Fall Provider Meeting 2018

Missouri Department of Health and Senior Services
Section for Long Term Care Regulation

- 19 CSR 30-86.042 (39) RCF
- 19 CSR 30-86.043 (34) RCF*
- 19 CSR 30-86.047 (35) ALFs

Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II

Protective Oversight

Residential Care Facility (RCF)

Any premises, other than an assisted living facility, intermediate care facility, or skilled nursing facility, which is utilized by its owner, operator, or manager to provide twenty-four (24) hour care to three (3) or more residents, who are not related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility and who need or are provided with shelter, board, and with ***protective oversight***, which may include storage and distribution or administration of medications and care during short-term illness or recuperation..

Protective Oversight

Assisted Living Facility (ALF)

Shall mean any premises, other than a residential care facility, intermediate care facility, or skilled nursing care facility, that is utilized by its owner, operator, or manager to provide twenty-four (24) hour care and services and ***protective oversight*** to three (3) or more residents who are provided with shelter, board, and who may need and are provided with…

Protective Oversight

What is protective oversight?

- An awareness twenty-four (24) hours a day of the location of a resident, the ability to intervene on behalf of the resident, supervision of nutrition, medication, or actual provisions of care, and the responsibility for the welfare of the resident, **except where the resident is on voluntary leave.**
  - Home with family for Weekend?
  - Signs self out to go to the corner store?

Resident Rights/Self Determination and Protective Oversight

- Does the facility have a responsibility to ensure resident receives medication as ordered by physician? Yes
- What if the resident refuses to take their medications?
- The facility has a responsible to provide protective oversight of resident by intervening and contacting physician, and the guardian or responsible party if the resident's refusal of medications is affecting their health, safety and/or welfare.

Protective Oversight Citation Examples

Failed to monitor and provide oversight to resident with history of polysubstance abuse, alcoholism and history of suicidal ideation with regard to taking medication.

- Failed to communicate with psychiatrist regarding alcohol consumption and previous attempts by resident to access medication cart.
- Medication aide left medication cart keys unattended
  - 4 hydrocodone discovered missing and resident believed to have taken them
  - Facility nurse called. Physician not called.

Protective Oversight Citations History of Behaviors

Resident experienced change in mental status including yelling, waking other residents at night, screaming, knocking on doors, accusing staff and other residents of trying to kill him/her, trying to leave the facility, acting out sexually to roommate and a staff person. Situation noted to have occurred for several months before SLCR went onsite.

Failure to safeguard rights of other residents and provide protective oversight:

- Previous roommate left facility due to resident acting out sexually towards him/her.
- New resident admitted and placed in room with resident. Same behavior occurred with new roommate. Roommate had to use the phone to contact staff to help them with resident.

Protective Oversight Citations
Elopement Examples

- Facility failed to provide protective oversight for three residents who were cognitively impaired and eloped from the building in freezing temperatures. It was determined that staff turned off the door alarm on the night shift to go outside to smoke.
- Facility failed to provide protective oversight to one resident, with a history of elopement. The resident was heard saying, "Where are my car keys, I want to go home!" The resident left the facility without staff knowledge at approximately 11:00 p.m. The Director of Nurses found the resident walking along a highway 7.2 miles from the facility the next morning.
- Facility failed to provide protective oversight for one cognitively impaired resident who eloped from the third floor secured memory care unit and walked outside the facility when the staff failed to reset and lock the delayed egress door for four days after a fire alarm disarmed the door. The resident exited the building unsupervised and was found along a busy street. The facility did not have a system in place to monitor the doors after a fire alarm activation or a plan to supervise the resident, despite several prior elopements.

Protective Oversight
Aggressive Behavior Example

- Resident #1 and Resident #2 are both alert and orientated.
- Resident #1 slapped Resident #2 in the dining room, the exact cause of the altercation is unknown.
- The staff created a seating chart that placed Resident #1 and Resident #2 at different tables.
- Two weeks later, Resident #1 punched Resident #2 in the activity room and caused a subdural hematoma on the resident's head which sent Resident #2 to the hospital.
- Even though the first incident happened in the dining room and staff put in an intervention, the staff did not provide protective oversight when they failed to implement a plan to keep Resident #1, with a known history of aggression, away from Resident #2 in other areas of the facility.

Resident Rights/Self Determination and Protective Oversight

The facility has a responsibility to have a procedure for residents to advise staff when they leave, to identify the estimated length of time they will be gone, and where they will be going.

Facility must have procedures for staff to follow if the resident does not come back at their anticipated time of return.

-What would you do?

-Do all staff know your plan?

-Do you provide training on your plan? How often?

Protective Oversight Returned to the Facility Example

- The resident has an history of substance abuse.
- The resident has chronic back pain and is on scheduled hydrocodone every six hours for pain (8 a.m, 2 p.m., 8 p.m., 2 a.m.).
- The resident returned to the facility from a family outing at 6 p.m. Staff assessed the resident as very lethargic and could barely keep his/her eyes open.
- Staff gave the resident his/her 8 p.m. pain medication.
- At 1:45 a.m., the resident came out of their room and said he/she could not sleep and felt nervous. He/she kept talking about the kids playing in the corner.
- Staff gave the resident his/her 2 a.m. pain medication.
- The resident went to the medication cart at 7:45 a.m. and "drifted off" while waiting for his/her 8 a.m. pain medication. Staff gave the resident his/her pain medication and the resident went back to his/her room.
- Breakfast starts at 8:00 a.m. and when the resident did not come to breakfast by 8:30 a.m., staff entered the resident's room and found the resident unresponsive .
- Emergency services were called and the resident became responsive after Narcan (reverses the effects of opioids) was administered by the EMT.

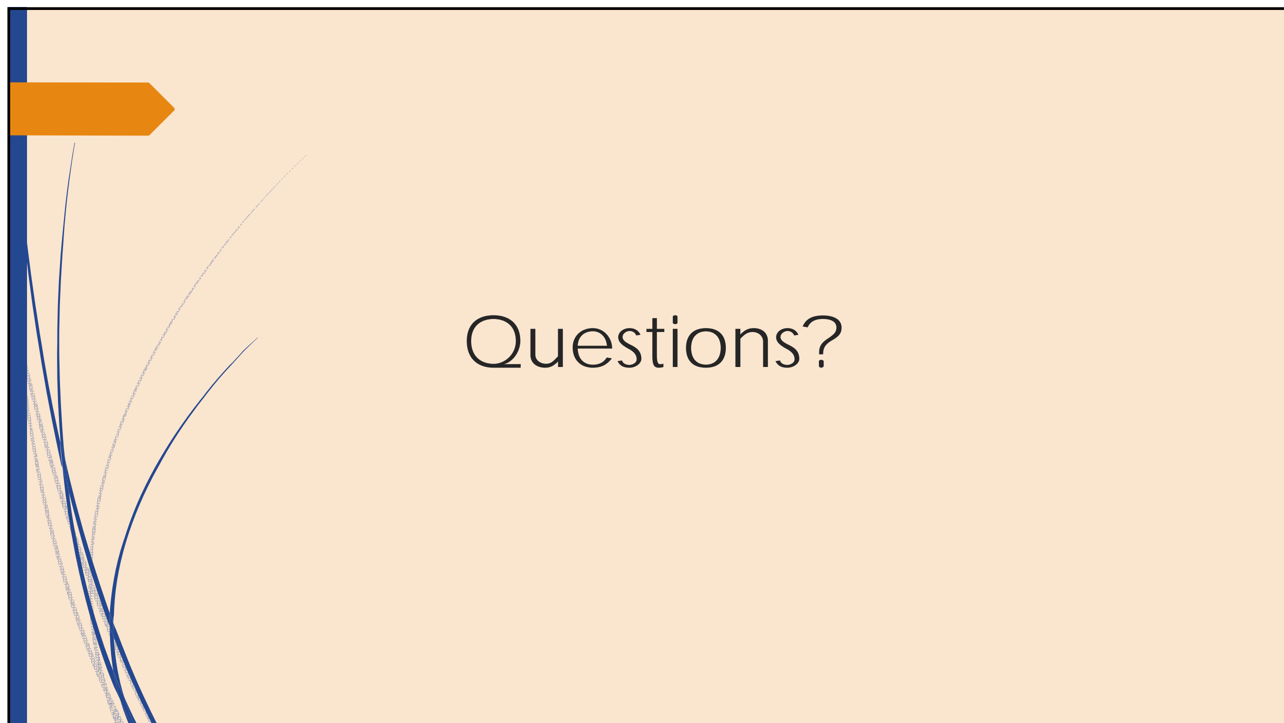
Resident Rights/Self Determination and Protective Oversight

What can a facility do to balance resident rights/self determination while providing protective oversight?

- Obtain a complete history of the resident prior to admission. This includes knowledge that you are able to provide for the care and oversight needed to keep the resident safe.
- Provide residents with information about their rights, responsibilities, and any "house rules" as a resident of the facility.
- Create plans with guidelines/instructions of how to address potential problems:
  - Behaviors, exit seeking, "cheeking" meds, examining the television mounting unit…
- Educate staff of the warning signs that may relate to protective oversight issues.
- Educate staff on rights, self determination, and responsibility to provide protective oversight.
- Educate the staff on how they can provide protective oversight without violating the resident's rights.

Resident Rights/Self Determination and Protective Oversight - Continued

- Develop policies and procedures and educate staff on them to ensure they are knowledgeable.
  - This training may include things like asking the staff questions to test their knowledge base – If a resident pockets a razor blade, what should you do?
  - Consider what resources may be available to help train the staff how to better prepare for residents who may have a condition that requires more protective oversight.
- Ensure the policies and procedures are followed by staff.
- Ensure the facility has sufficient trained and knowledgeable staff to intervene to prevent potential issues related to protective oversight.
- Take prompt action – **Don't Wait** - if a resident displays behaviors that present a reasonable likelihood of serious harm to himself/herself or others, serious illness, significant change in condition, injury, or death.


Questions?