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37.40.110 SERVICES FURNISHED The following sections list those services commonly furnished by nursing personnel in skilled nursing homes and their usual skill classification. Any generally non-skilled service could, because of special medical complications in an individual case, require skilled performance, supervision or observation. However, the complications and special services involved should be documented by nursing notes and/or physician orders with progress notes. These records should include the observations made of physical findings, new developments in the course of the disease, the carrying out of details of treatment prescribed, and the results of the treatment.

(1) Medications given by intravenous or intramuscular injections usually require skilled services. The frequency of injections would be particularly significant in determining whether the patient needs continuous skilled nursing care. Injections which can usually be self-administered -- for example, the well-regulated diabetic who receives a daily insulin injection -- do not require skilled services. Oral medications which require immediate changes in dosages because of sudden undesirable side effects or reactions should be administered to the patient and observed by licensed nurses, e.g., anti-coagulants, quinidine. This is a skilled service. Where a prolonged regimen of oral drug therapy is instituted, the need for continued presence of skilled nursing personnel can be presumed only during the period in which the routine is being established and changes in dosage cannot be anticipated or accomplished by unskilled personnel, e.g., digitalis.

(a) Administration of eye drops and topical ointments (including those required following cataract surgery) is not a skilled service. In Montana, institutional patients must receive all medications from licensed nurses; this fact, however, would not make the administration of oral medication a skilled service where the same type of medications are frequently prescribed for home use without skilled personnel being present.

(2) Levine tube and gastrostomy feedings must be properly prepared and administered. Supervision and observation by licensed nurses are required, thus making this procedure a skilled service.

(3) The services and observation required for nasopharyngeal aspiration constitute skilled nursing care.

(4) Colostomy or ileostomy may require skilled service during the immediate postoperative period following a newly created or revised opening. The need for such care should be documented by a physician and nursing notes. General maintenance care of this condition can usually be performed by the patient himself or by a person without professional raining and would not usually require skilled services.

(5) Repeated catheterizations during the immediate post-operative period following abdominal

surgery could, with a few other skilled services, constitute continuous skilled nursing care. Routine services in connection with indwelling bladder catheters do not constitute skilled care. Catheters used in other parts of the body, such as bile ducts, chest cavity, etc., require skilled care.

(6) General methods of treating incontinence, such as use of diapers and rubber sheets, are not skilled services. A catheter used for incontinence would not require skilled care. Secondary skin problems should indicate the treatment required and should be noted in the patient's record.

(7) Special service in connection with application of dressings involving prescription medications and aseptic technique constitute skilled services. Routine changes of dressings, particularly in non-infected postoperative or chronic conditions, generally do not require skilled services or supervision.

(8) Routine care in connection with braces and similar devices appliances does not constitute skilled services. Care involving training in proper use of a particular appliance should be evaluated in relation to the need for physical therapy.

(9) The use of protective restraints generally does not require services of skilled personnel. This includes such devices as bed rails, soft binders, and wheelchair patient supports.

(10) Any regimen involving regular administration of inhalation therapy can be instituted only upon specific physician order. The initial phases of instituting such a regimen would be skilled care. However, when such administration becomes a part of regular routine, it would not generally be considered a skilled service since patients can usually be taught to operate their own inhalation equipment, or non-skilled personnel can supervise its administration, as in cases of chronic asthma, emphysema, etc. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)

37.106.606 MINIMUM STANDARDS FOR A SKILLED AND SKILLED/ INTERMEDIATE CARE FACILITY: DRUG SERVICES

...(3) Any deviation from the prescribed drug dosage, route or frequency of administration and unexpected drug reactions shall be reported immediately to the patient's licensed physician with an entry made on the patient's medical record and on an incident report.

50-5-1201. USE OF SAFETY DEVICES -- REQUEST AND CONSENT -- ALLOWED INDIVIDUALS -- INTENT.

(1) The following individuals may request the use of and provide informed consent for the use of certain safety devices aimed at ensuring the physical safety of the resident by reducing the risk of falls and injuries associated with a resident's medical symptom even if the resident cannot easily remove the device or the device restricts the resident's total freedom of movement:

(a) a resident;

(b) a family member of a resident who is unable to make decisions because the resident has a communication barrier or has been found by a physician to be medically incapable of granting informed consent, as provided in 50-5-1203;

(c) a guardian, as defined in 72-1-103; or

(d) a person granted the power of attorney for health care decisions.

(2) A concern for a resident's physical safety or a resident's fear of falling may provide the basis for a medical symptom. A safety device may not be used for the convenience of staff or for disciplinary purposes.

(3) This part is intended to provide residents and authorized or designated representatives with the authority to request and consent to the use of safety devices but is not intended to interfere with the right of licensed health care providers acting within their scope of practice to recommend and order treatments and services, including physical restraints, for residents in their care.

History: En. Sec. 1, Ch. 347, L. 2001.

50-5-1202. DEFINITIONS. AS USED IN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

(1) "Department" means the department of public health and human services provided for in 2-15-2201.

(2) "Long-term care facility" means a licensed facility that provides skilled nursing care or intermediate nursing care or that is an assisted living facility, as defined in 50-5-101.

(3) "Medical symptom" means an indication of a physical or psychological condition or of a physical or psychological need expressed by the patient.

(4) "Physician" includes an advanced practice registered nurse to the extent permitted by federal law.

(5) "Resident" means a person who lives in a long-term care facility.

(6) (a) "Safety devices" means side rails, tray tables, seatbelts, and other similar devices.

(b) The term does not include protective restraints as defined in 21 CFR 880.6760. History: En. Sec. 2, Ch. 347, L. 2001; amd. Sec. 6, Ch. 54, L. 2003.

50-5-1203. Procedures -- informed consent -- physician involvement.

(1) Upon receiving a request for use of a safety device, a long-term care facility shall inform the requestor of the alternatives and risks associated with the use of the safety device. The long-term care facility shall provide the requested safety device to the resident upon receipt of:

(a) a signed consent form authorizing its use and acknowledging receipt of specific information about available alternatives and risks; and

(b) a written order from the attending physician that specifies the circumstances under and the duration for which the safety device may be used and the medical symptoms that the safety device is intended to address.

(2) The requirements of subsection (1) do not apply if a side rail or other device is used only as an assistive device and does not restrict the resident's movement from bed or chair. History: En. Sec. 3, Ch. 347, L. 2001.

50-5-1204. Long-term care facility procedures. A long-term care facility that provides a safety device under 50-5-1203 shall:

(1) document that the procedures outlined in 50-5-1203 have been followed;

(2) monitor the use of the safety device in accordance with accepted standards of practice;

(3) reevaluate the resident's need for the safety device, no less than quarterly, in consultation with the resident, the resident's family, and the attending physician. History: En. Sec. 4, Ch. 347, L. 2001.

50-5-1205. Survey compliance and department enforcement -- rulemaking authority.

(1) The department is granted rulemaking authority for the purposes of implementing this part.

(2) When determining compliance with state and federal standards for the use of a safety device, the department is bound by the statements and determinations contained in the attending physician's order regarding medical symptoms. A written order from the attending physician that contains statements and determinations regarding medical symptoms is sufficient evidence of the medical necessity of the safety device.

(3) A long-term care facility may not be subject to fines, civil penalties, or other state or federal survey enforcement remedies solely as the result of allowing the use of a safety device as authorized in this part.

(4) This section does not preclude the department from taking action to protect the safety and health of the resident if there is clear and convincing evidence that:

(a) the use of the safety device has jeopardized the health and safety of the resident; and

(b) the long-term care facility has failed to take reasonable measures to protect the health and safety of the resident. History: En. Sec. 5, Ch. 347, L. 2001.