should be directed to notify the state every time an

employee is disciplined and/or terminated for failure to perform his/her assigned duties (or performs them incorrectly)? For example, if administrative staff find someone who has been incontinent and likely not toileted in a timely manner, should this be reported as neglect? Should the involved aides be reported to the registry as well? Please consider clarification as to anticipated facility reporting should employees warrant discipline and/or termination on the basis of care provided (or lack thereof).

> **Answer to Question 1 [February 2008]:** Facilities are required to report allegations of abuse, neglect, or misappropriation of resident property. If the facility disciplines an employee, up to and including terminates, for failing to "provide goods and services necessary to avoid physical harm, mental anguish or mental illness" to a resident, then it should be reported to the ISDH.

Question 2 [February 2008]: Coding of Pressure Ulcers. The facility was informed by the survey team that it had staged the resulting mushy heel of the above incident incorrectly. The NPUAP staging system is not congruent with the MDS 2.0 (or the 3.0 version that is due to be released soon for use) coding of pressure ulcers. According to the MDS manual, there is no way to code an unstageable wound or a suspected deep tissue injury wound other than to code as a stage IV. This is how it was coded by the facility and how it has always been done and reviewed by EDS. There has always been an unstageable classification per NPUAP, but for MDS coding, an unstageable wound is coded as a stage IV. The facility coded the wound as a stage IV, as there was obviously underlying tissue damage and believed this to be the appropriate MDS coding.

This dilemma of disparity in coding was addressed by the guest speaker at the recent Leadership Conference. She stated during her presentation that she understood we had to work within the framework of the MDS, even though she felt it unfortunate and hoped the MDS would change. When the survey supervisor was questioned in regard to the aforementioned, she replied that she did not care about the MDS or EDS, that we were to follow the "Wound Care Essentials" book we were provided at the Leadership Conference.

Please provide clarification as to the standard of coding by which the facility will be held.

> **Answer 2 [February 2008]:** RAI Version 2.0 Manual, Section M.-- Skin Condition indicates that the NPUAP standards and definitions cannot be used for coding on the MDS. However, the facility may use NPUAP standards or the AMDA guidance when doing current and accurate clinical assessment and treatment of pressure ulcers. [February 2008]

Background Relating to Questions 3A-3D [February 2008]: Per review of the Interpretive Guidance of F226, under "VII Reporting/ Response" it states:

> *Have procedures to:*
>
> *-Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation.*

As background to discussion, please also review the following two questions/answers previously provided per ISDH roundtable documents:

3-31-2000

Question 15: If a non-interviewable resident (due to diagnosis) makes an unsubstantiated allegation, is this reportable? For example – a resident with a diagnosis of dementia who alleges that the nursing assistant used abusive language or gestures.

Answer 15: An investigation is still required to determine if the incident(s) actually occurred. F 225 requires that all alleged violations be reported, investigated, and results reported to the state survey agency. Facilities are encouraged to provide as many facts as possible regarding the situation, such as the resident's cognitive status, past history, and the facility's investigation.

5/2006

Question 2: The reportable unusual occurrence guidance requires the reporting of "allegations" of abuse yet the definition for physical abuse states that resident-to-resident abuse would only be reported if there is injury. Thus, if there is an allegation made by a resident in regard to another resident, but there is no evidence of injury, should the "allegation" still yet be reported as there is no verification of injury?

Answer 2: Yes, the new policy effective 4-1-06 indicates the resident to resident physical abuse with or without injury is to be reported.

This is reportable if circumstances indicate one resident intended harm to a particular resident regardless of the resident's cognitive status.

Slide #26 of the CMS Training for "Accidents & Supervision" Guidance Training for F323 states the following:

Supervision
Resident-to-Resident Altercations

- An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance for 42 C.F.R. § 483.13(b) at F223.
- "Willful" means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under this tag, F323.

In that providers are reporting being cited for failure to report an incident, provider questions relative to reporting are as follows:

Question 3A [February 2008]: Does this verbiage (addressed by CMS) mean that regardless of cognitive status we report?

Answer 3A [February 2008]: Cognitive impairment does not automatically preclude the possibility that the resident could intend to harm the other resident. The facility must look at the facts in the situation and determine if the act was a random, perhaps an unknowing or uncontrollable, or if the resident intended to cause harm.

Question 3B [February 2008]: What does "should have known" mean?

> **Answer 3B [February 2008]:** "Should have known" means that the act committed was one that would normally be intended to cause someone harm like kicking, pummeling with fists, throwing a heavy object, using a cane, etc. versus the accidental flailing of arms, a pat on the head or arm, etc.

Question 3C [February 2008]: What do the last two sentences mean? (i.e, "However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under this tag.")

> **Answer 3C [February 2008]:** If, after thorough investigation, the facts about the situation do not demonstrate willful intent to harm another, i.e. absence of anger; multiple and random "targets" or "victims;" reaction to stimulus, etc. In those circumstances, the surveyors need to look at whether or not the facility failed to adequately supervise the residents thus allowing the situation to occur.

Question 3D [February 2008]: Recently, a facility had a severely cognitively impaired resident Most recent MMSE was 6/30 last summer. She has declined and can no longer answer questions - just smile and nod inappropriately. She kicked at another resident as he walked by. She did not hurt him and staff immediately intervened. The facility did not report because it believed that the resident could not process "willful intent" given her mental status. Is the facility in error for not reporting?

> **Answer 3D [February 2008]:** The facility may be correct. However, if the resident was angry, targeted a particular resident, or otherwise demonstrated an intent to cause the other resident harm, then it could be reportable.

Question 4 [February 2008]: IAHSA supports the use of Silverchair Learning for facilities interested in computer based training. The training effectiveness is measured and the training modules are ANCC and NAB certified. Here is the concern: Some nurses and others may be able to complete the modules in fewer minutes than the training is rated. Are facilities able to credit that training by the minutes certified by the company? Example: Everyone who completed the first one-hour dementia training would be credited for one hour even if it only took 51 minutes but they successfully completed the entire module and post-test. Does the ISDH agree that the training rated at one hour would be credited as one hour?

> **Answer 4 [February 2008]:** Yes, we would agree. Likewise, if it took the employee 90 minutes to complete the training, that employee would only be credited for one hour.

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