VHCAVCAL

http://www.vhca.org/covid-19-resources

Assisted Living Update and Clinical and Operational Opportunities

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Participants will explore clinical and operational practices to:

- Enhance Resident Outcomes
- Reduce Resident Risks
- Improve Survey Outcomes

VHCA-VCAL

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Top 5 Clinical and Operational Opportunities

1. Medication Administration / Management
2. Individual Service Plans
3. Resident Safety
4. Resident Record Management
5. Incident Reporting Requirements

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22VAC40-73-680
Administration Of Medications And Related Provisions

22VAC40-73-640
Medication Management Plan And Reference Materials

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22VAC40-73-680-D

Medications shall be administered in accordance with the physician's or other prescriber's instructions and consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.

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22VAC40-73-680-I - The MAR shall include:

1. Name of the resident
2. Date prescribed
3. Drug product name
4. Strength of the drug
5. Dosage
6. Diagnosis, condition, or specific indications for administering the drug or supplement
7. Route of administration
8. How often the medication is to be given
9. Date and time given and initials of direct care staff administering the medication
10. Dates the medication is discontinued or changed
11. Any medication errors or omissions
12. Description of significant adverse effects suffered by the resident
13. For "as needed" (PRN) medications:
    a)Symptoms for which medication was given
    b)Exact dosage given
    c)Effectiveness
14. The name, signature, and initials of all staff administering medications. A master list may be used in lieu of this documentation on individual MARs

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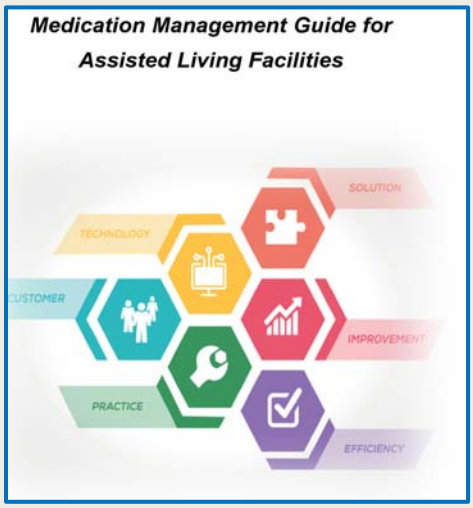
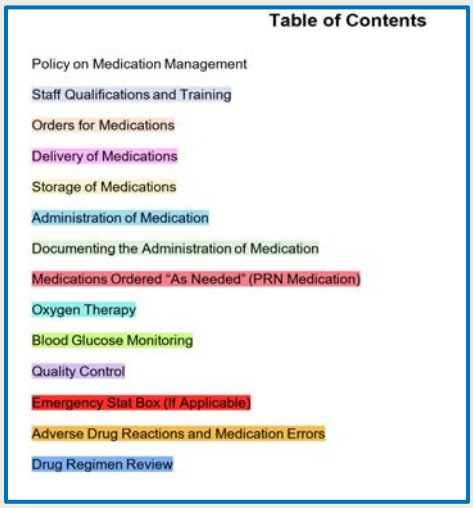
22VAC40-73-640 - Medication Management Plan And Reference Materials





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Medication Administration Opportunities

- Management of prescriptions
- Complete and accurate orders
- Order entry into MAR [hard copy v. EMR]
- Managing parameters for administration [i.e.vital signs, labs, etc.]
- Self-administration of medications
- Documentation

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22VAC40-73-450. Individualized Service Plans

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22VAC40-73-450 - Individualized Service Plans.

C. The comprehensive individualized service plan shall be completed within 30 days after admission and shall include the following:

1. Description of identified needs and date identified based upon the (i) UAI; (ii) admission physical examination; (iii) interview with resident; (iv) fall risk rating, if appropriate; (v) assessment of psychological, behavioral, and emotional functioning, if appropriate; and (vi) other sources;

2. A written description of what services will be provided to address identified needs, and if applicable, other services, and who will provide them;

3. When and where the services will be provided;

4. The expected outcome and time frame for expected outcome;

5. Date outcome achieved; and

6. For a facility licensed for residential living care only, if a resident lives in a building housing 19 or fewer residents, a statement that specifies whether the resident does or does not need to have a staff member awake and on duty at night

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22VAC40-73-450. Individualized Service Plans

E. The individualized service plan shall be signed and dated by the licensee, administrator, or his designee, (i.e., the person who has developed the plan), and by the resident or his legal representative. The plan shall also indicate any other individuals who contributed to the development of the plan, with a notation of the date of contribution. The title or relationship to the resident of each person who was involved in the development of the plan shall be included. These requirements shall also apply to reviews and updates of the plan.

F. Individualized service plans shall be reviewed and updated at least once every 12 months and as needed as the condition of the resident changes. The review and update shall be performed by a staff person with the qualifications specified in subsection B of this section and in conjunction with the resident and, as appropriate, with the resident's family, legal representative, direct care staff, case manager, health care providers, qualified mental health professionals, or other persons.

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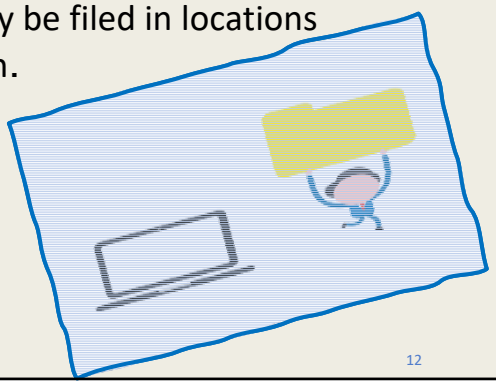
22VAC40-73-450. Individualized Service Plans

G. The master service plan shall be filed in the resident's record. A current copy shall be provided to the resident and shall also be maintained in a location accessible at all times to direct care staff, but that protects the confidentiality of the contents of the service plan. Extracts from the plan may be filed in locations specifically identified for their retention.



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22VAC40-73-450C. The comprehensive individualized service plan shall be completed within 30 days after admission and shall include the following:

1. Description of identified needs and date identified based upon the (i) UAI; (ii) admission physical examination; (iii) interview with resident; (iv) fall risk rating, if appropriate; (v) assessment of psychological, behavioral, and emotional functioning, if appropriate; and (vi) other sources;

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5. Date outcome achieved; and

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ISP Opportunities

- Updating the plan for changes in resident needs / risks
- Team Training
- Coordination with UAI
- Communication with team
- Team / Resident / Representative signatures

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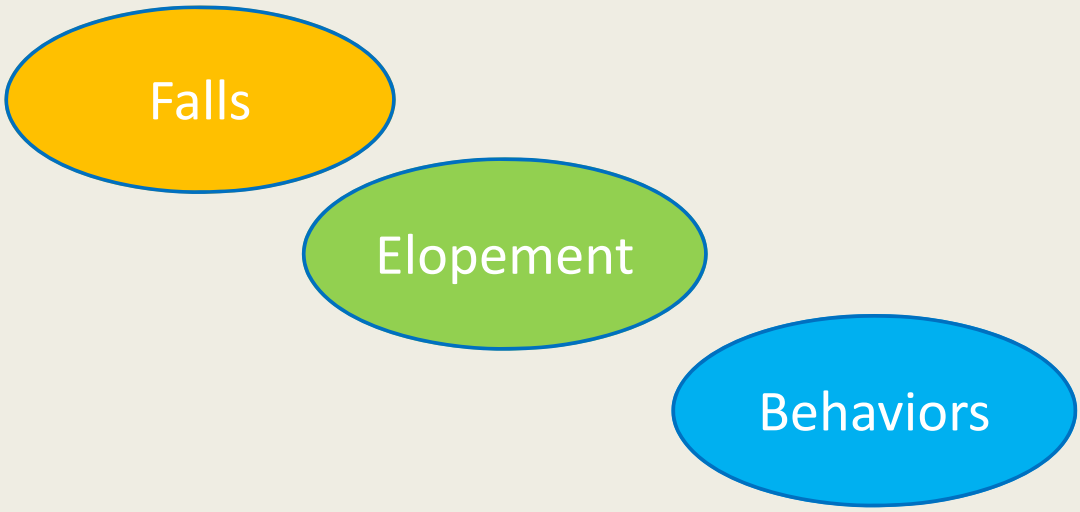
Resident Safety



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Resident Safety - Opportunities

- Risk Assessments – Falls / Wandering
- Elopement
- Responsive and resident centered interventions
- Collaboration within team and with resident / representative
- Collaboration with care partners [i.e. providers, therapy, mental health, etc.]
- Validation that interventions are being implemented

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Resident Record Management

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22VAC40-73-560 - Resident Records

A. The facility shall establish written policy and procedures for documentation and recordkeeping to ensure that the information in resident records is accurate and clear and that the records are well-organized.

B. Resident records shall be identified and easily located by resident name, including when a resident's record is kept in more than one place. This shall apply to both electronic and hard copy material.

C. Any physician's notes and progress reports in the possession of the facility shall be retained in the resident's record

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22VAC40-73-560 - Resident Records

E. All resident records shall be kept current, retained at the facility, and kept in a locked area, except that information shall be made available as noted in subsection F of this section.

F. The licensee shall ensure that all records are treated confidentially and that information shall be made available only when needed for care of the resident. All records shall be made available for inspection by the department's representative.

G. Residents shall be allowed access to their own records. A legal representative of a resident shall be provided access to the resident's record or part of the record as allowed by the scope of his legal authority.

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Resident Record Opportunities

- Completeness and accuracy
- Legibility
- Professionalism
- Timeliness
- Protocols for electronic records
  - *Use of defined tool*
  - *Scanning*

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Resident Record

Does the record tell the story that you know?

If you read the record one year from now, would you come away with the same story / understanding?

If someone else read the record, would they come away with the same story/understanding that you have?

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Incident Reporting

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22VAC40-73-70 - Incident Reports

A. Each facility shall report to the regional licensing office within 24 hours any major incident that has negatively affected or that threatens the life, health, safety, or welfare of any resident.

D. The facility shall submit to the regional licensing office amendments to the written report when circumstances require, such as when substantial additional actions are taken, when significant new information becomes available, or there is resolution of the incident after submission of the report

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22VAC40-73-70 - Incident Reports

C. The facility shall submit a written report of each incident specified in subsection A of this section to the regional licensing office within seven days from the date of the incident. The report shall be signed and dated by the administrator and include the following information:

1. Name and address of the facility
2. Name of the resident or residents involved in the incident
3. Date and time of the incident
4. Description of the incident, the circumstances under which it happened, and, when applicable, extent of injury or damage
5. Location of the incident
6. Actions taken in response to the incident
7. Actions to prevent recurrence of the incident, if applicable
8. Name of staff person in charge at the time of the incident
9. Names, telephone numbers, and addresses of witnesses to the incident, if any
10. Name, title, and signature of the person making the report, if other than the administrator, and date of the completion of the report.

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Technical Assistance – Updated-July, 2015

Question (Q1): *What is considered a major incident that has negatively affected or that threatens the life, health, safety or welfare of a resident that has to be reported?*
Answer: The following are considered to be major incidents that have negatively affected or that threaten the life, health, safety or welfare of any resident that must be reported as required by the standard:

- **Death** – The death of a resident when the death is unanticipated.
- **Injury** – ***Any*** injury to a resident that requires emergency treatment and/or admission to a hospital. This does not include minor injuries that require only first aid provided in the facility or minimal intervention by a licensed health care professional.
- **Any event** requiring the application of **emergency restraints**.
- **The development of a pressure sore of Stage 2 or higher** or stasis ulcers that are consistent with the description of a Stage 2 wound (refer to detailed answer for reporting pressure sores under this standard).

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Technical Assistance – Updated July 2015

- **Abuse/neglect/exploitation** – Suspected abuse, neglect, or exploitation of a resident that is required to be reported by mandated reporters (§ 63.2-1606 of the Code of Virginia) or is investigated by Adult Protective Services.
- **Absence/elopement**
  - Residents with no serious cognitive impairment: Unanticipated absence/elopement of a resident from the facility must be reported when the following conditions are present: (i) the resident cannot be located; (ii) there is sufficient question as to the whereabouts of the resident; and (iii) there is deviation from the normal behavior/routine of the resident. This does not include situations where a resident without serious cognitive impairment is found within 24 hours, there has been no serious harm to the resident, and no laws have been broken.
  - Residents with serious cognitive impairment who cannot recognize danger or protect their own safety and welfare: whether living in a mixed population or on a secure unit, an elopement when the resident actually exits the building without staff knowledge must be reported. (This does not include exiting to a secured outdoor area.) If a missing resident is located within the building, but more than an hour was required to locate the resident, this must also be reported.

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Technical Assistance – Updated July 2015

- **Disaster** – A fire, natural disaster or other occurrence that causes significant physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the building.
- **Incidents that require the assistance of an outside agency** such as police, fire, rescue or emergency community service board contact. This does not include "routine" medical health issues

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Thank You !

We appreciate your engagement and will gladly answer questions. We hope this discussion has been helpful.

If you would like to be added to our FOCUS POINT [newsletter] distribution list please let us know.

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