CHAPTER 40
SENIOR AND LONG TERM CARE SERVICES
Subchapter 1 Nursing Home Care
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37.40.101 LEVEL OF CARE DETERMINATIONS
(1) The three basic considerations in every level of care determination are the individual patient's medical, psychological and social needs; the specific services required to fill these needs; and, the health and other personnel required to adequately provide these services.
(a) Specific level of care criteria, as well as preadmission screening procedures, are found in ARM 37.40.201 and 46.12.1303.
(2) Assessing a patient's medical condition and evaluating the appropriateness of services for that condition is primarily a nurse coordinator's function. If questions arise regarding the patient's medical condition or the propriety of some or all of the services ordered by the attending physician, physician advisor review, including peer review, may be requested by the attending physician.
(3) Assessing a patient's psychological and social condition and evaluating the appropriate services for that condition is primarily a function of the department or its designee.
(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, Eff. 1/3/77; AMD, 1983 MAR p. 863, Eff. 7/15/83; TRANS, from
SRS, 2000 MAR p. 489.)
Rules 02 through 04 reserved
37.40.105 SKILLED CARE
(1) The goal of skilled care is to provide care for patients who require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting.
(2) Skilled nursing care includes components which distinguish it from supportive care. Supportive care does not require professional health training. One component is the observation and assessment of the total needs of the patient.
Another component is the rendering of direct services to a patient where the ability to provide the services requires specialized training, such as a registered or a licensed practical nurse.
(3) In evaluating whether the services required by the patient are the continuous skilled services which constitute skilled care, several basic principles are considered.
(a) Since skilled care represents skilled nursing care on a continuous basis, the need for a single skilled service – for example, intramuscular injections twice a week -- would rarely justify a finding that the care constitutes skilled care.

(b) The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient, following instructions, can normally take oral medication. Consequently, the act of giving an oral medication to a patient who is too senile to take it himself would not be skilled service, even when a licensed nurse gives the medication.
(c) The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a non-ambulatory patient may be frequent changes of position in order to avoid development of decubiti. If changing the patient's position is the only regular and frequent service provided, it would not be a skilled service. Routine prophylactic and palliative skin care such as bathing, application of creams, etc. does not constitute skilled services. Presence of a small decubitis ulcer, rash or other relatively minor skin irritation does not generally indicate a need for skilled care. Existence of extensive decubiti or other widespread skin disorder may necessitate skilled care. Physicians' orders for treating the skin, rather than diagnosis, are the principal indication of whether skilled care is required.
(d) The possibility of adverse effects from improper performance of an otherwise unskilled service -- for example, improper transfer of patients from bed to wheelchair -- does not
(4) Any of the following treatment services or care indicate need for skilled nursing care:
(a) oral administered medications requiring constant changes of dosage upon sudden undesirable side effects;
(b) oral medication before routine dosage established and must be watched for reactions;
(c) gastrostomy feedings;
(d) nasopharyngeal aspiration;
(e) recent postoperative colostomy and ileostomy care;
(f) repeated catheterizations during recent postoperative period;
(g) special services in application of dressings involving prescribed medications;
(h) initial phases of operation of inhalation equipment;
(i) physical therapy directed by the physician;
(j) intravenous or instramuscular injections except for the well controlled diabetic;
(k) patient on narcotics for pain;
(l) the very hostile, belligerent and demanding patient who is disruptive to other patients and staff, constantly refusing to take medication or treatment, may be destructive, may attack other patients or personnel, may have frequent periods of agitation and needs constant and close supervision; and
(m) the patient with severe impairments, or who is so withdrawn to the degree that he no longer can communicate and his needs must be anticipated.
(History: Sec. 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, Eff. 1/3/77; AMD, 1983 MAR p. 863, Eff. 7/15/83; TRANS, from SRS, 2000 MAR p. 489.)
37.40.106 INTERMEDIATE NURSING CARE
(1) Intermediate care services may be included in facilities licensed as a skilled nursing home or a personal care home which has a registered or a licensed practical nurse on duty eight hours a day, seven days a week, and with adequate personnel to provide the necessary nursing supervision and care to the intermediate care cases. No additional professional nurses will be required to render skilled nursing care.

(2) The intermediate nursing care patient needs some nursing service which is largely routine and whose major needs are for light personal care services. The following treatment services may indicate the need for intermediate nursing home care: oral medication after routine dosage established; routine catheter care; routine service for indwelling catheter; routine change in dressing to non-infected area; routine skin care; care of small decubitus ulcer; routine inhalation therapy; and maintenance care of colostomy or ileostomy.

(3) The following personal care services usually indicate the need for intermediate care. The incontinent patient needs to be dressed and bathed, may be a bed to chair patient, may need some restraints and constant watching for safety, needs help with toileting, needs help for ambulation or constant watching to prevent falls, needs help with eating, may be confused or senile and at times uncooperative, may have impairment, such as blindness or deafness and these impairments require some extra attention.

(History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)

Rules 07 through 09 reserved

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 postoperative 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.
(11) Physical therapy, one aspect of restorative care, consists of the application of a complex and sophisticated group of physical modalities and therapeutic services. Physical therapy, therefore, is a skilled service. However, a provision of physical therapy only would not justify a finding that the patient requires skilled care. In some situations, however, a patient whose primary need is for physical therapy will also require sufficient skilled nursing to meet the definition of skilled care. The need for such supportive skilled nursing on a continuing basis may be presumed when all four of the following conditions are met.
(a) The therapy is directed by the physician who determines the need for therapy, the capacity and tolerance of the patient, and the treatment objectives.
(b) The physician, in consultation with the therapist, prescribes the specific modalities to be used and frequency of therapy services.
(c) The therapy is rendered by or under the supervision of a physical therapist who meets the qualifications established by regulations; when the qualified therapist is the

supervisor, he is available and on the premises of the facility while the therapy is being given, he makes regular and frequent evaluations of the patient, records findings on the patient's chart, and communicates with the physician as indicated.
(d) The therapy is actively concerned with restoration of a lost or impaired function. For example, frequent physical therapy treatments in connection with a fractured back or hip or a CVA can be presumed to be directed toward restoration of lost or impaired function during the early phase --when physical therapy can be presumed to be effective. However, when the condition has stabilized, the presumption that continuing supportive skilled nursing services are required is no longer valid. Such cases must be evaluated in relation to the specific amount of skilled nursing attention required in the individual case as evidenced by physician orders and nursing notes. The routine ambulation and/or transfer of patients is not a skilled service.
(History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)
Rules 11 through 19 reserved
37.40.120 PROBLEM CASES
(1) There are some situations in which a patient's condition requires the institutional services provided by a skilled care facility, but does not require the type of care which is defined as skilled care. Such situations often arise where a patient needs extensive personal services due to permanent handicap or general debility, and alternative living arrangements are impractical or impossible due to socioeconomic, physical or emotional reasons.
(2) Certain emotional conditions, or disturbed patients may require continuous services of sufficient degree of skill as to be considered as skilled service. However, when such is the case the exact services and medications should be sufficiently documented to justify claiming this as a skilled service.
(3) When any of the following circumstances exist, there must be evidence that continuous skilled nursing service is also concurrently required and received. These are not of themselves considered skilled services, but in combination with others may be skilled services.
(a) The primary service is one or more of the following:
(i) oral medication;
(ii) skin care to prevent decubiti;
(iii) restraints;
(iv) frequent laboratory tests;
(v) routine incontinence care;
(vi) routine care for the blind;
(vii) supervision of daily living activities.
(b) The patient is capable of independent ambulation,
dressing, feeding, and hygiene.
(c) The patient has outside privileges.
(d) The diagnosis shown is not of a type which is sufficiently specific to indicate skilled treatment regimen;
i.e., the diagnosis is chronic brain syndrome, senility, arteriosclerosis, "old" CVA, 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.)