

EALR Workgroup Q&A

➔ **HHA/CNA/PCA Scope of Practice. - What is the scope of practice for HHA/CNA/PCA in an EALR?**

- Home Health Aide (HHA) – An individual must meet the minimum training requirements set forth by their respective training program in order to be a certified Home Health Aide. The LHCSA and Home Care Framework and Guidelines, which require 75 hours of training and mandated in-services, are applicable. Please review 10 NYCRR § 1001.10 (m) (3), as well as 10 NYCRR §§ 700.2 (b) (9) and 700.2 (c) (15) for further information.
- Certified Nurse’s Assistant (CNA) – While an individual who has a valid CNA title may be hired in an Adult Care Facility (ACF) or Enhanced Assisted Living Residence (EALR), they may not perform CNA duties as a CNA is not a recognized title. As a result, an individual with a CNA title, in this situation, must be trained and obtain certification through an appropriate and approved training program, as either a RCA or a HHA to provide care to EALR residents as an employee of the EALR.
- Personal Care Aide (PCA) - In the Assisted Living Residence (ALR), the PCA is referred to as a Resident Care Aide (RCA) (10 NYCRR §§ 1001.10 (j) (3) and 1001.11 (c) (2)). For scope of practice and training requirements of RCA’s, please refer to DAL #10-04.

➔ **Can a CNA work in an EALR under a CNA title? Can a CNA perform CNA duties in an ALR?**

The CNA is not a recognized title in the ACF, which includes the ALR and EALR. While a staff person who has a valid CNA title may be hired in an ACF, they may not perform CNA duties identified within their scope of practice.

➔ **CNAs vs. HHA Requirements - Can a CNA become an HHA? If so, do they need additional training? Since a CNA requires more training hours than HHA, can we bridge the title?**

If an individual who has a valid CNA title wishes to become a HHA, that individual must take additional training to become a certified HHA through an approved Home Health Aide Training Program (HHATP). HHATP’s must have the capability to augment a Nurse Aide’s training with classroom and supervised practical training, in those skills not included in the Nurse’s Aide training program. Such skills include but are not limited to: assistance with medications; handling the patient’s money; maintaining a clean, safe home environment; safety, accident prevention and response to emergencies in the home; taking of blood pressure; and observe, recording and reporting in the home care setting. The individual with the CNA certificate must meet the minimum training requirements for HHA as outlined in the LHCSA and Home Care Framework and Guidelines.

→ HHA Certification – Does the HHA certification actually expire? Can the Residence offer a yearly program to keep the certification valid? How does that work?

Yes, a HHA certificate can expire. Home Health Aides in New York State remain certified as long as they work for a home health agency, which is certified or licensed by the New York State Department of Health. The home health agency where the Home Health Aide is employed must provide nursing supervision and 12 hours of in-service training per year. If the aide leaves the employment of an agency to work privately in New York State or to work out of state, the Home Health Aide certification lapses two years from the date that the person (aide) last worked at a home health agency in New York State. This has been previously addressed in Home Health Aide Training Program FAQs June 2012.

Only Home Health Aide Training Programs approved by DOH or the State Education Department can provide training and/or a competency evaluation program for Home Health Aides.

HHA Training/Certification Requirements:

- An individual must successfully complete a HHATP approved by Department of Health (DOH) or the State Education Department to become certified.
- An individual must be issued a certificate of completion and be listed on the Home Care Registry (HCR) in order to be employed as a Home Health Aide.
- An individual requiring a Competency Evaluation must successfully complete a Competency Evaluation Program offered by an approved HHATP, be issued a certificate of completion, and be listed on the HCR in order to be employed as a Home Health Aide.
- There are approximately 300 approved HHATPs in NYS sponsored by LHCSAs, CHHAs, Hospices and State Education. A listing of approved HHATPs is available on the DOH website.

EALRs employing HHAs must:

- Verify (continual) that the HHA is certified.
- Verify that the HHA is listed on the HCR with a valid certificate (meaning they have completed training). In addition, the HCR will show employment history of the HHA. Please note if the HHA has not worked for a Home Health Agency there will be no statement on employability and the HHA will not have an employability status. An “unknown” status may mean that an individual has applied for employment with a home care services agency and the background investigation is still pending. It may also mean that the individual has never applied to work with a home care services agency, as these individuals are not required to submit to a background investigation but would still be in the HCR because of their completion of a personal care or HHATP. The Department strongly encourages additional reference checks if the person they are considering for employment is listed with an “unknown” status on the HCR.
- Have written and DOH approved policies and procedures on how HHAs will be supervised.
- Ensure that the HHA completes the required 12 hours of in-service trainings, annually. The employer is responsible for orientation training to the policies and procedures of the EALR and in-service education necessary for the HHA to perform his/her responsibilities at the time of employment. There must be documentation in the employees file of training

at time of employment and annually thereafter on universal precautions/HIV transmission.

- The HHA must participate in 12 hours of in-service education per year (in addition to the annual Universal Precaution/HIV training requirements). The in-services may be obtained outside of the EALR however there must be documentation in the HHA's personnel record of in-service training including date, content, and provider. All materials must be available for review by DOH survey staff when requested.
- Perform an initial and annual competency evaluation of the HHA.
- HHAs may only perform tasks permitted within the HHA Scope of Task and must be supervised by an RN. Background checks are required to be performed upon hire of the HHA.

➔ LPNs and PRN Medications - Explain the difference between observation and assessment and the LPNs ability to provide PRN medications without consulting with an RN.

According to Section 6902 of Article 139 of NYS Education Law, an LPN does not have assessment privileges in New York State. LPNs may not interpret patient clinical data or act independently on such data; they may not triage; they may not create, initiate, or alter nursing care goals or establish nursing care plans. LPNs function, by law, in a dependent role at the direction of the RN or other selected authorized health care providers. Under such direction, LPNs may administer medications, provide nursing treatments, and gather patient measurements, sign and symptoms, which can be used by the RN in making decisions about the nursing care of specific patients. However, LPNs may not function independent of direction. (<http://www.op.nysed.gov/prof/nurse/nursepracticefaq.htm>)

PRN Medications: The RN must initially perform an assessment of the resident that identifies behaviors that indicate the need for a PRN medication. This assessment is discussed with the LPN and documented in the resident's record/plan of care. The LPN can then administer the PRN medication without consulting with the RN if the resident exhibits these behaviors. Additionally, the RN and LPN must work closely together with discussing the resident's plan of care. The RN must assume the leadership role. The LPN must also be directed as to when to contact the physician and inform the RN of any changes in the resident. The LPN cannot continue to administer medication without ongoing assessment by the RN. This collaboration must be clearly documented in the resident's record as well as the identified resident behaviors/response to medication.

NYS Office of the Professions "Nursing Guide to Practice" (NYS Education Department, 2009) states:

The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this

title and in accordance with the commissioner's regulations.

Licensed Practical Nurses function by law in a dependent role at the direction of the RN or other select authorized health care providers. Under such direction, Licensed Practical Nurses may administer medications, provide nursing treatments, and gather patient measurements, signs, and symptoms that can be used by the RN in making decisions about the nursing care of specific patients. However, they may not function independent of direction.

➔ **Provision of nursing services in an EALR and SNALR.**

If an ACF has an EALR and wishes to employ a nurse (RN/LPN) in the EALR, the Nurse may perform all duties within the scope of practice for their licensure. Please be advised, these services may only be provided to individuals occupying an EALR bed and not to all residents of the ACF, and may only be performed after appropriate policies and procedures have been approved by the NYS Department of Health.

If an ACF has a Special Needs Assisted Living Residence (SNALR) and wishes to employ a nurse (RN/LPN), while this individual may be employed by the ACF, they may not perform duties in their scope of practice for individuals occupying an SNALR bed.

If the facility elects to have nursing services as part of the EALR, then pursuant to 10 NYCRR § Sec. 1001.10(m)(2), "If an EALR provides healthcare services that would ordinarily be provided by a home care service agency licensed pursuant to Article 36 of the public health law, then the operator of the EALR shall develop appropriate policies and procedures related to such health care services to include but not be limited to..."

An EALR operator may choose to limit the range of services a nurse may provide to residents to those minimally required in 10 NYCRR § 1001.10, so long as the resident's needs are otherwise met pursuant to his/her ISP. At a minimum, the EALR operator will need to have DOH approved policies and procedures addressing the contracting of necessary services and oversight of contracted staff. If at a later date, the operator decides to use their facility nurses to provide these services, the operator must have appropriate and approved policies and procedures in place. Any limitations on the provision of nursing care by an EALR as it affects resident admission/retention must be explained in the required disclosure information.

➔ **Can an RN of an EALR make the determination to give a PRN medication either on or off-site?**

Yes. This is within their scope of practice.

➔ **Would nurses be allowed to provide total assistance with feeding?**

Total assistance with feeding is permissible only for a resident occupying an EALR bed, in an ACF who has Department of Health approved policies and procedures regarding the total feeding of residents.

→ Are the tasks performed by a nurse in an EALR required to be listed in a Residency Agreement, specifically if the operator chooses to limit the range of services?

The EALR Addendum to the Residency Agreement specifies services to be provided. Whenever there is a change in the scope of services provided, the resident is notified of services no longer available through an updated EALR Addendum to the Residency Agreement. As a reminder, all updates to a Residency Agreement or Addendums must be submitted, reviewed, and approved by DOH prior to use.

→ If an EALR originally does not have a nurse, and then later decides to hire a nurse, or if the EALR increases the nursing services they provide, do they need to submit additional policies and procedures to the regional office for review?

Yes. The EALR would need to submit policies and procedures to the regional office for review and approval prior to providing the additional services.

→ If an EALR has a nurse and then decides to limit the range of services, must the residents in the facility be notified? Do they have to sign an agreement of the change?

Residents are not required to sign an updated agreement when the facility changes the range of services provided. However, residents must be notified if previously provided services are no longer available. If the resident should continue to require these services, the facility must arrange for the provision of such services or assist the resident in transferring to a facility that can meet their needs. Conversely, if services are added, residents should be notified of the additional services that are available to them.

It is expected that a revised Addendum will be submitted for review and approval to the appropriate DOH Regional Office, ensuring all future residents have an accurate Residency Agreement.

→ What is expected from the ACF/EALR when a resident has a DNR? Should the facility perform CPR?

The ACF and ALR regulations are silent on the issue of Do Not Resuscitate (DNR). Therefore, procedures for ALRs and their staff response to a DNR will be consistent with current practice in the ACF. In both an ACF and an ALR, the facility does not take on the responsibility of the DNR but are required to call emergency medical personnel (911), immediately.

The facility must document in the resident's record the existence of a DNR and any other advance directives. The original DNR and other advance directive(s) must be given to the emergency medical personnel (911) or when the resident is transferred to another facility. The facility should maintain a copy of the DNR and other advance directive(s) in the resident's record.

In an EALR, the facility must have written and DOH approved policies and procedures documenting staff response to DNR and other advance directive(s). Staff must be trained on these policies.

- If the EALR elects not to perform cardiopulmonary resuscitation (CPR), staff would follow the same procedures as in the ACF/ALR and call emergency medical personnel (911), immediately. If a registered nurse is available on site, the nurse may perform an assessment of the EALR resident but emergency medical services (911) must still be called.
- If the EALR elects to perform CPR, trained staff must maintain a current CPR certification and be available on site during all shifts. Whenever CPR is performed by staff, emergency medical service (911) is still required to be called, immediately.
- For a hospice patient, ACF/ALR/EALR and Hospice staff must follow the approved hospice plan of care. Please refer to the Dear Administrator Letters on the provision of hospice services in an ACF.

➔ **What is required of an EALR for TB testing?**

An operator shall not accept nor retain any resident *who suffers from a communicable disease* or health condition, which constitutes a danger to other residents and staff (§487.4(b)(13) or §488.4(b)(13)). An operator of an ALR shall admit and retain only those individuals who meet the admission and retention standards prescribed in sections §487.4(a)-(e) or §488.4(a)-(d) of Title 18 NYCRR, depending upon the facility's certification under Title 18 NYCRR (ALR Regulation 1001.7(a)).

The October 20, 2007 DAL HCBC 07-11 states "All residents are required to be screened for TB with a TST prior to admission as part of the medical evaluation. The resident's physician is required to screen for signs of active TB when the TST is contraindicated. When screening is performed, the resident's physician must attest that the resident is free of signs and symptoms of TB (symptoms of active TB include persistent or productive cough for longer than three weeks, along with loss of appetite, unexplained weight loss night sweats, bloody sputum (hemoptysis), hoarseness, fever, fatigue or chest pain).

No resident diagnosed with active TB will be admitted to the facility *until after they have started the appropriate course of treatment and are determined by a physician to no longer be infectious*. Documentation of the physician's determination will be in the resident's record.

After baseline testing has been completed, the New York State Department of Health does not require routine, periodic TB screening tests for residents in ACFs or ALRs. However, any resident with symptoms suggesting of active TB disease *must immediately referred for evaluation and treatment*.

➔ **Can full side rails be used in an EALR?**

No. Full side rails are not permissible in the Adult Care Facility, including an EALR. Please review 18 NYCRR § 487.11 (i)(6).

➔ **Can gait-belts be used in an EALR?**

Gait-belts may be used as long as the facility has DOH approved policy and procedures, and staff are properly trained on the appropriate use of the equipment. Please be advised, policies and procedures, and training documentation must be available to survey staff upon request.

➔ **Can residents in a SNALR “age-in-place” like in an EALR?**

No. SNALRs, in and of themselves, do not have the ability to allow “aging-in-place”: only EALRs. Therefore, if a SNALR resident wishes to “age-in-place”, the facility must be dually-certified for SNALR and EALR, and such resident would need to occupy both an available EALR and SNALR bed.

➔ **Is it considered a skilled task to obtain a urine and stool sample from a resident if you have a script for a “hat” (clean catch) specimen collection?**

This is an acceptable practice as long as the facility has DOH approved policies and procedures, and staff is appropriately trained. Please be advised, policies and procedures, and training documentation must be available to survey staff upon request.

➔ **ACF must post 30-day calendar for Activities – Can an LCD screen be used to replace calendar?**

Yes. However, the LCD screen must be visible to all residents and a hardcopy of text displayed on the LCD screen must be maintained for facility records.

➔ **When using electronic copies, must the facility have a hardcopy on hand?**

ACFs are required by regulation to have personal records for each resident which contain at a minimum, personal data, including identification for the resident’s next of kin, family and sponsor; the name and address of the person or person to be contacted in the event of emergency; copies of the resident’s medical evaluation and other medical information; summaries of the social evaluations; details of referral; and such other correspondence and papers as are available to document the physical, mental and social status of the resident, and records which are readily available to food service staff to plan and accommodate for prescribed diets and food preferences. If a facility is considering moving towards maintaining this information electronically, prior to implementing an electronic record, facilities must notify their appropriate regional office and comply with the current Equivalency conditions and HIPAA Privacy and Security Rules. Facilities need to have a DOH approved policy on computerized systems along with appropriate QA measures. Electronic systems should be routinely and readily available for surveyors.

➔ **Do private hire aides/companions have to be counted on the census if they are staying overnight or is that just for a live-in aide? Also, do overnight guests with a family member have to be counted on the census at 11:59pm?**

DRS/ACF DAL #09-02, dated May 8, 2009 on Companion Services in Adult Care Facilities states that Facilities that allow companions to stay overnight must count the overnight companion in the census for safety and fire policies and procedures. The facility must have a system in place for logging the presence of companions and overnight visitors and this information must be available for staff in case of an emergency.

→ If a companion is with a resident on Hospice, are they counted towards the “Fire Safety – over capacity code”?

Anyone providing services to a resident, such as a Home Care aide or Hospice companion, should be taken into account in the Emergency and Disaster Plan. The Hospice and the ACF should develop a plan to evacuate the resident, and any Hospice personnel with the resident.

If the question is whether the companion counts toward over-capacity for the facility’s bed capacity, it does not per DAL 09-02 which discusses companions who provide only companionship and states: “Adult Care Facilities must address in their policy and procedures whether companions may stay overnight with residents, and if so, clear guidelines must be in place to address any concerns such as night coverage and emergency evacuation. Facilities that allow companions to stay overnight must have adequate square footage in the room in which the companion will be staying, and must count the overnight companion in the census for safety and fire policies and procedures.”

Dal 07-21, regarding Hospice Services, does not address this issue. It is recommended that facilities contact their local code enforcer/fire department for guidance.

→ Do you need an equivalency to use a hospital bed as a means of evacuation for a Hospice Resident?

The use of a hospital bed is an equivalency. Once the conditions of the equivalency are met, any additional equivalency for the use of a hospital bed as a means of evacuation is not required. The facility’s evacuation plan must identify the type of staff available (e.g. EALR and/or Hospice) and must assure that adequately trained staff are available on all shifts to safely evacuate the resident(s). The Hospice Plan of Care must be reviewed and agreed upon between the hospice and the ACF and must address the increased needs of the resident. This plan must not only assure that the resident’s care needs can be safely and appropriately met, but that the resident is able to be evacuated safely. If EALR staff are used, they must be trained on moving the bed and any required equipment that the resident needs (IV, oxygen, other medical equipment, etc.) Factors such as corridor width must be taken into account to ensure that the bed can be readily moved to the next horizontal fire zone. The operator must ensure 1) that there is appropriate space in the corridors to move the bed and in the next fire zone for the bed, and 2) that use of the bed will not inhibit the movement of the other residents, or slow the evacuation. The operator is advised to consult with the local fire department regarding the revised evacuation plan.

References

New York State Education Department (2009). Office of the Professions Nursing Guide to Practice. Retrieved from <http://www.op.nysed.gov/prof/nurse/nurse-guide-april09.pdf>