RB Health Partners, Inc.
Clinical Risk Medicare & Operational Consulting
www.rbhealthpartners.com • 727.786.3032

# Skilled Nursing Facility

# Policy & Procedure Manual

# FEDERAL REGULATIONS

November 2017

[FACILTIY NAME HERE]

CLINICAL RISK PROGRAMS MANUALS

The Clinical Risk Programs Manuals were reviewed and approved by the Quality Assurance Committee on _____.

_____ _____
Nursing Home Administrator Date

_____ _____
Director of Nursing Date

_____ _____
Medical Director Date

_____ _____
Additional Staff Member/Title Date

_____ _____
Additional Staff Member/Title Date

_____ _____
Additional Staff Member/Title Date

# RB HEALTHPARTNER'S POLICY INDEX

## I. PHASE 2 CROSSWALKS – COMPLIMENTS OF CMS

## II. DEFINITIONS

a. F540 Definition of a Facility — SNF & NF

## III. RESIDENT RIGHTS

Resident Rights General Policy

a. F550 Resident Rights/Exercise of Rights
b. F551 Rights Exercised by Representative
c. F552 Right to be Informed/Make Treatment Decisions
d. F553 Right to Participate in Planning Care
e. F554 Resident Self-Admin Meds-Clinically Appropriate
f. Self-Administration of Medication Program
g. F555 Right to Choose/Be Informed of Attending Physician
h. F557 Respect, Dignity/Right to have Personal Property
i. F558 Reasonable Accommodations of Needs/Preferences
j. F559 Choose/Be Notified of Room/Roommate Change
k. F560 Right to Refuse Certain Transfers
l. F561 Self Determination
m. F562 Immediate Access to Resident
n. F563 Visitation
o. F564 Inform of Visitation Rights/Equal Visitation Privileges
p. F565 Resident/Family Group and Response
q. F566 Right to Perform Facility Services or Refuse
r. F567 Protection/Management of Personal Funds
s. F568 Accounting and Records of Personal Funds
t. F569 Notice and Conveyance of Personal Funds
u. F570 Surety Bond - Security of Personal Funds
v. F571 Limitations on Charges to Personal Funds
w. F572 Notice of Rights and Rules
x. F573 Right to Access/Purchase Copies of Records
y. F574 Required Notices and Contact Information
z. F575 Required Postings
aa. F576 Right to Forms of Communication with Privacy
bb. F577 Right to Survey Results/Advocate Agency Info
cc. F578 Request/Refuse/Discontinue Treatment
dd. Refusal of Experimental Research
ee. Advance Directive Tracking Program
ff. Do Not Resuscitate Orders
gg. F579 Posting/Notice of Medicare/Medicaid on Admission
hh. F580 Notify of Changes (Injury/Decline/Room, Etc.)
ii. Change in Condition Process
jj. F582 Medicaid/Medicare Coverage/Liability Notice
kk. F583 Personal Privacy/Confidentiality of Records
ll. F584 Safe/Clean/Comfortable/ Homelike Environment
mm. F585 Grievances

nn. Grievance Program
oo. F586 Resident Contact with External Entities

## IV. FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

Freedom from Abuse, Neglect, and Exploitation General Policy

a. F600 Free from Abuse and Neglect
   F602 Free from Misappropriation/Exploitation
   F603 Free from Involuntary Seclusion
b. F604 Right to be Free from Physical Restraints
   F605 Right to be Free from Chemical Restraints
   Restraint Reduction Program
c. F606 Not Employ/Engage Staff with Adverse Actions
d. F607 Develop/Implement Abuse/Neglect, etc. Policies
e. F608 Reporting of Reasonable Suspicion of a Crime
   F609 Reporting of Alleged Violations
   F610 Investigate/Prevent/Correct Alleged Violations
f. Abuse, Neglect, Exploitation, Prevention
g. Personal Property Theft and Loss Risk
h. Photographs and Social Media
i. Sexual Abuse
j. Video Surveillance Closed-Circuit TVs

## V. ADMISSION, TRANSFER & DISHCARGE

Admission, Transfer and Discharge General Policy

a. F620 Admission Policy
b. F621 Equal Practices Regardless of Payment Source
c. F622 Transfer and Discharge Requirements
d. F623 Notice Requirements Before Transfer/Discharge
   F624 Preparation for Safe/Orderly Transfer/Discharge
e. F625 Notice of Bed Hold Policy Before/Upon Transfer
f. Bed Hold Policy
g. F626 Permitting Residents to Return to Facility

## VI. RESIDENT ASSESSMENTS

Resident Assessment General Policy

a. F635 Admission Physician Orders for Immediate Care
b. Resident Assessment Instrument (RAI)
   F636 Comprehensive Assessments & Timing
   F637 Comprehensive Assessment After Significant Change
   F638 Quarterly Assessment At Least Every 3 Months
   F639 Maintain 15 Months of Resident Assessments
   F640 Encoding/Transmitting Resident Assessment
   F641 Accuracy of Assessments
   F642 Coordination/Certification of Assessment
c. F644 Coordination of PASARR and Assessments
   F645 PASARR Screening for MD & ID
   F646 MD/ID Significant Change Notification

## VII. COMPREHENSIVE RESIDENT CENTERED CARE PLANS

Comprehensive Resident Centered Care Plans General Policy

a. F655 Baseline Care Plan
b. F656 Develop/Implement Comprehensive Care Plan
   F657 Care Plan Timing and Revision
   F658 Services Provided Meet Professional Standards
   F659 Qualified Persons
c. F660 Discharge Planning Process
d. Discharge Planning Procedure
e. F661 Discharge Summary

## VIII. QUALITY OF LIFE

Quality of Life General Policy

a. F675 Quality of Life
b. F676 Activities of Daily Living (ADLs)/Maintain Abilities
   F677 ADL Care Provided for Dependent Residents
   F678 Cardio-Pulmonary Resuscitation (CPR)
c. F679 Activities Meet Interest/Needs of Each Resident
   F680 Qualifications of Activity Professional

## IX. QUALITY OF CARE

Quality of Care General Policy

a. F684 Quality of Care
b. F685 Treatment/Devices to Maintain Hearing/Vision
c. F686 Treatment/Services to Prevent/Heal Pressure Ulcers
d. Wound Prevention Program
e. Wound Management Program
f. Clean Dressing Change Procedure
g. Skin Prep Application Procedure
h. F687 Foot Care
i. F688 Increase/Prevent Decrease in ROM/Mobility
j. Specialized Rehabilitative and Restorative Services
k. Restorative Nursing Program
l. Restorative Nursing Bed Mobility Program
m. Mobility
n. F689 Free of Accident Hazards/Supervision/Devices
o. Reporting Accidents and Incidents
p. Medical Errors Occurrence Reporting
q. Falling Star Program
r. Missing Resident
s. Elopement
t. F690 Bowel/Bladder Incontinence, Catheter, UTI
u. Bowel and Bladder Program
v. Indwelling Catheter Justification and Removal
w. F691 Colostomy, Urostomy, or Ileostomy Care
x. Assisted Nutrition and Hydration
y. F692 Nutrition/Hydration Status Maintenance

z. F693 Tube Feeding, Management/Restore Eating Skills
aa. Enteral Tube Feeding via Bolus
bb. Enteral Tube Feeding via Pump
cc. Enteral Tube Feeding via Gravity Bag
dd. Changing a Gastrostomy Tube
ee. Gastrostomy/Jejunostomy Site Care
ff. Cleaning and Storing Reusable Syringe
gg. Enteral Feeding Medication Administration
hh. Placement and Residual Volume Check for Enteral Feeding Tubes
ii. F694 Parenteral/IV Fluids
jj. PICC Line Removal Procedure
kk. F695 Respiratory/Tracheostomy Care and Suctioning
ll. F696 Prostheses
mm. F697 Pain Management
nn. Pain Management Program
oo. F698 Dialysis
pp. F700 Bedrails

**X. PHYSICIAN SERVICES**

Physician Services General Policy

a. F710 Resident's Care Supervised By a Physician
F711 Physician Visits — Review Care/Notes/Orders
F712 Physician Visits – Frequency/Timeliness/Alternate NPPs
F713 Physician for Emergency Care, Available 24 Hours
F714 Physician Delegation of Tasks to NPP
F715 Physician Delegation to Dietitian/Therapist

**XI. NURSING SERVICES**

Nursing Services General Policy

a. F725 Sufficient Nursing Staff
F726 Competent Nursing Staff
F727 RN 8 Hrs./7 day/Wk. Full Time DON
b. F728 Facility Hiring and Use of Nurse
c. F729 Nurse Aide Registry Verification, Retraining
F730 Nurse Aide Perform Review – 12Hr/Year In-service
d. F732 Posted Nurse Staffing Information

**XII. BEHAVIOR HEALTH SERVICES**

Behavior Health Services General Policy

a. F740 Behavioral Health Services
F741 Sufficient/Competent Staff-Behavior Health Needs
b. F742 Treatment/Services for Mental/Psychosocial Concerns
F743 No Pattern of Behavioral Difficulties Unless Unavoidable
F744 Treatment/Service for Dementia
F745 Provision of Medically Related Social Services
c. Behavior Management and Psychoactive Program

## XIII. PHARMACY SERVICES

Pharmacy Services General Policy

a. F755 Pharmacy Services/Procedures/Pharmacist/Records
   F759 Free of Medication Error Rate of 5% or More
   F760 Residents Are Free of Significant Med Errors
   F761 Label/Store Drugs & Biologicals
b. F756 Drug Regimen Review, Report Irregular, Act On
c. F757 Drug Regimen is Free From Unnecessary Drugs
   F758 Free From Unnecessary Psychotropic Meds/PRN Use
d. Drug Regimen Review Process

## XIV. LABORATORY, RADIOLOGY, AND OTHER DIAGNOSTIC SERVICES

Laboratory, Radiology, and Other Diagnostic Services General Policy

a. F770 Laboratory Services
   F771 Blood Bank and Transfusion Services
   F772 Lab Services Not Provided On-Site
   F773 Lab Services Physician Order/Notify of Results
   F774 Assist with Transport Arrangements to Lab Services
   F775 Lab Reports In Record-Lab Name/Address
   F776 Radiology/Other Diagnostic Services
   F777 Radiology/Diagnostic Services Ordered/Notify Results
   F778 Assist with Transport Arrangements to Radiology
   F779 X-ray/Diagnostic Report In Record – Sign/Dated

## XV. DENTAL

Dental General Policy

a. F790 Routine/Emergency Dental Services in Skilled Nursing Facilities
   F791 Routine/Emergency Dental Services Nursing Facilities

## XVI. FOOD AND NUTRITION SERVICES

Food and Nutrition Services General Policy

a. Food and Nutrition Services
   F800 Provide Diet Meets Needs of Each Resident
   F801 Qualified Dietary Staff
   F802 Sufficient Dietary Support Personnel
   F808 Therapeutic Diet Prescribed by Physician
   F809 Frequency of Meals/Snacks at Bedtime
   F810 Assistive Devices – Eating Equipment/Utensils
   F812 Food Procurement, Store/Prepare/Serve – Sanitary
   F813 Personal Food Policy
   F814 Disposal Garbage & Refuse Properly
b. Menus and Nutritional Adequacy
   F803 Menus Meet Resident Needs/Prepare in Advance/Followed
c. Food and Drink
   F804 Nutritive Value/Appear Palatable/Prefer Temp
   F805 Food In Form to Meet Individual Needs
   F806 Resident Allergies, Preferences and Substitutes

F807 Drinks Available to Meet Needs/Preferences/Hydration

d. F811 Feeding Assistant – Training/Supervision/Resident
e. Use and Storage of Food Brought in by Family or Visitors
f. Weight Management

## XVII. SPECIALIZED REHAB SERVICES

Specialized Rehab Services General Policy

a. F825 Provide/Obtain Specialized Rehab Services
   F826 Rehab Services — Physician Order/Qualified Person

## XVIII. ADMINISTRATION

Administration General Policy

a. F835 Administration
   F836 License/Comply With Federal/State/Local Law/Professional Standards
   F837 Governing Body
b. F838 Facility Assessment
c. F839 Staff Qualifications
   F840 Use of Outside Resources
d. F841 Responsibilities of Medical Director
e. F842 Resident Records – Identifiable Information
f. Record Retention
g. F843 Transfer Agreement
h. F844 Disclosure of Ownership Requirements
i. F845 Facility Closure – Administrator
   F846 Facility Closure
j. F849 Hospice Services
k. F850 Qualifications of Social Worker >120 Beds
l. F851 Payroll Based Journal

## XIX. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement

a. F865 QAPI Program/Plan, Disclosure/Good Faith Attempt
   F867 QAPI/QAA Improvement Activities
b. F868 QAA Committee

## XX. INFECTION CONTROL

Infection Control General Policy

a. F880 Infection Prevention and Control
b. F881 Infection Control - Antibiotic Stewardship Program
c. F883 Influenza and Pneumococcal Immunizations Residents
d. Influenza and Pneumococcal Immunizations for Staff
e. Infection Control - Standard and Transmission-based Precautions
f. Infection Control - Cleaning and Disinfection/Non-critical care and shared equipment
g. Infection Control - Central Venous Catheter/Central Line Access and Maintenance
h. Infection Control - Clean Dressing Change
i. Infection Control - Food Handling
j. Infection Control - Hand Hygiene

k. Infection Control - Indwelling Catheter Care
l. Infection Control - Indwelling Urinary Catheter Use
m. Infection Control - Linen Management
n. Infection Control - Medication Administration
o. Infection Control - Point of Care Devices and Injection Safety
p. Infection Control - Tuberculosis (TB) Screening Program

## XXI. PHYSICAL ENVIRONMENT

Physical Environment General Policy

a. F906 Emergency Electrical Power System (Blank)
b. F907 Space and Equipment
   F908 Essential Equipment, Safe Operating Condition
c. F909 Resident Bed
d. Resident Rooms
   F910 Bedrooms Accommodate No More Than 4 Residents
   F912 Bedrooms Measure at least 80 square foot/resident
   F913 Bedrooms Have Direct Access to Exit Corridor
   F914 Bedrooms Assure Full Visual Privacy
   F915 Bedrooms Window/Floor, Bed/Furniture/Closet
   F916 Bedrooms Floor Above Grade
   F917 Bedrooms Bed/Furniture/Closet
   F918 Bedrooms Equipped/Near Lavatory/Toilet
e. F919 Resident Call System — Rooms/Toilet/Bath
   F920 Requirements for Dining and Activity Rooms
   F921 Safe/Functional/Sanitary/Comfortable Environment
   F922 Procedures to Ensure Water Availability
   F923 Ventilation
   F924 Corridors Have Firmly Secured Handrails
   F925 Maintains Effective Pest Control Program
   F926 Smoking Policies
f. Resident Smoking Policy

## XXII. TRAINING REQUIREMENTS

Training Requirements General Policy

a. F943 Abuse, Neglect, and Exploitation Training
b. F947 Required In-Service Training for Nurse Aides
c. F948 Training for Feeding Assistants
d. Staff Education Plan

PLACE TAB FOR PHASE 2 CROSSWALKS HERE

## PHASE 2 TAG CROSSWALKS – COMPLIMENTS OF CMS

| New Tag # | SQC Tag? X = Yes | Tag Title | CFR | Regulatory Groupings | Tags / Subparts Implemented in Phase 3 | Old Tag # | Regulation Text that was Moved to New Tag |
|---|---|---|---|---|---|---|---|
| F540 | | Definitions | 483.5 | | | F150 | 483.5 |
| F550 | X | Resident Rights/Exercise of Rights | 483.10(a)(1)(2)(b)(1)(2) | 483.10 Resident Rights | | F151 | 483.10(b)(1)(2) |
| F551 | | Rights Exercised by Representative | 483.10(b)(3)-(7)(i)-(iii) | 483.10 Resident Rights | | F152 | 483.10(b)(3)-(7) |
| F573 | | Right to Access/Purchase Copies of Records | 483.10(g)(2)(i)(ii)(3) | 483.10 Resident Rights | | F153 | 483.10(g)(2)(3) |
| F552 | | Right to be Informed/Make Treatment Decisions | 483.10(c)(1)(4)(5) | 483.10 Resident Rights | | F154 | 483.10(c)(1)(4)(5) |
| F553 | | Right to Participate in Planning Care | 483.10(c)(2)(3) | 483.10 Resident Rights | | F154 | 483.10(c)(2)(iii) |
| F578 | | Request/Refuse/Discontinue Treatment; Formulate Advance Directives | 483.10(c)(6)(8)(g)(12)(i)-(v) | 483.10 Resident Rights | | F155 | 483.10(c)(6)(8)(g)(12) |
| F678 | X | Cardio-Pulmonary Resuscitation (CPR) | 483.24(a)(3) | 483.24 Quality of Life | | F155 | 483.24(a)(3) |
| F572 | | Notice of Rights and Rules | 483.10(g)(1)(16) | 483.10 Resident Rights | | F156 | 483.10(g)(1)(16) |
| F574 | | Required Notices and Contact Information | 483.10(g)(4)(i)-(vi) | 483.10 Resident Rights | | F156 | 483.10(g)(4) |
| F575 | | Required Postings | 483.10(g)(5)(i)(ii) | 483.10 Resident Rights | | F156 | 483.10(g)(5) |
| F579 | | Posting/Notice of Medicare/Medicaid on Admission | 483.10(g)(13) | 483.10 Resident Rights | | F156 | 483.10(g)(13) |
| F582 | | Medicaid/Medicare Coverage/Liability Notice | 483.10(g)(17)(18)(i)-(v) | 483.10 Resident Rights | | F156 | 483.10(g)(17)-(18) |
| F580 | | Notify of Changes (Injury/Decline/Room, Etc.) | 483.10(g)(14)(i)-(iv) | 483.10 Resident Rights | | F157 | 483.10(g)(14) |
| F567 | | Protection/Management of Personal Funds | 483.10(f)(10)(i)(ii) | 483.10 Resident Rights | | F158 | 483.10(f)(10)(i) |
| F567 | | Protection/Management of Personal Funds | 483.10(f)(10)(i)(ii) | 483.10 Resident Rights | | F159 | 483.10(f)(ii) |
| F568 | | Accounting and Records of Personal Funds | 483.10(f)(10)(iii) | 483.10 Resident Rights | | F159 | 483.10(f)(10(iii) |
| F569 | | Notice and Conveyance of Personal Funds | 483.10(f)(10)(iv)(v) | 483.10 Resident Rights | | F159 | 483.10(f)(iv) |
| F570 | | Surety Bond - Security of Personal Funds | 483.10(f)(10)(vi) | 483.10 Resident Rights | | F161 | 483.10(f)(10(vi) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F571 | | Limitations on Charges to Personal Funds | 483.10(f)(11)(i)-(iii) | 483.10 Resident Rights | | F162 | 483.10(f)(11)(i)-(iii) |
| F555 | | Right to Choose/Be Informed of Attending Physician | 483.10(d)(1)-(5) | 483.10 Resident Rights | | F163 | 483.10(d)(1)(2)(4)(5) |
| F583 | | Personal Privacy/Confidentiality of Records | 483.10(h)(1)-(3)(i)(ii) | 483.10 Resident Rights | | F164 | 483.10(h)(1)(3)(i) |
| F842 | | Resident Records - Identifiable Information | 483.20(f)(5) 483.70(i)(1)-(5) | 483.20 Resident Assessments 483.70 Administration | | F164 | 483.70(i)(2) |
| F585 | | Grievances | 483.10(j)(1)-(4) | 483.10 Resident Rights | | F165 | 483.10(j)(1) |
| F585 | | Grievances | 483.10(j)(1)-(4) | 483.10 Resident Rights | | F166 | 483.10(j)(2-4) |
| F577 | | Right to Survey Results/Advocate Agency Info | 483.10(g)(10)(11) | 483.10 Resident Rights | | F167 | 483.10(g)(10)(i)(11) |
| F577 | | Right to Survey Results/Advocate Agency Info | 483.10(g)(10)(11) | 483.10 Resident Rights | | F168 | 483.10(g)(10)(ii) |
| F586 | | Resident Contact with External Entities | 483.10(k) | 483.10 Resident Rights | | F168 | 483.10(k) |
| F566 | | Right to Perform Facility Services or Refuse | 483.10(f)(9)(i)-(iv) | 483.10 Resident Rights | | F169 | 483.10(f)(9) |
| F576 | | Right to Forms of Communication with Privacy | 483.10(g)(6)-(9) | 483.10 Resident Rights | | F170 | 483.10(g)(8)(i)(9)(i)-(iii) |
| F576 | | Right to Forms of Communication with Privacy | 483.10(g)(6)-(9) | 483.10 Resident Rights | | F171 | 483.10(g)(7)(ii)(iii) |
| F562 | | Immediate Access to Resident | 483.10(f)(4)(i)(A)-(G) | 483.10 Resident Rights | | F172 | 483.10(f)(4)(i) |
| F563 | | Right to Receive/Deny Visitors | 483.10(f)(4)(ii)-(v) | 483.10 Resident Rights | | F172 | 483.10(f)(4)(ii)-(v) |
| F564 | | Inform of Visitation Rights/Equal Visitation Privileges | 483.10(f)(4)(vi)(A)-(D) | 483.10 Resident Rights | | F172 | 483.10(f)(4)(vi)(A)-(D) |
| F583 | | Personal Privacy/Confidentiality of Records | 483.10(h)(1)-(3)(i)(ii) | 483.10 Resident Rights | | F173 | 483.10(h)(3)(ii) |
| F576 | | Right to Forms of Communication with Privacy | 483.10(g)(6)-(9) | 483.10 Resident Rights | | F174 | 483.10(g)(6)(7)(i) |
| F559 | X | Choose/Be Notified of Room/Roommate Change | 483.10(e)(4)-(6) | 483.10 Resident Rights | | F175 | 483.10(e)(4)(5) |
| F554 | | Resident Self-Admin Meds-Clinically Appropriate | 483.10(c)(7) | 483.10 Resident Rights | | F176 | 483.10(c)(7) |
| F560 | | Right to Refuse Certain Transfers | 483.10(e)(7)(i)-(iii)(8) | 483.10 Resident Rights | | F177 | 483.10(e)(7)-(8) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F622 | | Transfer and Discharge Requirements | 483.15(c)(1)(i)(ii)(2)(i)-(iii) | 483.15 Admission, Transfer, and Discharge | | F201 | 483.15(c)(1)(i)(ii) |
| F622 | | Transfer and Discharge Requirements | 483.15(c)(1)(i)(ii)(2)(i)-(iii) | 483.15 Admission, Transfer, and Discharge | | F202 | 483.15(c)(2)(i)-(iii) |
| F623 | | Notice Requirements Before Transfer/Discharge | 483.15(c)(3)-(6)(8) | 483.15 Admission, Transfer, and Discharge | | F203 | 483.15(c)(3)-(6)(8) |
| F624 | | Preparation for Safe/Orderly Transfer/Discharge | 483.15(c)(7) | 483.15 Admission, Transfer, and Discharge | | F204 | 483.15(c)(7) |
| F625 | | Notice of Bed Hold Policy Before/Upon Transfer | 483.15(d)(1)(2) | 483.15 Admission, Transfer, and Discharge | | F205 | 483.15(d)(1)(i)-(iv)(2) |
| F626 | | Permitting Residents to Return to Facility | 483.15(e)(1)(2) | 483.15 Admission, Transfer, and Discharge | | F206 | 483.15(e)(1)(2) |
| F621 | | Equal Practices Regardless of Payment Source | 483.15(b)(1)-(3)(c)(9) | 483.15 Admission, Transfer, and Discharge | | F207 | 483.15(b)(1)-(3)(c)(9) |
| F620 | | Admissions Policy | 483.15(a)(1)-(7) | 483.15 Admission, Transfer, and Discharge | | F208 | 483.15(a)(1)-(7) |
| F604 | X | Right to be Free from Physical Restraints | 483.10(e)(1)<br>483.12(a)(2) | 483.10 Resident Rights<br>483.12 Freedom from Abuse, Neglect, and Exploitation | | F221 | 483.10(e )(1),<br>483.12(a)(2) |
| F604 | X | Right to be Free from Physical Restraints | 483.10(e)(1)<br>483.12(a)(2) | 483.10 Resident Rights<br>483.12 Freedom from Abuse, Neglect, and Exploitation | | F222 | 483.10(e )(1),<br>483.12(a)(2) |
| F605 | X | Right to be Free from Chemical Restraints | 483.10(e)(1)<br>483.12(a)(2) | 483.10 Resident Rights<br>483.12 Freedom from Abuse, Neglect, and Exploitation | | F222 | 483.10(e )(1),<br>483.12(a)(2) |
| F600 | X | Free from Abuse and Neglect | 483.12(a)(1) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F223 | 483.12(a)(1) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F602 | X | Free from Misappropriation/Exploitation | 483.12 | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F223 | 483.12 |
| F603 | X | Free from Involuntary Seclusion | 483.12(a)(1) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F223 | 483.12(a)(1) |
| F602 | X | Free from Misappropriation/Exploitation | 483.12 | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F224 | 483.12 |
| F606 | X | Not Employ/Engage Staff with Adverse Actions | 483.12(a)(3)(4) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F225 | 483.12(a)(3)(4) |
| F609 | X | Reporting of Alleged Violations | 483.12(c)(1)(4) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F225 | 483.12(c)(1)(4) |
| F610 | X | Investigate/Prevent/Correct Alleged Violation | 483.12(c)(2)-(4) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | F225 | 483.12(c)(2)-(4) |
| F607 | X | Develop/Implement Abuse/Neglect, etc. Policies | 483.12(b)(1)-(4) | 483.12 Freedom from Abuse, Neglect, and Exploitation | (b)(4) - Phase 3 Will not be in ASPEN until Phase 3 | F226 | 483.12(b)(1)-(4) |
| F943 | | Abuse, Neglect, and Exploitation Training | 483.95(c)(1)-(3) | 483.95 Training Requirements | | F226 | 483.95(c)(1)-(3) |
| F550 | X | Resident Rights/Exercise of Rights | 483.10(a)(1)(2)(b)(1)(2) | 483.10 Resident Rights | | F240 | 483.10(a)(1)(2) |
| F550 | X | Resident Rights/Exercise of Rights | 483.10(a)(1)(2)(b)(1)(2) | 483.10 Resident Rights | | F241 | 483.10(a)(1) |
| F561 | X | Self Determination | 483.10(f)(1)-(3)(8) | 483.10 Resident Rights | | F242 | 483.10(f)(1)-(3) |
| F565 | X | Resident/Family Group and Response | 483.10(f)(5)(i)-(iv)(6)(7) | 483.10 Resident Rights | | F243 | 483.10(f)(5)(i)-(iii)(6)(7) |
| F565 | X | Resident/Family Group and Response | 483.10(f)(5)(i)-(iv)(6)(7) | 483.10 Resident Rights | | F244 | 483.10(f)(5)(iv) |
| F561 | X | Self Determination | 483.10(f)(1)-(3)(8) | 483.10 Resident Rights | | F245 | 483.10(f)(8) |
| F558 | X | Reasonable Accommodations of Needs/Preferences | 483.10(e)(3) | 483.10 Resident Rights | | F246 | 483.10(e)(3) |
| F559 | X | Choose/Be Notified of Room/Roommate Change | 483.10(e)(4)-(6) | 483.10 Resident Rights | | F247 | 483.10(e)(6) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F679 | X | Activities Meet Interest/Needs of Each Resident | 483.24(c)(1) | 483.24 Quality of Life | | F248 | 483.24(c)(1) |
| F680 | X | Qualifications of Activity Professional | 483.24(c)(2)(i)(ii)(A)-(D) | 483.24 Quality of Life | | F249 | 483.24(c)(2)(i)(ii)(A)-(D) |
| F745 | X | Provision of Medically Related Social Services | 483.40(d) | 483.40 Behavioral Health Services | | F250 | 483.40(d) |
| F850 | X | Qualifications of Social Worker >120 Beds | 483.70(p)(1)(2) | 483.70 Administration | | F251 | 483.70(p)(1)(2) |
| F557 | | Respect, Dignity/Right to have Personal Property | 483.10(e)(2) | 483.10 Resident Rights | | F252 | 483.10(e)(2) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F252 | 483.10(i)(1)(i)(ii) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F253 | 483.10(i)(2) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F254 | 483.10(i)(3) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F256 | 483.10(i)(5) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F257 | 483.10(i)(6) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F258 | 483.10(i)(7) |
| F635 | | Admission Physician Orders for Immediate Care | 483.20(a) | 483.20 Resident Assessments | | F271 | 483.20(a) |
| F636 | | Comprehensive Assessments & Timing | 483.20(b)(1)(2)(i)(iii) | 483.20 Resident Assessments | | F272 | 483.20(b)(1) |
| F636 | | Comprehensive Assessments & Timing | 483.20(b)(1)(2)(i)(iii) | 483.20 Resident Assessments | | F273 | 483.20(b)(2)(i) |
| F637 | | Comprehensive Assmt After Significant Change | 483.20(b)(2)(ii) | 483.20 Resident Assessments | | F274 | 483.20(b)(2)(ii) |
| F636 | | Comprehensive Assessments & Timing | 483.20(b)(1)(2)(i)(iii) | 483.20 Resident Assessments | | F275 | 483.20(b)(2)(iii) |
| F638 | | Quarterly Assessment At Least Every 3 Months | 483.20(c) | 483.20 Resident Assessments | | F276 | 483.20(c ) |
| F641 | | Accuracy of Assessments | 483.20(g) | 483.20 Resident Assessments | | F278 | 483.20(g) |
| F642 | | Coordination/Certification ofAssessment | 483.20(h)-(j) | 483.20 Resident Assessments | | F278 | 483.20(h)-(j) |
| F639 | | Maintain 15 Months of Resident Assessments | 483.20(d) | 483.20 Resident Assessments | | F279 | 483.20(d) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F656 | | Develop/Implement Comprehensive Care Plan | 483.21(b)(1) | 483.21 Comprehensive Resident Centered Care Plans | | F279 | 483.21(b)(1) |
| F553 | | Right to Participate in Planning Care | 483.10(c)(2)(3) | 483.10 Resident Rights | | F280 | 483.10(c)(2)(i)(ii)(iv)(v)(3)(i)-(iii) |
| F657 | | Care Plan Timing and Revision | 483.21(b)(2)(i)-(iii) | 483.21 Comprehensive Resident Centered Care Plans | | F280 | 483.21(b)(2)(i)-(iii) |
| F658 | | Services Provided Meet Professional Standards | 483.21(b)(3)(i) | 483.21 Comprehensive Resident Centered Care Plans | | F281 | 483.21(b)(3)(i) |
| F659 | | Qualified Persons | 483.21(b)(3)(ii)(iii) | 483.21 Comprehensive Resident Centered Care Plans | (b)(iii) - Phase 3 Will not be in ASPEN until Phase 3 | F282 | 483.21(b)(3)(ii) |
| F661 | | Discharge Summary | 483.21(c)(2)(i)-(iv) | 483.21 Comprehensive Resident Centered Care Plans | | F283 | 483.21(c)(2)(i)-(iii) |
| F660 | | Discharge Planning Process | 483.21(c)(1)(i)-(ix) | 483.21 Comprehensive Resident Centered Care Plans | | F284 | 483.21(c)(1)(i)-(ix) |
| F661 | | Discharge Summary | 483.21(c)(2)(i)-(iv) | 483.21 Comprehensive Resident Centered Care Plans | | F284 | 483.21(c)(2)(iv) |
| F644 | | Coordination of PASARR and Assessments | 483.20(e)(1)(2) | 483.20 Resident Assessments | | F285 | 483.20(e) |
| F645 | | PASARR Screening for MD & ID | 483.20(k)(1)-(3) | 483.20 Resident Assessments | | F285 | 483.20(k)(1)-(3) |
| F646 | | MD/ID Significant Change Notification | 483.20(k)(4) | 483.20 Resident Assessments | | F285 | 483.20(k)(4) |
| F639 | | Maintain 15 Months of Resident Assessments | 483.20(d) | 483.20 Resident Assessments | | F286 | 483.20(d) |
| F640 | | Encoding/Transmitting Resident Assessment | 483.20(f)(1)-(4) | 483.20 Resident Assessments | | F287 | 483.20(f)(1)-(4) |
| F675 | X | Quality of Life | 483.24 | 483.24 Quality of Life | | F309 | 483.24 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F684 | X | Quality of Care | 483.25 | 483.25 Quality of Care | | F309 | 483.25 |
| F697 | X | Pain Management | 483.25(k) | 483.25 Quality of Care | | F309 | 483.25(k) |
| F698 | X | Dialysis | 483.25(l) | 483.25 Quality of Care | | F309 | 483.25(l) |
| F744 | X | Treatment /Service for Dementia | 483.40(b)(3) | 483.40 Behavioral Health Services | | F309 | 483.40(b)(3) |
| F676 | X | Activities of Daily Living (ADLs)/ Maintain Abilities | 483.24(a)(1)(b)(1)-(5)(i)-(iii) | 483.24 Quality of Life | | F310 | 483.24(a)(b)(1)-(5)(i)-(iii) |
| F676 | X | Activities of Daily Living (ADLs)/ Maintain Abilities | 483.24(a)(1)(b)(1)-(5)(i)-(iii) | 483.24 Quality of Life | | F311 | 483.24(a)(1) |
| F677 | X | ADL Care Provided for Dependent Residents | 483.24(a)(2) | 483.24 Quality of Life | | F312 | 483.24(a)(2) |
| F685 | X | Treatment/Devices to Maintain Hearing/Vision | 483.25(a)(1)(2) | 483.25 Quality of Care | | F313 | 483.25(a)(1)-(2) |
| F686 | X | Treatment/Svcs to Prevent/HealPressure Ulcers | 483.25(b)(1)(i)(ii) | 483.25 Quality of Care | | F314 | 483.25(b)(1)(i)(ii) |
| F690 | X | Bowel/Bladder Incontinence, Catheter, UTI | 483.25(e)(1)-(3) | 483.25 Quality of Care | | F315 | 483.25(e)(1)-(3) |
| F688 | X | Increase/Prevent Decrease in ROM/Mobility | 483.25(c)(1)-(3) | 483.25 Quality of Care | | F317 | 483.25(c)(1) |
| F688 | X | Increase/Prevent Decrease in ROM/Mobility | 483.25(c)(1)-(3) | 483.25 Quality of Care | | F318 | 483.25(c)(2)(3) |
| F742 | X | Treatment/Svc for Mental/Psychosocial Concerns | 483.40(b)(1) | 483.40 Behavioral Health Services | | F319 | 483.40(b)(1) |
| F743 | X | No Pattern of Behavioral Difficulties Unless Unavoidable | 483.40(b)(2) | 483.40 Behavioral Health Services | | F320 | 483.40(b)(2) |
| F693 | X | Tube Feeding Management/Restore Eating Skills | 483.25(g)(4)(5) | 483.25 Quality of Care | | F322 | 483.25(g)(4)(5) |
| F689 | X | Free of Accident Hazards/Supervision/ Devices | 483.25(d)(1)(2) | 483.25 Quality of Care | | F323 | 483.25(d)(1)(2) |
| F700 | X | Bedrails | 483.25(n)(1)-(4) | 483.25 Quality of Care | | F323 | 483.25(n)(1)-(3) |
| F692 | X | Nutrition/Hydration Status Maintenance | 483.25(g)(1)-(3) | 483.25 Quality of Care | | F325 | 483.25(g)(1)(3) |
| F692 | X | Nutrition/Hydration Status Maintenance | 483.25(g)(1)-(3) | 483.25 Quality of Care | | F327 | 483.25(g)(2) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F687 | X | Foot Care | 483.25(b)(2)(i)(ii) | 483.25 Quality of Care | | F328 | 483.25(b)(2)(i)(ii) |
| F691 | X | Colostomy, Urostomy, or Ileostomy Care | 483.25(f) | 483.25 Quality of Care | | F328 | 483.25(f) |
| F694 | X | Parenteral/IV Fluids | 483.25(h) | 483.25 Quality of Care | | F328 | 483.25(h) |
| F695 | X | Respiratory/Tracheostomy care and Suctioning | 483.25(i) | 483.25 Quality of Care | | F328 | 483.25(i) |
| F696 | X | Prostheses | 483.25(j) | 483.25 Quality of Care | | F328 | 483.25(j) |
| F757 | X | Drug Regimen is Free From Unnecessary Drugs | 483.45(d)(1)-(6) | 483.45 Pharmacy Services | | F329 | 483.45(d) |
| F758 | X | Free from Unnec Psychotropic Meds/PRN Use | 483.45(c)(3)(e)(1)-(5) | 483.45 Pharmacy Services | | F329 | 483.45(e)(1)-(5) |
| F759 | X | Free of Medication Error Rates of 5% or More | 483.45(f)(1) | 483.45 Pharmacy Services | | F332 | 483.45(f)(1) |
| F760 | X | Residents Are Free of Significant Med Errors | 483.45(f)(2) | 483.45 Pharmacy Services | | F333 | 483.45(f)(2) |
| F883 | X | Influenza and Pneumococcal Immunizations | 483.80(d)(1)(2) | 483.80 Infection Control | | F334 | 483.80(d)(1)(2) |
| F725 | | Sufficient Nursing Staff | 483.35(a)(1)(2) | 483.35 Nursing Services | | F353 | 483.35(a)(1)(2) |
| F726 | | Competent Nursing Staff | 483.35(a)(3)(4)(c) | 483.35 Nursing Services | | F353 | 483.35(a)(3)(4) |
| F727 | | RN 8 Hrs/7 days/Wk, Full Time DON | 483.35(b)(1)-(3) | 483.35 Nursing Services | | F354 | 483.35(b)(1)-(3) |
| F731 | | Waiver-Licensed Nurses 24 Hr/Day and RN Coverage | 483.35(e)(1)-(7)(f)(1)(2) | 483.35 Nursing Services | | F355 | 483.35(e)(1)-(7)(f)(1)(2) |
| F732 | | Posted Nurse Staffing Information | 483.35(g)(1)-(4) | 483.35 Nursing Services | | F356 | 483.35(g)(1)-(4) |
| F800 | | Provided Diet Meets Needs ofEach Resident | 483.60 | 483.60 Food and Nutrition Services | | F360 | 483.60 |
| F801 | | Qualified Dietary Staff | 483.60(a)(1)(2) | 483.60 Food and Nutrition Services | | F361 | 483.60(a)(1)(2) |
| F802 | | Sufficient Dietary Support Personnel | 483.60(a)(3)(b) | 483.60 Food and Nutrition Services | | F362 | 483.60(a)(3)(b) |
| F803 | | Menus Meet Res Needs/Prep in Advance/Followed | 483.60(c)(1)-(7) | 483.60 Food and Nutrition Services | | F363 | 483.60(c )(1)-(7) |
| F804 | | Nutritive Value/Appear, Palatable/Prefer Temp | 483.60(d)(1)(2) | 483.60 Food and Nutrition Services | | F364 | 483.60(d)(1(2) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F805 | | Food in Form to Meet Individual Needs | 483.60(d)(3) | 483.60 Food and Nutrition Services | | F365 | 483.60(d)(3) |
| F806 | | Resident Allergies, Preferences and Substitutes | 483.60(d)(4)(5) | 483.60 Food and Nutrition Services | | F366 | 483.60(d)(4)(5) |
| F807 | | Drinks Avail to Meet Needs/ Preferences/ Hydration | 483.60(d)(6) | 483.60 Food and Nutrition Services | | F366 | 483.60(d)(6) |
| F808 | | Therapeutic Diet Prescribed by Physician | 483.60(e)(1)(2) | 483.60 Food and Nutrition Services | | F367 | 483.60(e)(1)(2) |
| F809 | | Frequency of Meals/Snacks at Bedtime | 483.60(f)(1)-(3) | 483.60 Food and Nutrition Services | | F368 | 483.60(f)(1)-(3) |
| F810 | | Assistive Devices - Eating Equipment/Utensils | 483.60(g) | 483.60 Food and Nutrition Services | | F369 | 483.60(g) |
| F812 | | Food Procurement, Store/Prepare/Serve - Sanitary | 483.60(i)(1)(2) | 483.60 Food and Nutrition Services | | F371 | 483.60(i)(1)(2) |
| F813 | | Personal Food Policy | 483.60(i)(3) | 483.60 Food and Nutrition Services | | F371 | 483.60(i)(3) |
| F814 | | Dispose Garbage & Refuse Properly | 483.60(i)(4) | 483.60 Food and Nutrition Services | | F372 | 483.60(i)(4) |
| F811 | | Feeding Asst - Training/Supervision/Resident | 483.60(h)(1)-(3) | 483.60 Food and Nutrition Services | | F373 | 483.60(h)(1)-(3) |
| F948 | | Training for Feeding Assistants | 483.95(h) | 483.95 Training Requirements | | F373 | 483.95(h) |
| F710 | | Resident's Care Supervised by a Physician | 483.30(a)(1)(2) | 483.30 Physician Services | | F385 | 483.30(a)(1)(2) |
| F711 | | Physician Visits- Review Care/Notes/Order | 483.30(b)(1)-(3) | 483.30 Physician Services | | F386 | 483.30(b)(1)-(3) |
| F712 | | Physician Visits- Frequency/Timeliness/Alternate NPPs | 483.30(c)(1)-(4) | 483.30 Physician Services | | F387 | 483.30(c)(1)(2) |
| F712 | | Physician Visits- Frequency/Timeliness/Alternate NPPs | 483.30(c)(1)-(4) | 483.30 Physician Services | | F388 | 483.30(c)(3)(4) |
| F713 | | Physician for Emergency Care, Available 24 Hours | 483.30(d) | 483.30 Physician Services | | F389 | 483.30(d) |
| F714 | | Physician Delegation of Tasks to NPP | 483.30(e)(1)(4)(f) | 483.30 Physician Services | | F390 | 483.30(e)(1)(4)(f) |
| F715 | | Physician Delegation to Dietitian/Therapist | 483.30(e)(2)(3) | 483.30 Physician Services | | F390 | 483.30(e)(2(3) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F825 | | Provide/Obtain Specialized Rehab Services | 483.65(a)(1)(2) | 483.65 Specialized Rehabilitative Services | | F406 | 483.65(a)(1)(2) |
| F826 | | Rehab Services- Physician Order/Qualified Person | 483.65(b) | 483.65 Specialized Rehabilitative Services | | F407 | 483.65(b) |
| F790 | | Routine/Emergency Dental Services in SNFs | 483.55(a)(1)-(5) | 483.55 Dental Services | | F411 | 483.55(a)(1)-(5) |
| F791 | | Routine/Emergency DentalServices in NFs | 483.55(b)(1)-(5) | 483.55 Dental Services | | F412 | 483.55(b)(1)-(5) |
| F755 | | Pharmacy Svcs/Procedures/Pharmacist /Records | 483.45(a)(b)(1)-(3) | 483.45 Pharmacy Services | | F425 | 483.45(a)(b)(1) |
| F756 | | Drug Regimen Review, Report Irregular, Act On | 483.45(c)(1)(2)(4)(5) | 483.45 Pharmacy Services | | F428 | 483.45(c)(1)(2)(4)(5) |
| F758 | X | Free from Unnec Psychotropic Meds/PRN Use | 483.45(c)(3)(e)(1)-(5) | 483.45 Pharmacy Services | | F428 | 483.45(c)(3) |
| F755 | | Pharmacy Svcs/Procedures/Pharmacist /Records | 483.45(a)(b)(1)-(3) | 483.45 Pharmacy Services | | F431 | 483.45(b)(2)(3) |
| F761 | | Label/Store Drugs & Biologicals | 483.45(g)(h)(1)(2) | 483.45 Pharmacy Services | | F431 | 483.45(g)-(h) |
| F880 | | Infection Prevention & Control | 483.80(a)(1)(2)(4)(e)(f) | 483.80 Infection Control | | F441 | 483.80(a)(1)(2)(4)€ |
| F915 | | Resident Room Window | 483.90(a)(7)(e)(1)(vi) | 483.90 Physical Environment | | F454 | 483.90(a)(7) |
| F906 | | Emergency Power | 483.90(c)(1)(2) | 483.90 Physical Environment | | F455 | 483.90(c)(1)(2) |
| F907 | | Space and Equipment | 483.90(d)(1) | 483.90 Physical Environment | | F455 | 483.90(d)(1) |
| F908 | | Essential Equipment, Safe Operating Condition | 483.90(d)(2) | 483.90 Physical Environment | | F456 | 483.90(d)(2) |
| F910 | | Resident Room | 483.90(e) | 483.90 Physical Environment | | F456 | 483.90(e) |
| F911 | | Bedroom Number of Residents | 483.90(e)(1))(i) | 483.90 Physical Environment | | F457 | 483.90(e)(1))(i) |
| F912 | | Bedrooms Measure at Least 80 Square Ft/Resident | 483.90(e)(1)(ii) | 483.90 Physical Environment | | F458 | 483.90(e)(1)(ii) |
| F913 | | Bedrooms Have Direct Access to Exit Corridor | 483.90(e)(1)(iii) | 483.90 Physical Environment | | F459 | 483.90(e)(1)(iii) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F914 | | Bedrooms Assure Full Visual Privacy | 483.90(e)(1)(iv)(v) | 483.90 Physical Environment | | F460 | 483.90(e)(1)(iv)(v) |
| F584 | X | Safe/Clean/Comfortable/ Homelike Environment | 483.10(i)(1)-(7) | 483.10 Resident Rights | | F461 | 483.10(i)(4) |
| F700 | X | Bedrails | 483.25(n)(1)-(4) | 483.25 Quality of Care | | F461 | 483.25(n)(4) |
| F909 | | Resident Bed | 483.90(d)(3) | 483.90 Physical Environment | | F461 | 483.90(d)(3) |
| F915 | | Resident Room Window | 483.90(a)(7)(e)(1)( vi) | 483.90 Physical Environment | | F461 | 483.90(e)(1)(vi) |
| F916 | | Resident Room Floor Above Grade | 483.90(e)(1)(vii) | 483.90 Physical Environment | | F461 | 483.90(e)(1)(vii) |
| F917 | | Resident Room Bed/Furniture/Closet | 483.10(i)(4) 483.90(e)(2)(3) | 483.10 Resident Rights 483.90 Physical Environment | | F461 | 483.10(i)(4) 483.90(e)(2)(3) |
| F918 | | Bedrooms Equipped/Near Lavatory/Toilet | 483.90(f) | 483.90 Physical Environment | | F462 | 483.90(f) |
| F919 | | Resident Call System | 483.90(g)(1)(2) | 483.90 Physical Environment | (g)(1)- Phase 3 Will not be in ASPEN until Phase 3 | F463 | 483.90(g)(1)(2) |
| F920 | | Requirements for Dining and Activity Rooms | 483.90(h)(1)-(4) | 483.90 Physical Environment | | F464 | 483.90(h)(1)-(4) |
| F921 | | Safe/Functional/Sanitary/ Comfortable Environment | 483.90(i) | 483.90 Physical Environment | | F465 | 483.90(i) |
| F922 | | Procedures to Ensure Water Availability | 483.90(i)(1) | 483.90 Physical Environment | | F466 | 483.90(i)(1) |
| F923 | | Ventilation | 483.90(i)(2) | 483.90 Physical Environment | | F467 | 483.90(i)(2) |
| F924 | | Corridors Have Firmly Secured Handrails | 483.90(i)(3) | 483.90 Physical Environment | | F468 | 483.90(i)(3) |
| F925 | | Maintains Effective Pest Control Program | 483.90(i)(4) | 483.90 Physical Environment | | F469 | 483.90(i)(4) |
| F835 | | Administration | 483.70 | 483.70 Administration | | F490 | 483.70 |
| F836 | | License/Comply w/Fed/State/Local Law/Prof Std | 483.70(a)-(c) | 483.70 Administration | | F491 | 483.70(a) |
| F836 | | License/Comply w/Fed/State/Local Law/Prof Std | 483.70(a)-(c) | 483.70 Administration | | F492 | 483.70(b)(c) |
| F837 | | Governing Body | 483.70(d)(1)-(3) | 483.70 Administration | (d)(3) - Phase 3 Will not be in ASPEN until Phase 3 | F493 | 483.70(d)(1)-(3) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F728 | | Facility Hiring and Use of Nurse Aide | 483.35(d)(1)-(3) | 483.35 Nursing Services | | F494 | 483.35(d)(1)(2) |
| F728 | | Facility Hiring and Use of Nurse Aide | 483.35(d)(1)-(3) | 483.35 Nursing Services | | F495 | 483.35(d)(3) |
| F729 | | Nurse Aide Registry Verification, Retraining | 483.35(d)(4)-(6) | 483.35 Nursing Services | | F496 | 483.35(d)(4)-(6) |
| F730 | | Nurse Aide Perform Review – 12 Hr/Year In- service | 483.35(d)(7) | 483.35 Nursing Services | | F497 | 483.35(d)(7) |
| F726 | | Competent Nursing Staff | 483.35(a)(3)(4)(c) | 483.35 Nursing Services | | F498 | 483.35(c) |
| F947 | | Required In-Service Training for Nurse Aides | 483.95(g)(1)-(4) | 483.95 Training Requirements | | F498 | 483.95(g)(1)-(4) |
| F839 | | Staff Qualifications | 483.70(f)(1)(2) | 483.70 Administration | | F499 | 483.70(f)(1)(2) |
| F840 | | Use of Outside Resources | 483.70(g)(1)(2) | 483.70 Administration | | F500 | 483.70(g)(1)(2)(i)(ii) |
| F841 | | Responsibilities of Medical Director | 483.70(h)(1)(2) | 483.70 Administration | | F501 | 483.70(h)(1)(2) |
| F770 | | Laboratory Services | 483.50(a)(1)(i) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F502 | 483.50(a)(1) |
| F771 | | Blood Blank and Transfusion Services | 483.50(a)(1)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F502 | 483.50(a)(1) |
| F770 | | Laboratory Services | 483.50(a)(1)(i) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F503 | 483.50(a)(i) |
| F771 | | Blood Blank and Transfusion Services | 483.50(a)(1)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F503 | 483.50(a)(ii) |
| F772 | | Lab Services Not Provided On-Site | 483.50(a)(1)(iv) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F503 | 483.50(a)(iv) |
| F773 | | Lab Svs Physician Order/Notify of Results | 483.50(a)(2)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F504 | 483.50(a)(2)(i) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F773 | | Lab Svs Physician Order/Notify of Results | 483.50(a)(2)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F505 | 483.50(a)(2)(ii) |
| F774 | | Assist with TransportArrangements to Lab Svcs | 483.50(a)(2)(iii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F506 | 483.50(a)(2)(iii) |
| F775 | | Lab Reports in Record-Lab Name/Address | 483.50(a)(2)(iv) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F507 | 483.50(a)(2)(iv) |
| F776 | | Radiology/Other Diagnostic Services | 483.50(b)(1)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F508 | 483.50(b)(1) |
| F776 | | Radiology/Other Diagnostic Services | 483.50(b)(1)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F509 | 483.50(b)(i)(ii) |
| F777 | | Radiology/Diag. Svcs Ordered/Notify Results | 483.50(b)(2)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F510 | 483.50(b(2)(i) |
| F777 | | Radiology/Diag. Svcs Ordered/Notify Results | 483.50(b)(2)(i)(ii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F511 | 483.50(b)(2)(ii) |
| F778 | | Assist with Transport Arrangements to Radiology | 483.50(b)(2)(iii) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F512 | 483.50(b)(2)(iii) |
| F779 | | X-Ray/Diagnostic Report in Record-Sign/Dated | 483.50(b)(2)(iv) | 483.50 Laboratory, Radiology, and Other Diagnostic Services | | F513 | 483.50(b)(2)(iv) |
| F842 | | Resident Records - Identifiable Information | 483.20(f)(5) 483.70(i)(1)-(5) | 483.20 Resident Assessments 483.70 Administration | | F514 | 483.70(i)1)(5) |
| F842 | | Resident Records - Identifiable Information | 483.20(f)(5) 483.70(i)(1)-(5) | 483.20 Resident Assessments 483.70 Administration | | F515 | 483.70(i)(4)(i)-(iii) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F842 | | Resident Records - Identifiable Information | 483.20(f)(5) 483.70(i)(1)-(5) | 483.20 Resident Assessments 483.70 Administration | | F516 | 483.20(f)(5); 483.70(i)(3) |
| F843 | | Transfer Agreement | 483.70(j)(1)(2) | 483.70 Administration | | F519 | 483.70(j)(1)(2) |
| F865 | | QAPI Program/Plan, Disclosure/Good Faith Attempt | 483.75(a)(b)(f)(h)(i) | 483.75 Quality Assurance and Performance Improvement | (a)(1)(3)(4)(b)(f) - Phase 3 Will not be in ASPEN until Phase 3 | F520 | 483.75(a)(2)(h)(i) |
| F866 | | QAPI/QAA Data Collection and Monitoring | 483.75(c)(1)-(4) | 483.75 Quality Assurance and Performance Improvement | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | F520 | 483.75(c)(1)-(4) |
| F867 | | QAPI/QAA Improvement Activities | 483.75(d)(1)(2)(e)(1)-(3)(g)(2) | 483.75 Quality Assurance and Performance Improvement | (d)(1)(2)(i)-(iii)(e)(1)-(3)(g)(2)(iii) will not be in ASPEN until Phase 3 | F520 | 483.75(g)(2)(ii) |
| F868 | | QAA Committee | 483.75(g)(1)(i)-(iv)(2)(i) | 483.75 Quality Assurance and Performance Improvement | (g)(1)(iv) - Phase 3 Will not be in ASPEN until Phase 3 | F520 | 483.75(g)(1)(i)-(iii)(2)(i) |
| F844 | | Disclosure of Ownership Requirements | 483.70(k)(1)-(3) | 483.70 Administration | | F522 | 483.70(k)(1)-(3) |
| F845 | | Facility closure-Administrator | 483.70(l)(1)-(3) | 483.70 Administration | | F523 | 483.70(l)(1)-(3) |
| F846 | | Facility closure | 483.70(m) | 483.70 Administration | | F524 | 483.70(m) |
| F849 | | Hospice Services | 483.70(o)(1)-(4) | 483.70 Administration | | F526 | 483.70(o)(1)-(4) |
| F851 | | Payroll Based Journal | 483.70(q)(1)-(5) | 483.70 Administration | | F527 | 483.70(q)(1)-(5) |
| F608 | X | Reporting of Reasonable Suspicion of a Crime | 483.12(b)(5)(i)-(iii) | 483.12 Freedom from Abuse, Neglect, and Exploitation | | | No Associated Tag |
| F655 | | Baseline Care Plan | 483.21(a)(1)-(3) | 483.21 Comprehensive Resident Centered Care Plans | | | No Associated Tag |
| F699 | X | Trauma Informed Care | 483.25(m) | 483.25 Quality of Care | Entire tag - Phase 3Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F740 | | Behavioral Health Services | 483.40 | 483.40 Behavioral Health Services | | | No Associated Tag |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| F741 | | Sufficient/Competent Staff-Behave Health Needs | 483.40(a)(1)(2) | 483.40 Behavioral Health Services | | | No Associated Tag |
| F838 | | Facility Assessment | 483.70(e)(1)-(3) | 483.70 Administration | | | No Associated Tag |
| F881 | | Antibiotic Stewardship Program | 483.80(a)(3) | 483.80 Infection Control | | | No Associated Tag |
| F882 | | Infection Preventionist Qualifications/Role | 483.80(b)(1)-(4)(c) | 483.80 Infection Control | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F895 | | Compliance and Ethics Program | 483.85(a)-(e) | 483.85 Compliance and Ethics Program | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F926 | | Smoking Policies | 483.90(i)(5) | 483.90 Physical Environment | | | No Associated Tag |
| F940 | | Training Requirements - General | 483.95 | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F941 | | Communication Training | 483.95(a) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F942 | | Resident's Rights Training | 483.95(b) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F944 | | QAPI Training | 483.95(d) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F945 | | Infection Control Training | 483.95(e) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F946 | | Compliance and Ethics Training | 483.95(f)(1)(2) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |
| F949 | | Behavioral Health Training | 483.95(i) | 483.95 Training Requirements | Entire tag - Phase 3 Will not be in ASPEN until Phase 3 | | No Associated Tag |

PLACE TAB FOR DEFINITIONS HERE

**POLICY/PROCEDURE**

**SUBJECT:** Definitions

**DATE:**

**INTENT:**

It is the policy of the facility to accept the following definitions as described by the Center for Medicare and Medicaid Services into the policies and procedures outlined within this manual.

**DEFINITIONS:**

As used in this subpart, the following definitions apply:

**Abuse** - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

**Adverse event** - An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

**Common area** - Common areas are areas in the facility where residents may gather together with other residents, visitors, and staff or engage in individual pursuits, apart from their residential rooms. This includes but is not limited to living rooms, dining rooms, activity rooms, outdoor areas, and meeting rooms where residents are located on a regular basis.

**Composite distinct part** -

1. Definition - A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in §413.65(a)(2) of this chapter.
2. Requirements - In addition to meeting the requirements of specified in the definition of “distinct part” of this section, a composite distinct part must meet all of the following requirements:
    a. A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.

b. If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care. If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.
c. To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.
d. To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.
e. *Use of composite distinct parts to segregate residents by payment source or on a basis other than care needs is prohibited.*

**Distinct part** -

1. Definition - A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (2) of this definition, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term “distinct part” also includes a composite distinct part that meets the additional requirements specified in the definition of “composite distinct part” of this section.
2. Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:
    a. The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:
        i. The SNF or NF is wholly owned by the institution of which it is a distinct part.
        ii. The SNF or NF is subject to the by-laws and operating decisions of common governing body.

iii. The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.
iv. The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.

b. The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part.
c. The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.
d. The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.
e. A single institution can have a maximum of only one distinct part SNF and one distinct part NF.
f. (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.
(B)The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI) are met for approval, and cannot be made retroactive.
(C)The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

**Exploitation** - Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

**Facility defined** - For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of section s1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in §440.40 and §440.155 of this chapter), but does not include an institution for individuals with intellectual disabilities or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, and NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in §435.1010 of this chapter.

**Fully sprinklered** - A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.

**Licensed health professional -** A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.

**Major modification** - A modification means the modification of more than 50 percent, or more than 4,500 square feet, of the smoke compartment.

**Misappropriation of resident property** - means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

**Mistreatment** - means inappropriate treatment or exploitation of a resident.

**Neglect** - is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

**Nurse aide** - A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.

**Person-centered care** - For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

**Resident representative** - For purposes of this subpart, the term resident representative means any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

**Sexual abuse** - is non-consensual sexual contact of any type with a resident.

**Transfer and discharge** - includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

**PLACE TAB FOR RESIDENT RIGHTS HERE**

**POLICY/PROCEDURE**

**SUBJECT:** Resident Rights

**DATE:**

**INTENT:**

All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input.

**PROCEDURE:**

This policy will include:

1. Resident Rights/Exercise of Rights
2. Rights exercised by representative
3. Right to be Informed/Make Treatment Decisions
4. Right to Participate in Planning Care
5. Resident Self-Admin Meds-Clinically Appropriate
6. Right to Choose/Be Informed of Attending Physician
7. Respect, Dignity/Right to have Personal Property
8. Reasonable Accommodations of Needs/Preferences
9. Choose/Be Notified of Room/Roommate Change
10. Right to Refuse Certain Transfers
11. Self Determination
12. Immediate Access to Resident
13. Right to Receive/Deny Visitors
14. Inform of Visitation Rights/Equal Visitation Privileges
15. Resident/Family Group and Response
16. Right to Perform Facility Services or Refuse
17. Protection/Management of Personal Funds
18. Accounting and Records of Personal Funds
19. Notice and Conveyance of Personal Funds
20. Surety Bond - Security of Personal Funds
21. Limitations on Charges to Personal Funds
22. Notice of Rights and Rules
23. Right to Access/Purchase Copies of Records
24. Required Notices and Contact Information
25. Required Postings

26. Right to Forms of Communication with Privacy
27. Right to Survey Results/Advocate Agency Info
28. Request/Refuse/Discontinue Treatment; Formulate Advance Directives
29. Posting/Notice of Medicare/Medicaid on Admission
30. Notify of Changes (Injury/Decline/Room, Etc.)
31. Medicaid/Medicare Coverage/Liability Notice
32. Personal Privacy/Confidentiality of Records
33. Safe/Clean/Comfortable/ Homelike Environment
34. Grievances
35. Resident Contact with External Entities

**POLICY/PROCEDURE**

**SUBJECT:** Resident Rights - Exercise of Rights

**DATE:**

**INTENT:**

All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input.

**PROCEDURE:**

1. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
2. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.
3. The facility will protect and promote the rights of the resident.
4. The facility will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.
5. The facility will establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.
6. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
7. The facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
8. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.
9. Each resident will be treated with dignity and respect.
10. All activities and interactions with residents by any staff, temporary agency staff or volunteers will focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices.
11. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Rights - Resident Exercise by Representative

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. When and where the resident has been deemed incapacitated or adjudicated incompetent in a court of law, the Resident Representative will be afforded the same right to exercise the resident's rights on behalf of the resident.

**DEFINITIONS:**

**Court of competent jurisdiction** - means any court with the authority to hear and determine a case or suit with the matter in question.
**Resident representative** - For purposes of this subpart, the term resident representative may mean any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

**PROCEDURE:**

1. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
    a. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.

b. The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

2. The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
3. The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.
4. If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.
5. In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
    a. In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
    b. The resident's wishes and preferences must be considered in the exercise of rights by the representative.
    c. To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right To Be Informed and Make Treatment Decisions

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**DEFINITIONS:**

**Total Health Status** -Total health status includes functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

**Treatment** - Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.

**PROCEDURE:**

The resident has the right to be informed of, and participate in, his or her treatment, including:

1. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
2. The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
3. The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Participate in Planning Care

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

1. The resident's right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
    a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
    b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
    c. The right to be informed, in advance, of changes to the plan of care.
    d. The right to receive the services and/or items included in the plan of care.
    e. The right to see the care plan, including the right to sign after significant changes to the plan of care.

1. The facility will inform the resident of the right to participate in his or her treatment and shall support the resident in this right.

2. The planning process will:
    a. Facilitate the inclusion of the resident and/or resident representative.
    b. Include an assessment of the resident's strengths and needs.
    c. Incorporate the resident's personal and cultural preferences in developing goals of care.

3. The facility staff will facilitate and document in the resident's clinical record, the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Self Administration of Meds – Clinically Appropriate

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident and or legal representative of the resident the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate.

**PROCEDURE:**

1. The resident has right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.
2. When a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) to determine that it is safe before the resident exercises that right.
3. A resident may only self-administer medications after the IDT has determined which medications may be self-administered.
4. When determining if self-administration is clinically appropriate for a resident, the IDT will at a minimum consider the following:
    a. The medications appropriate and safe for self-administration;
    b. The resident's physical capacity to swallow without difficulty and to open medication bottles;
    c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;
    d. The resident's capability to follow directions and tell time to know when medications need to be taken;
    e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
    f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.
    g. The resident's ability to ensure that medication is stored safely and securely.
5. Appropriate notation of these determinations will be documented in the resident's medical record and care plan.

**PROCEDURE**

**SUBJECT:** Self-Administration of Medication Program

**DATE:**

**POLICY:**

It is the policy of the facility to allow the resident and or legal representative of the resident the right to self-administer medication when it has been deemed by the interdisciplinary team that it is clinically appropriate.

**PROCEDURE:**

1. The facility will allow the resident to self-administer drugs if the interdisciplinary team, has determined that this practice is safe.

2. The admitting Nurse will ask the resident and or responsible party, if they are interested in participating in the Self-Administration of Medication Program.

3. When the resident and or responsible party requests to participate in the program, the admitting Nurse will inform the resident's Interdisciplinary Team (IDT).

4. The IDT may consist of: The Director of Nursing or designee, Unit Manager; of which the resident resides, the MDS/Care Plan Coordinator, an Occupational Therapist, a Speech Therapist, the Social Service Director, the resident's physician or physician extender, any other staff members the team deems appropriate.

5. If a resident requests to self-administer drugs, it is the responsibility of the IDT to determine that it is safe for the resident to self-administer drugs, before the resident may exercise that right.

6. When determining if self-administration is clinically appropriate for a resident, the IDT will at a minimum consider the following:
    h. The medications appropriate and safe for self-administration;
    i. The resident's physical capacity to swallow without difficulty and to open medication bottles;
    j. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;
    k. The resident's capability to follow directions and tell time to know when medications need to be taken;
    l. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
    m. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.

n. The resident's ability to ensure that medication is stored safely and securely.

7. The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report the findings to the Unit Manager or designee.

8. The interdisciplinary team must also determine:
    a. Who will be responsible (the resident or the nursing staff) for storage (See F431); If medications are stored at the resident's bedside, a lockbox or locked drawer must be used to store the medication(s);
    b. Who will be responsible (the resident or the nursing staff) for documentation of the administration of drugs; If the resident is responsible for documentation, maintain a Medication Administration Record (MAR) in the resident's room for the resident to sign and maintain a duplicate MAR for nursing staff; as well as,
    c. The location of the drug administration (e.g., resident's room, nurses' station, or activities room).

9. Once the resident has been deemed safe by the IDT an order will be obtained from the resident's physician or physician extender listing the medication(s) that may be self-administered, where the medications will be stored, who will be responsible for documentation and the location of administration.

10. Appropriate documentation of the above determinations will be documented in the resident's care plan.

11. The resident will be monitored every shift for the first three days for compliance to the program, with written documentation by the nurse noting findings. If further every-shift monitoring is needed, it will be brought to the attention of the Unit Manager, who will then inform the IDT and report concerns. If compliance is noted within the first three days, then daily documentation will be completed by the 3 – 11 shift nurses for the remaining four days of the first week.

12. Weekly documentation will occur after the first week for the next two weeks by the 3-11 shift nurses, followed periodic monitoring.

13. The decision that a resident has the ability to self-administer medication(s) is subject to periodic re-evaluation based on change in the resident's status.

14. The resident will be re-evaluated on their ability to continue to self-administer medications in conjunction with the resident assessment instrument.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Choose/Be Informed of Attending Physician

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

1. The resident has the right to choose his or her attending physician.
2. The physician must be licensed to practice, and
3. If the physician chosen by the resident refuses to or does not meet visitation requirements, the facility may seek alternate physician participation to assure provision of appropriate and adequate care and treatment.
4. The facility will ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.
5. The facility will inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment.
6. The facility will discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.
7. If the resident subsequently selects another attending physician who meets the requirements, the facility will honor that choice.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Respect, Dignity/Right to have Personal Property

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

1. The resident has a right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Reasonable Accommodations of Needs/Preferences

**DATE:**

**INTENT:**

It is the policy of the facility to accommodate the needs and preferences of the resident that are essential to creating an individualized, home-like environment..

**PROCEDURE:**

1. The resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Choose/Be Notified of Room/Roommate Change

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident and or their legal representative the right to choose a roommate, be notified of room changes as well as roommate changes in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The resident has:

1. The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
2. The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
3. The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility changes.
4. The right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements will include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Refuse Certain Transfers

**DATE:**

**INTENT:**

It is the policy of the facility to protect resident's right to refuse certain transfers in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The resident has the right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
   a. to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
   b. to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
   c. solely for the convenience of staff.

2. A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Self Determination

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

1. The resident has the right to and the facility will promote and facilitate resident self-determination through support of resident choice, including but not limited to the following:
    a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.
    b. The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.
    c. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
    d. The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Immediate Access to Resident

**DATE:**

**INTENT:**

It is the policy of the provide access to the resident in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The facility must provide immediate access to any resident by:
    a. Any representative of the Secretary,
    b. Any representative of the State,
    c. Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.),
    d. The resident's individual physician,
    e. Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq),
    f. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and
    g. The resident representative.

**POLICY/PROCEDURE**

**SUBJECT:** Visitation

**DATE:**

**INTENT:**

It is the policy of the facility to comply with state and federal law as to visitation and access to residents.

**PROCEDURE:**

1. This facility will permit residents to receive visitors of his or her own choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

2. The facility will provide immediate access to any resident by:
    a. Any representative of the Secretary of HHS;
    b. Any representative of the State of Florida;
    c. Any representative of the Office of the State Long Term Care Ombudsman;
    d. The resident's physician;
    e. Any representative of the protection and advocacy systems, as designated by the State of Florida, and as established under the Developmental Disabilities Assistance and Bill of rights of 2000;
    f. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000;
    g. The resident representative; or
    h. Immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.

3. The facility will provide immediate to others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to withdraw or deny consent at any time:
    a. The clinically necessary reasons for denying access include infectious outbreaks that could potentially affect the public.
    b. The reasonable safety restrictions for denying access include internal or external disasters.
    c. Other reasonable restrictions are subject to the decisions of Administration where the health and or safety of our residents, staff or the public could be compromised.

4. This facility will provide reasonable access to a resident by any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

5. Each resident and/or resident representative shall receive a copy of this facility's policies and procedures for visitation as set out herein.

6. Each resident will be informed as to the restrictions set out in section 3 herein, the reasons for each and to whom they will apply.

7. Each resident will be informed of the right, subject to his or her consent, to receive visitors whom he or she designates, including, but not limited to, a spouse (including a same sex spouse), a domestic partner (including a same sex domestic partner) a family member, or a friend and the right to withdraw consent at any time.

8. This facility will not restrict, limit or otherwise deny any visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.

9. Visitors may enjoy full and equal visitation privileges consistent with resident preference.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Inform of Visitation Rights/Equal Visitation Privileges

**DATE:**

**INTENT:**

It is the policy of the facility to inform residents and resident representatives of visitation rights and privileges in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The facility will meet the following requirements:

1. Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.

2. Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

3. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

4. Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Resident/Family Group and Response

**DATE:**

**INTENT:**

It is the policy of the facility to encourage and assist the resident to organize and participate in resident groups within the facility in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The resident has a right to organize and participate in resident groups in the facility.

1. The facility will provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
2. Staff, visitors, or other guests will attend resident group or family group meetings only at the respective group's invitation.
3. The facility will provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
4. The facility will consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
    a. The facility will be able to demonstrate their response and rationale for such response.
    b. This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.
5. The resident has a right to participate in family groups.
6. The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Perform Facility Services or Refuse

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

1. The resident has a right to choose or refuse to perform services for the facility and the facility will not require a resident to perform services for the facility.

2. The resident may perform services for the facility, if he or she chooses, when:
    a. The facility has documented the resident's need or desire for work in the plan of care;
    b. The plan specifies the nature of the services performed and whether the services are voluntary or paid;
    c. Compensation for paid services is at or above prevailing rates; and
    d. The resident agrees to the work arrangement described in the plan of care.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Protection/Management of Personal Funds

**DATE:**

**INTENT:**

It is the policy of the facility to protect and manage the personal funds of the resident in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.

1. The facility will not require residents to deposit their personal funds with the facility.
2. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility will act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.

Deposit of Funds.

1. The facility will deposit any residents' personal funds in excess of $100 in an interest bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account.
2. There will be a separate accounting for each resident's share. The facility will maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

Residents whose care is funded by Medicaid:

1. The facility will deposit the residents' personal funds in excess of $50 in an interest bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account.
2. There will be a separate accounting for each resident's share. The facility will maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Accounting and Records of Personal Funds

**DATE:**

**INTENT:**

It is the policy of the facility to protect and manage the personal funds of the resident in such a manner to acknowledge and respect resident rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

**PROCEDURE:**

Accounting and Records.

1. The facility will establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.
2. The system will preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.
3. The individual financial record will be available to the resident through quarterly statements and upon request.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Notice and Conveyance of Personal Funds

**DATE:**

**INTENT:**

It is the policy of the facility to protect the resident's personal funds in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

Notice of certain balances.

The facility will notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, and
2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person; the resident may lose eligibility for Medicaid or SSI.

Conveyance upon discharge, eviction, or death.

Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Surety Bond - Security of Personal Funds

**DATE:**

**INTENT:**

It is the policy of the facility to protect the resident's personal funds in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

Assurance of financial security.

The facility will purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Limitation on Charges to Personal Funds

**DATE:**

**INTENT:**

It is the policy of the facility to limit charges to personal funds in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The facility will not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

2. The facility may charge the resident for requested services that are more expensive than or in excess of covered services.

3. During the course of a covered Medicare or Medicaid stay, the facility will not charge a resident for the following categories of items and services:
    a. Nursing services,
    b. Food and Nutrition services,
    c. An activities program,
    d. Room/bed maintenance services,
    e. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry,
    f. Medically-related social services,
    g. Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

4. Items and services that may be charged to residents' funds are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

a. Telephone, including a cellular phone,
b. Television/radio, personal computer or other electronic device for personal use,
c. Personal comfort items, including smoking materials, notions and novelties, and confections,
d. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare,
e. Personal clothing,
f. Personal reading matter,
g. Gifts purchased on behalf of a resident,
h. Flowers and plants,
i. Cost to participate in social events and entertainment outside the scope of the activities program,
j. Non-covered special care services such as privately hired nurses or aides,
k. Private room, except when therapeutically required (for example, isolation for infection control), and
l. Specially prepared or alternative food requested instead of the food and meals generally prepared by the facility.

5. The facility will not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist.

6. The facility will only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.

7. The facility will not require a resident to request any item or service as a condition of admission or continued stay.

8. The facility will inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Notice of Rights and Rules

**DATE:**

**INTENT:**

It is the policy of the facility to inform its residents and resident in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

Information and Communication.

1. The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
2. The facility will provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.
3. The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.
4. The facility will also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.
5. Receipt of such information, and any amendments to it, must be acknowledged in writing.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Access/Purchase Copies of Records

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident access to personal and medical records pertaining to the resident in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The resident has the right to access personal and medical records pertaining to him or herself.

1. The facility will provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and
2. The facility will allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:
    a. Labor for copying the records requested by the individual, whether in paper or electronic form;
    b. Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and
    c. Postage, when the individual has requested the copy be mailed.
3. The facility will ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Required Notices and Contact Information

**DATE:**

**INTENT:**

It is the policy of the facility to inform its residents and resident in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

1. The facility will furnish to each resident a written description of legal rights which includes:
   a. A description of the manner of protecting personal funds.
   b. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
   c. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
   d. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

2. Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)

3. Information regarding Medicare and Medicaid eligibility and coverage;

4. Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
5. Contact information for the Medicaid Fraud Control Unit; and
6. Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Required Postings

**DATE:**

**INTENT:**

It is the policy of the facility to inform its residents and resident in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

1. A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

2. A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Forms of Communication with Privacy

**DATE:**

**INTENT:**

It is the policy of the facility to allow access to a phone and privacy when making those phone calls in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

2. The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:
   a. A telephone, including TTY and TDD services;
   b. The internet, to the extent available to the facility; and
   c. Stationery, postage, writing implements and the ability to send mail.

3. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
   a. Privacy of such communications consistent with this section; and
   b. Access to stationery, postage, and writing implements at the resident's own expense.

4. The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
   a. If the access is available to the facility
   b. At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
   c. Such use must comply with State and Federal law.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Right to Survey Results/Advocate Agency Info

**DATE:**

**INTENT:**

It is the policy of the facility to inform its residents of Survey Results and Advocate Agencies in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The resident has the right to:

1. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and
2. Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

The facility will:

1. Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.
2. Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and
3. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
4. The facility shall not make available identifying information about complainants or residents.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Request/Refuse/Discontinue Treatment

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident to be informed and made aware of the risks, benefits, and procedures to be used in providing treatment as well as alternatives, if any, and to give informed consent or refuse treatment. This includes the institution of the treatment and the continued application of treatment. The term treatment as used herein includes treatments, services and medications.

**PROCEDURE:**

1. While the resident* can consent to or refuse treatment, the resident does not have the right to receive the provision of medical treatment, medications or medical services deemed medically unnecessary or inappropriate.
2. Prior to changing medication, services or treatment, get informed consent, and document in the resident's clinical record. If the individual is unable to give informed consent, then notification is given the resident's representative. Once he or she is able to receive such information it will then be provided to the individual directly at the appropriate time.
3. If a resident refuses medication or treatment, the facility will notify the resident or the resident's legal representative of the consequences of such a decision and must document the resident's decision in his or her medical record. The facility will continue to provide other services the resident agrees to in accordance with the resident's care plan.
4. If a resident’s refusal of treatment brings about a significant change, the facility will reassess the resident and institute care planning changes.

*The term resident includes the individual with the legal right to make medical decisions on behalf of the resident.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Refusal of Experimental Research

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident the right to participate or to refuse to participate in Experimental Research.

**PROCEDURE:**

1. The resident has the right to refuse to participate in experimental research.
2. When the resident chooses to participate in Experimental Research those programs have protocols that the facility would have to adopt.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Advanced Directive Tracking Program

**DATE:**

**INTENT:**

It is the policy of the facility to honor the advance directives of all residents and to make information available to the resident on how to prepare such directives, should the resident not have them in place or to change existing directives.

**PROCEDURE:**

1. During the admission process the Social Services Director or designee will discuss with each resident and/or the person accompanying the resident the following:
   a. Whether they have an advance directive such as a health care surrogate designation, living will or durable power of attorney?
   b. Whether they have a Uniform Do Not Resuscitate form?
   c. If so, is it printed on yellow (goldenrod) paper?
   d. If they have those forms with them? If so, secure copies.
   e. If not, inquire as to where the documents can be found.
   f. If they are in the possession of a third party (this may be the doctor, family member, friend or the like) get contact information for that party and contact him/her as quickly as possible to get a copy.
   g. If the resident is capable of executing an advance directive and does not have a living will, health care surrogate designation and/ or yellow DNRO ask if he/she would be interested in preparing one. Staff cannot prepare Durable Powers of Attorney. These must be prepared by an attorney or someone at an attorney's direction.

2. The resident and or the person accompanying them will be given a copy, of the advance directives information, including the forms used by the facility, whether they have completed advance directives or not. The resident or the person accompanying them should sign that they have received this information.

3. Upon receipt of the advanced directive forms, copies will be made for the resident's clinical record and will be scanned into the electronic medical record under the Advance Directives Tab. Copies should not be made on goldenrod or yellow paper except for the Uniform Do Not Resuscitate Order.

4. Social Services or the appropriate designee will carefully review any and all advanced directive related documents to ensure that the information is complete and that the requirements of the law are met. If there is a question it is the responsibility of the reviewer to seek clarification.

5. Social Services or the appropriate designee should visit the resident and discuss advance directives with them to ensure that he/she has executed the advance directives that he/she would want.

6. Social Services should also ensure that information was given to the resident on admission. Social Services will advise the resident that at any time he/she may amend, revoke or write a new advance directive and staff will assist. If no advance directives were desired, explain that this is a resident right and the resident is not required to prepare an advance directive to stay in the facility. Explanation of this and resident's response should also be documented in the clinical record.

7. If there is no designation of a health care surrogate and the resident indicates that they do not wish to name one, social services should explain the proxy statute and inquire of the resident as to who is available under the proxy statute and how to contact that person or those people. This should be documented accordingly.

8. The individual who visited the resident as described in # 5, 6, and 7. Should document this conversation in the resident's social services notes.

9. Record-keeping:
    a. The Advance Directives, such as Living Will, Healthcare Surrogate, Durable Power of Attorney, shall be placed in the resident's record under the Advance Directive Tab and shall remain there throughout his/her stay.
    b. When the resident has a Do Not Resuscitate Order, place the original DNRO directly behind the front cover of the medical record in a plastic sleeve with additional copies, so that it is the first document you see when you open the chart.
    c. A copy shall be scanned into the resident's electronic medical record and stored under the Advance Directives Tab.

10. Training on advanced directives will be provided to health care staff during initial orientation and will be incorporated in the facility's annual education plan. This training will include the types and meaning of advanced directives and the current applicable laws. Staff will also be trained that residents may revoke or amend their advance directives so long as they are capable and should report to the charge nurse if any resident expresses a desire to do so in their presence.

11. Nursing and the interdisciplinary team (IDT) shall be aware that in the event that a resident is determined incapable of making medical decisions by their attending physician (in some cases when there is a question of capacity, a second doctor must be consulted), the nursing department shall notify the person named as the surrogate and get a written acknowledgement of that person's agreement to do so. If nursing or IDT staff believe that a resident is not capable of making medical decisions but has not been declared so by their attending physician, that nurse should notify the physician of this concern and ask for an examination of the resident. If the physician does not respond promptly, the medical director should be notified.

12. If a health care surrogate has been named nurses should contact that person about any medical decisions, changes in condition and care plan changes of that resident. Surrogate should be invited to care plan meetings.

13. If there is no surrogate but a proxy has been appointed that proxy shall be contacted as would be the surrogate.

14. Proxies and surrogates may make the same decisions except that when a life prolonging procedure is implicated the proxy must show the resident's wishes by clear and convincing evidence. If the wishes are not known the proxy should consult with the physician to ensure that the decision being made is in the best interest of the resident.

15. A resident who has not been determined incapable of making medical decisions and who appears to understand enough information to make care decisions should be permitted to do so. This does not relieve the nurse of contacting the physician if the resident appears unable to make medical decisions.

16. The determination of incapacity to make medical decisions does not mean that the resident is incapable of making other decisions.

17. All residents who wish to have resuscitation withheld should have a physician's order in their medical record. The goldenrod uniform Do Not Resuscitate Order is a physician's order if properly completed. Additionally, when a uniform Do Not Resuscitate Order is obtained and completed, the nurse responsible for that resident will obtain an order in the electronic medical record.

18. In the event that a resident experiences cardiopulmonary arrest the nurse on duty shall immediately determine the resident's status as a code or no-code.

19. If the person is a full code, the nurse or designee shall begin Cardiopulmonary resuscitation and direct someone to call 911.

**POLICY/PROCEDURE**

**SUBJECT:** Do Not Resuscitate Orders

**DATE:**

**INTENT:**

It is the policy of the facility to honor Do Not Resuscitate Orders in accordance to State and Federal regulations.

**PROCEDURE:**

1. Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45.

2. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law. Therefore, a properly completed physician's order in the chart should be honored.

3. The facility will provide the following to each resident or resident's representative, at the time of admission:
    a. Information regarding advance directives,
    b. Written information concerning the facilities policy on Advance Directives, including DNROs, and
    c. Information about how to obtain a Florida Do Not Resuscitate Order Form.

4. The facility will document in the resident's record whether or not he or she has executed a DNRO.

5. When the resident has executed a DNRO, a copy of that document will be made a part of the resident's record.

6. When the facility has requested a copy of the resident's DNRO; this will be documented in the resident's record.

7. The facility will honor a properly executed DNRO as follows:
    a. In the event a resident experiences cardiopulmonary arrest, staff trained in cardiopulmonary resuscitation (CPR) or a licensed health care provider is present in the facility, may withhold cardiopulmonary resuscitation.
    b. In the event a resident is receiving hospice services and experiences cardiopulmonary arrest, the facility staff must immediately contact the hospice provider.
    c. The hospice procedures will take precedence over those of the facility.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Posting/Notice of Medicare/Medicaid on Admission

**DATE:**

**INTENT:**

It is the policy of the facility to inform the resident and or legal representative about Medicare/Medicaid by posting such information within the facility and providing such information upon admission.

**PROCEDURE:**

1. The facility will display in the facility written information about how to apply for and use Medicare and Medicaid benefits.
2. The facility will also provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
3. Documentation of receipt of this information will be maintained within the resident record.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Notify of Changes (Injury/Decline/Room, Etc.)

**DATE:**

**INTENT:**

It is the policy of the facility to notify the resident and or legal representative of changes in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. A facility will immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:
    a. An accident involving the resident which results in injury and has the potential for requiring physician intervention;
    b. A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
    c. A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
    d. A decision to transfer or discharge the resident from the facility.

2. When making notification the facility will ensure that all pertinent information is available and provided upon request to the physician.

3. The facility will also promptly notify the resident and the resident representative, if any, when there is:
    a. A change in room or roommate assignment as specified in §483.10(e)(6); or
    b. A change in resident rights under Federal or State law or regulations.

4. The facility will record and periodically update the address (mailing and email) and phone number of the resident representative(s).

5. The facility will notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification may occur within 30 days after the acknowledgement of such signs by facility staff. If an underlying condition is determined to exist, the facility will arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

**PROCEDURE**

**SUBJECT:** Change in Condition Process

**DATE:**

**INTENT:**

The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification.

**PROCEDURE:**

The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification.

**<u>Situations requiring notification include:</u>**

1. An accident involving the resident which:
    a. Resulting in injury.
    b. Potential to require physician intervention.
2. A significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.

    This may include:
    a. life-threatening conditions, or
    b. Clinical complications.
3. A need to alter treatment significantly; that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.

    This may include:
    a. A new infection or wound.
    b. Discontinuing a treatment or changing a medication due to:
        i. Adverse consequences.
        ii. Acute condition.
        iii. Exacerbation of a chronic condition.
4. A decision to transfer or discharge the resident from the facility.
5. The facility must also promptly notify the resident and the resident representative, if any, when there is:

a. A change in room or roommate assignment, or
b. A change in resident rights under Federal or State law or regulations.

4. Upon the identification of a change in condition in a resident the Nurse will complete an evaluation of the resident's status, and document findings on the SBER Change in Condition in the resident's electronic medical record.

**Situations to Consider:**

Competent individuals:

- The facility must still contact the resident's physician and notify the resident and or resident's representative, if known and approved by the resident.
- A family that wishes to be informed would designate a member to receive calls.
- When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.

Residents incapable of making decisions:

- The representative would make any decisions that have to be made.
- The resident should still be told what is happening to him or her.

Death of a resident:

- The resident's physician is to be notified immediately in accordance with State law.

Notice of room/roommate changes:

- Necessary to avoid decline in physical, mental, or psychosocial well-being.

Contact information of the resident's legal representative or family member must be recorded and periodically updated.

**Right to Privacy:**

The facility is required to inform the resident of his/her rights upon admission and during the resident's stay including the resident's right to privacy (§483.10(h), F164).

If a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident's interested family member or legal representative, if known.

If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Medicaid/Medicare Coverage/Liability Notice
**DATE:**

**INTENT:**

It is the policy of the facility to notify the resident and or legal representative of Medicaid/Medicare Coverage/Liability in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

The facility will:

1. Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of:
    a. The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
    b. Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each Medicaid-eligible resident when changes are made to the items and services.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
    a. Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
    b. Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
    c. If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
    d. The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
    e. The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Personal Privacy/Confidentiality of Records

**DATE:**

**INTENT:**

It is the policy of the facility to provide the resident and or legal representative personal privacy and confidentiality of records in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

2. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident,

3. The facility will respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

4. The resident has a right to secure and confidential personal and medical records.

5. The resident has the right to refuse the release of personal and medical records except where applicable federal or state laws apply.

6. The facility will allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Safe/Clean/Comfortable/ Homelike Environment

**DATE:**

**INTENT:**

It is the policy of the facility to provide a safe, clean, comfortable homelike environment such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

2. The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
    a. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
    b. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

3. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

4. Clean bed and bath linens that are in good condition;

5. Private closet space in each resident room;

6. Adequate and comfortable lighting levels in all areas;

7. Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

8. For the maintenance of comfortable sound levels.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Grievances

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident and or legal representative to voice a grievance in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

2. The resident has the right to and the facility will make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

3. The facility will maintain a Grievance Program with a designated professional responsible for grievance management that answers to the Administrator.

4. The designated professional will maintain the facility Grievance Program.

5. All residents, staff, and visitors will have access to the professional designated to manage the Grievance Program, Grievance Officer.

6. Residents, resident representatives and Staff will be information on how to file grievances.

7. Facility staff will not discourage residents or their representatives filing of a grievance and or the communication with federal, state, or local officials.

8. The facility will establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights.

9. Upon request, the facility will give a copy of the grievance policy to the resident. The grievance policy must include:
    a. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a

reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

b. Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

c. As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

d. Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

e. Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

f. Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

g. Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

**PROCEDURE**

**SUBJECT:** Grievance Program

**DATE:**

**Purpose:**

To promote an environment and culture open to feedback positive and or negative from residents, family members, employees, physicians, and any other visitors. Both positive and negative comments from these individuals helps to provide information which will be incorporated into policies, procedures, and practices within the organization that focus on creating a culture of excellence through identification and resolution within continuous quality improvement.

Right to file Grievances: residents and visitors have the right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility either verbally or in writing, to governmental officials, or to any other persons; to file grievances anonymously; to receive a written decision related to the grievance filed, if requested; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, and be free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

**Definition:**

A grievance is a concern that cannot be resolved to the satisfaction of the person making the objection at the bedside and or immediately.

**Immediately:**

For the sake of this document, 'immediately' is defined as within four or less hours.

**Policy:**

It is the policy of the facility to ensure that individuals are encouraged to discuss comments and concerns which may be positive or negative and when indicated to bring such to a formal grievance status. The intent is to evaluate such matters for the purpose of resolution as well as performance improvement. Acceptance of a grievance does not mean the facility representative and or the facility agrees with the statement. Actions taken in response to customer grievances are undertaken with the goal of improving care and service delivery and include, but are not limited to, the following:

- investigation and most practicable resolution,
- routing to the appropriate departments for ongoing improvement,

- identifying trends in care, service delivery, and system organization, and
- developing long term solutions, implementing changes to improve care/service systems.

**Process:**

1. Grievances – grievances are formal written or verbal complaints made to the facility when prompt or bedside resolution to the satisfaction of the person making the objection was not possible. Grievances can also be made anonymously. When there is a grievance it will be:

    a. Documented on the facility Grievance Report.
    b. Routed to the Grievance Officer.
    c. Listed on the facility Grievance Tracking Log.
    d. Discussed with the appropriate individuals (such as Risk Manager, Director of Nursing, and Administrator and additional staff) as warranted.
    e. Investigated accordingly.
    f. Reported as required by State and Federal Laws, as warranted.
    g. The grievance decisions will include the following: dates, summary statement of resident's grievance, and summary of findings, statement confirming or not confirming grievance, correction actions as indicated, and the date that the written decision was issued to the person filing the grievance.
    h. Discussed through meetings which may be in person and/or telephone conferences.
    i. Included in facility quality improvement program.

2. The Director of Social Services is the key contact in the facility responsible to implement the Grievance Procedure. In the absence of the Social Service Director, the Administrator, or their designee is the key facility contact for grievances.

    <u>Pines of Sarasota's Grievance Official</u>
    Jennifer Tonnesen, MSW
    Social Services Director
    1501 N. Orange Avenue, Sarasota, FL 34236
    Email: JTonneson@pinesofsarasota.org
    Phone: (914) 356-5696 or (914) 365-0250 ext. 2810

3. Grievance forms will be sporadically placed in easy to find locations in the facility such as nurses' stations, Social Service office, to encourage independent usage unless assistance is requested.

4. Review will occur during the daily stand up meeting, which is held Monday through Friday, excluding holidays.

5. When a grievance is received by a staff member they will notify their supervisor and forward the completed report to the Grievance Official.

6. When a grievance is received orally and the resident does not choose to complete a written report; then the staff member receiving the grievance will complete the report and forward it to the Grievance Official.

7. If, at any time, a resident/family member or a visitor cannot complete the Grievance form, the Social Service Director or facility staff member will assist the resident / family member in doing such.

All grievances whether filed with staff or the Grievance Official will be completed by the following procedure:

1. The grievance will be logged on the facility grievance log.

2. At the time of the grievance, the employee's supervisor will attempt to intervene in an appropriate manner in an effort to resolve the stated grievance as they related to their department and services. If this is accomplished to the satisfaction of the filing party, the interventions will be documented and the completed grievance form will be returned to the Social Services Director of designee.

3. If the person filing the grievance is not satisfied with the department manager's interventions, the Grievance Officer will contact them to assist in resolution and ask if the person would like to receive the decision in writing.

4. If the person filing the grievance requests the decision in writing, the Grievance Officer will be responsible for completing the Grievance Summary, providing them a copy and obtaining a signature upon receipt.

5. All Grievance Summaries will include at a minimum: the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.

6. A Copy of the Grievance Summary will be maintained with the Grievance Report and any other investigation findings related to the Grievance.

7. All facility grievance investigations will be initiated as soon as possible after the grievance is filed. Completed and timely follow up will be conducted by the department supervisor, the Grievance Officer and/or the Administrator.

8. The Grievance Log will be maintained by the Grievance Officer and presented monthly at the facility QA/RM Meeting.

9. Although we hope that the person filing the grievance is satisfied with the result of the investigation, he/she can contact the Administrator or the Long Term Care Ombudsman or the Agency for Health Care Administration, if they are not.

10. Grievances will be maintained for three years after the date of the grievance decision.

Long Term Care Ombudsman Council:
4040 Esplanade Way, Suite 380
Tallahassee, FL 32399
1-888-831-7000

Local Long Term Care Ombudsman Council:
8695 College Pkwy
Fort Myers, FL 33919
(239) 433-6702

Agency for Health Care Administration:
2727 Mahan Drive
Tallahassee, FL 32399
(888) 419-3456

Quality Improvement Organization:
KEPRO (Area2)
216-447-9604
KEPRO.Communictaions@hcqis.org

Medicaid Fraud Control Unit
Office of Inspector General
U.S. Department of Health & Human Services
ATTN: HOTLINE
PO Box 23489
Washington, DC 20026

Phone: (800) HHS-TIPS [(800) 447-8477]
Fax: (800) 223-8164
TTY: (800) 377-4950

Florida Medicaid Fraud Control Unit
The Office of Medicaid Program Integrity of the Inspector General at the Agency for Health Care Administration accepts complaints associated with Medicaid billing fraud. These complaints may be filed online using the Medicaid billing fraud online complaint form at http://myfloridalegal.com/ or by telephone at 1-888-419-3456.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Right – Resident Contact with External Entities

**DATE:**

**INTENT:**

It is the policy of the facility to allow the resident to have contact with external entities in such a manner to acknowledge and respect resident rights.

**PROCEDURE:**

1. A facility will not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder, regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.

PLACE TAB FOR FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION HERE

**POLICY/PROCEDURE**

**SUBJECT:** Freedom from Abuse, Neglect, and Exploitation

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

This policy will include:

1. Free from Abuse and Neglect
2. Free from Misappropriation/Exploitation
3. Free from Involuntary Seclusion
4. Right to be Free from Physical Restraints
5. Right to be Free from Chemical Restraints
6. Not Employ/Engage Staff with Adverse Actions
7. Develop/Implement Abuse/Neglect, etc. Policies
8. Reporting of Reasonable Suspicion of a Crime
9. Reporting of Alleged Violations
10. Investigate/Prevent/Correct Alleged Violation

**POLICY/PROCEDURE**

**SUBJECT:** Freedom from Abuse, Neglect, Misappropriation, Exploitation

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

1. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required treating the resident's medical symptoms.
2. The facility will not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

**POLICY/PROCEDURE**

**SUBJECT:** Freedom from Physical and Chemical Restraints

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

1. The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
2. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required treating the resident’s medical symptoms.
3. The facility will ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident’s medical symptoms.
4. When the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

**PROCEDURE**

**SUBJECT:** Restraint Reduction Program

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to resident respect and dignity, as it relates to the use of physical and chemical restraints, according to state and federal regulations.

**PROCEDURE:**

1. Whenever restraint use is considered, the facility will explain to the resident and or legal representative how the use of the restraint would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being.

2. The facility will also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence.

3. Before using a device for mobility or transfer, evaluation will include a review of the resident's bed mobility, and ability to transfer between positions, to and from bed or chair, to stand and toilet. All documentation of evaluations, communication and care planning considerations will be maintained in the resident's clinical record.

4. The resident will be re-evaluated for the appropriate use of the least restrictive device in conjunction with the Resident Assessment Instrument.

**POLICY/PROCEDURE**

**SUBJECT:** Not Employ/Engage Staff with Adverse Actions

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

1. The facility will not employ or otherwise engage individuals who:

    a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
    b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
    c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

2. The facility will report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

**POLICY/PROCEDURE**

**SUBJECT:** Develop/Implement Abuse/Neglect, etc. Policies

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

1. The facility will develop and implement written policies and procedures that:

    a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
    b. Establish policies and procedures to investigate any such allegations, and
    c. Include training.

**POLICY/PROCEDURE**

**SUBJECT:** Reporting of Reasonable Suspicion of a Crime & Alleged Violations

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**PROCEDURE:**

1. The facility will ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act.

2. This policy includes but is not limited to the following elements:
    a. Annually covered individuals will have in-services training of that individual's obligation to comply with the following reporting requirements:
        i. Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.
        ii. Posting a conspicuous notice of employee rights, as defined at section 1150B (d) (3) of the Act.
        iii. Prohibiting and preventing retaliation, as defined at section 1150B (d) (1) and (2) of the Act.

3. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:
    a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in

long-term care facilities) in accordance with State law through established procedures.

b. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

4. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:
   a. Have evidence that all alleged violations are thoroughly investigated.
   b. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
   c. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

5. If several individuals form a similar suspicion, they may group their report jointly.

6. Any multi-person report will include identification of all individuals making the report.

7. Any individual may make both an individual report and be part of a larger report.

8. Reports will be made to the City Police @ 941-954-7025 at 2099 Adams Lane, Sarasota, Florida State Agency (AHCA). Please notify the Administrator or designee as well.

9. Staff may use the facility Suspected Crime Report Form.

10. The facility Risk Manager or Designee will be responsible for the Form completion when a staff member does not complete one and will also be responsible for the investigation and documentation of final findings.

11. The facility Risk Manager or designee will be responsible for maintaining the all documentation related to all reports of Suspected Crime.

**POLICY/PROCEDURE**

**SUBJECT:** Abuse Neglect Exploitation Mistreatment and Misappropriation of Property Prevention

**DATE:**

**INTENT:**

The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

**DEFINITIONS:**

- **Abuse** is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
- **Neglect** is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of patient/resident care and services to assure care is provided as required.
- **Verbal/Written Abuse** is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
- **Sexual Abuse** includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
- **Physical Abuse** includes hitting, slapping, pinching, pulling, and kicking. It also includes controlling behavior through corporal punishment.
- **Mental Abuse** includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation.
- **Involuntary Seclusion** is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other Residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.
- This facility's Abuse Preventionist and Risk Manager is Charlene Cimeno, RN LHRM.

- Residents of this facility shall be protected from occurrences of abuse, exploitation, misappropriation of property, mistreatment or neglect.
- Staff and other relevant parties as determined by management shall be trained at least annually on abuse, neglect and exploitation, procedures for reporting incidents of this nature, dementia management and abuse prevention.

**PROCEDURE:**

**I. Screening :**

- Screen potential employees for a history of abuse, neglect or mistreating residents. This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.
- The facility must not employ or otherwise engage individuals who:
  I. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
  II. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
  III. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
- The facility will report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
- Applicants for our Volunteer Program are screened through the Verified Volunteer background check.
- Eligibility of individuals and entities are verified through the Office of the Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE). Not employ of any and all ineligible individuals.

**II. Training :**

- Train employees, through orientation and on-going sessions on issues related to abuse prohibition practices such as:
  - Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents;
  - How staff should report their knowledge related to allegations without fear of reprisal;
  - How to recognize signs of burnout, frustration and stress that may lead to abuse;

- What constitutes abuse, neglect and misappropriation of resident property;
- In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on:
    1. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property.
    2. Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.
    3. Dementia management and resident abuse prevention.

**III. Prevention:**

- Provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and provide feedback regarding the concerns that have been expressed.
- Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur.
- This includes an analysis of:
    - Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility;
    - The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs;
    - The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds; and
    - The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff.

**IV. Identification:**

- Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.

**V. Investigation:**

- Investigate different types of incidents; and
- Identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities.

**VI. Protection:**

- Protect residents from harm during an investigation.
- When an allegation or suspicion of one of the activities set out in the definitions herein occurs the facility shall:
    1. Promptly protect the resident(s) who is/are the alleged victim(s);
    2. Monitor the resident for signs and symptoms of mental, emotional or physical issues;
    3. Notify the resident's physician and appropriate resident representative;
    4. Protect other residents who might be at risk;
    5. The protections employed shall be based on the details of the allegation;
    6. Ensure that no retribution occurs to the complainant;
    7. Immediately remove the accused team member from the resident areas and take further action with that team member as warranted; and
    8. Any employee who is suspended to have committed an act as set out in the definitions herein will be immediately suspended or placed in a position in which no further acts could occur. In the event the investigation identifies a perpetrator, that individual will be terminated and reported to their board, where applicable.

**VII. Reporting/Response:**

- Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation;
- Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and
- Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.
- The facility must develop and implement written policies and procedures that:
    1. Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Social Security Act. The policies and procedures must include but are not limited to the following elements.
- In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:

1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
2. Have evidence that all alleged violations are thoroughly investigated.
3. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
4. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

**POLICY/PROCEDURE**

**SUBJECT:** Personal Property Theft and Loss Risk

**DATE:**

**INTENT:** The Facility provides for the reasonable safekeeping of personal property and funds for residents in the facility per state and federal requirements.

**PROCEDURE:**

1. The Facility recommends that residents, employees, and others do not bring items of value into the facility. Facility reserves the right, whenever necessary for the protection of valuables be excluded or removed from the facility. It is further recommended that residents keep only small amounts of cash on their person, and that employees store their parcels in the locked trunk of their vehicle.
2. The Facility has a safe for cash, wallets, and other valuables and also provides a locked space for small items, such as a handbag, that residents may wish to secure.
3. The Facility provides labeling of the resident's clothing and personal property at the residents request. We recommend that you request to have items labeled such as razors, glasses, cell phones, charging cords, etc.
4. All thefts or loss of resident's or employee's property shall be reported to the Facility's management or Grievance Officer immediately. All efforts will be made to locate the missing item.
5. The Facility documents all thefts and loss of resident's personal property. The documentation is maintained by the Social Services Department.
6. The Facility's loss prevention policy is provided to all residents and employees.
7. Theft of property will be reported to the Police Department in the Facility's jurisdiction by management at the direction of the resident or employee and with notification of the Administrator.
8. Recommendations for safekeeping of your personal items:

    a. Do not leave your wallet/purse in unlocked drawers, cabinets, or in open, non-secure areas. **A lock-box will be provided to you upon request.**
    b. Do not wrap items in tissues/napkins or place them on your meal tray, under your pillow, in your tissue box, etc.
    c. Don't "flash" cash or other valuables.
    d. Keep any cash or valuables in our safe.

e. Make sure all your property is listed on your Inventory Record and is updated if new items are brought in. Ask a staff member to label your personal belongings.
f. Report persons you don't recognize going from room to room or looking suspicious.
g. Report any missing items immediately.

**POLICY/PROCEDURE**

**SUBJECT:** Photographs and Social Media

**DATE:**

**INTENT:**

This policy is to serve as a general guidance for employee use of social media, which should be broadly understood for purposes of this policy to include blogs, wikis, microblogs, message boards, chat rooms, electronic newsletters, online forums, social networking sites, and other sites and services that permit users to share information with others in a contemporaneous manner.

As a company, we understand that social media can be a fun and rewarding way to share your life and opinions with family, friend, and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. To assist employees in making responsible decisions about the use of social media, we have established these guidelines for appropriate use of social media.

It is very important that we provide a safe and homelike environment for our residents so that they feel protected, free from embarrassment, free of abuse of any kind and secure that their privacy is protected. This includes the resident himself, their private space and their belongings.

**POLICY INTERPRETATION AND IMPLEMENTATION**

**General Guidelines**

The principles and guidelines found in the Company Policies apply to employees' activities in recording and putting that information on a social network or private communications on line. Employees are solely responsible for what they record and post online. Before creating online content, employees should consider that there are many risks that are involved. Employees should keep in mind that any of their conduct that adversely affects their job performance, the performance of fellow employees or otherwise adversely affects employees, residents, suppliers, people who work on behalf of the Company or the Company's legitimate business interests may result in disciplinary action up to and including termination.

**Implementation**

1. While photos may be taken of residents for clinical purposes, these are maintained in confidential files for that use only. This may include elopement, treatment or other care.

2. Employees must understand and follow the guidelines related to the use of social media, including but not limited to the Prohibition of Harassment and Discrimination

Policy, and ensure postings are consistent with these policies. Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence, lack of respect for residents' privacy or similar inappropriate or unlawful conduct will not be tolerated and my subject employees to disciplinary action up to and including termination.

3. Taking photographs of residents, their belongings and their private space is not permitted. Any photographs which show resident information, such as a chart in the background should not be taken.

4. This facility respects the Employee's right to express concerns with the workplace and their conditions of work. We will not impede this right if lawfully used. However, Employees should use the facility's open door policy and complaint procedures to resolve any work-related complaints or concerns, whenever possible. This does not preclude you from posting complaints to a social media outlet, but will likely get the issue resolved quickly. Should an employee choose to post a complaint or criticism, the employee should avoid using statements, photographs, video or audio that reasonably could be viewed as malicious, obscene, threatening, or intimidating, that disparage residents, or that might constitute harassment or bullying. Examples of such conduct might include offensive posts meant to intentionally harm someone's reputation rather than express concerns about working conditions, or posts by managers that could contribute to a hostile work environment on the basis of race, sex, disability, religion or any other status protected by law or company policy.

5. Employees are expected to maintain the confidentiality of the company's confidential information and all health related or private information about our residents. Employees should not create a link from their blog or website or other social networking site to a company website without identifying themselves as a current employee. Employees should express only personal opinions, and never represent themselves as a company spokesperson.

6. Employees should refrain from using social media on work time or on equipment the company provides, except during breaks. This includes but is not limited to internet, email, cell phones and computers. Employees should never use a company email address to register on social networks, blogs or other online tools utilized for personal use.

7. Although not an exclusive list, some specific examples of prohibited social media conduct include posting photographs, videos, audios, commentary, content, images, protected health information, or any other type of information prohibited by HIPAA rules, laws and regulations regarding our residents, images that are defamatory, pornographic, proprietary, harassing, libelous, or that can create a hostile work environment. If an employee is unsure of what social media content is considered confidential, he / she should direct inquiries to company administration for guidance. Photograph and videos of residents, their private space and property is always considered confidential unless management has secured written authorization for its use.

8. Willful posting of protected health information, images, commentary, or content meant to disparage residents, or any other information set out in this policy is grounds for immediate disciplinary action, up to and including termination, as well as any and all legal ramifications from such action.

9. Willful posting of resident protected health information, images, commentary, or content or any other type of information prohibited by HIPAA rules, laws and regulations will be considered as mentally and / or emotionally abusive, and will be investigated according to the facility's ANE Policy and Procedure, including mandatory reporting to regulatory agencies. Willful posting of any photographs or video of any resident, their private space and/or their belongings will be considered a violation of their privacy rights and will be treated as above.

10. If you observe another Employee or an outside party such as a visitor or family member taking photographs or videos of the resident they are visiting and other residents are in the area, advise the person that the other residents have a right to privacy. The same action should be taken if the photograph or video will show another resident's private space or belongings. If the person does not discontinue taking inappropriate pictures notify your supervisor.

11. Also if you observe anyone taking a picture of a resident which you believe a reasonable person would consider embarrassing, humiliating or demeaning, notify your supervisor.

12. Consent to photographs or videos taken by Employees must be in writing and signed by the resident or the resident's legal representative who has that authority. You must have permission from your supervisor to take photographs or videos using any resident's permission.

13. For additional information refer to the facility's policy on use of electronic devices in the workplace and the use of facility-owned computers and other electronic equipment and reporting abuse.

**POLICY/PROCEDURE**

**SUBJECT:** Sexual Abuse

**DATE:**

**INTENT:**

It is the policy of the facility to immediately report and completes an investigation in the event of allegation known or suspected related sexual abuse.

**PROCEDURE:**

In the event of an allegation of sexual abuse please refer to the facility Abuse Neglect Exploitation and Misappropriation to include separation, protection, outside report, investigation and complete the following as indicated:

1. The internal risk manager of the facility will investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact when the allegation is that the sexual misconduct occurred at the facility or at the grounds of the facility.

2. The facility will immediately report allegations of this nature to the law enforcement and abuse registry. A Proper medical evaluation should not be delayed in allegations of rape or sexual assault. The following process will be followed:
    a. Follow directives given by law enforcement.
    b. Avoid showing or cleansing the resident in any way to avoid washing away any possible evidence.
    c. Collect, bag, and tag any and all linens and or washable items that may have come in contact with the resident (e.g., linen, towels, clothing, etc.).
    d. Tag the bag with identification information (e.g., resident name, date bagged, time bagged, and the name of the individual completing the process, etc.).

3. Report every allegation of sexual misconduct to the administrator immediately; and

4. Notify the resident representative or guardian of the victim that an allegation of sexual misconduct has been made and that an investigation is being conducted.

PLACE TAB FOR ADMISSION, TRANSFER, AND DISCHARGE HERE

**POLICY/PROCEDURE**

**SUBJECT:** Admission, Transfer & Discharge

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Admissions, Transfers and Discharges in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Admissions Policy
2. Equal Practices Regardless of Payment Source
3. Transfer and Discharge Requirements
4. Notice Requirements before Transfer/Discharge
5. Preparation for Safe/Orderly Transfer/Discharge
6. Permitting Residents to Return to Facility
7. Equal Practices Regardless of Payment Source
8. Prohibiting Certain Admission Policies

**POLICY/PROCEDURE**

**SUBJECT:** Admissions

**DATE:**

**INTENT:**

It is the policy of the facility to provide admissions according to state and federal regulations.

**PROCEDURE:**

1. No potential or current resident will be requested or required to:
    a. Waive any rights afforded by state, local and federal law applicable to nursing facilities;
    b. Waive rights to Medicare or Medicaid reimbursement for care and services;
    c. Waive potential liability for losses of personal property; or
    d. Have a third party guarantor as a condition of admission, expedited admission or continued stay.

2. The facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

3. The facility will not, in the case of a person eligible for Medicaid, charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation or other consideration as a precondition of admission, expedited admission or continued stay in the facility; however:
    a. The facility will charge a resident eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services," and will give proper notice of the availability and cost of those services and that they are not a condition of admission or continued stay; and
    b. The facility will notify the resident and/or the resident representative of additions, deletions or changes for the cost of these items or services.

4. The Facilities will provide residents at the time of admission and periodically during resident's stay of:
    a. Services included under state plan and what is not included;
    b. 60-day notice when changes are made to what services are covered by Medicare and Medicaid;
    c. Resident's eligibility for Medicaid;
    d. A list of names, addresses, including email address, and telephone numbers of all pertinent State regulatory and informational agencies;

e. Long-Term Care Ombudsman program;
f. Information about returning to the community;
g. Statement resident may file a complaint with State Survey Agency; and
h. Filing grievances.

5. The facility will notify the resident of the facility's special characteristics as follows:
    a. Rehabilitation Unit with faculty staff that are licensed and or certified therapist:
        i. Solostep
        ii. Biodex
        iii. Bounce-back Room
        iv. Aquatic Therapy
    b. Outpatient therapy for continuity of care
    c. Ready Steady Program
    d. Facility accepts most insurance plans
    e. Smoke Free Facility
    f. In-house Transportation
    g. Evening Security
    h. Multilingual Staff
    i. Concierge
    j. Intergenerational Activities
    k. 80% of meals prepared from scratch
    l. Secured dementia unit
    m. Future Independent wing
    n. All beds except the beds on the 3100 and 3200 units are all dully certified.

6. Facility does not accept residents who:
    a. Require TPN
    b. Require pain pump
    c. Have a trach and require trach care
    d. Ventilator dependent
    e. Weigh more than 350 pounds
    f. Require deep suctioning

**POLICY/PROCEDURE**

**SUBJECT:** Equal Practices Regardless of Payment Sources

**DATE:**

**INTENT:**

It is the policy of the facility to ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source.

**PROCEDURE:**

1. A facility will establish, maintain and implement identical policies and practices regarding transfer and discharge, and the provision of services for all individuals regardless of source of payment;

2. The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and these charges will be listed within the admission packet; and

3. The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

4. Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e) (7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

**POLICY/PROCEDURE**

**SUBJECT:** Transfer and Discharge Requirements

**DATE:**

**INTENT:**

It is the policy of the facility to ensure residents are treated equally regarding transfer, discharge, and the provision of services, regardless of their payment source in accordance to state and federal regulations.

**PROCEDURE:**

1. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:
    a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
    b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
    c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
    d. The health of individuals in the facility would otherwise be endangered;
    e. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
    f. The facility ceases to operate.
    g. The facility will not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a) (3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

**Documentation:**

When the facility transfers or discharges a resident under any of the circumstances, the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

1. Documentation in the resident's medical record will include:
    a. The basis for the transfer;
    b. In the case of inability to meet resident needs, the specific resident need(s) that cannot be met, the facility's attempts to meet the resident needs, and the service available at the receiving facility to meet those need(s).

2. The resident's physician will also document in the clinical record when the transfer or discharge is necessary.

3. Information provided to the receiving provider must include a minimum of the following:
    a. Contact information of the practitioner responsible for the care of the resident;
    b. Resident representative information including contact information;
    c. Advance Directive information;
    d. All special instructions or precautions for ongoing care, as appropriate;
    e. Comprehensive care plan goals;
    f. All other necessary information, including a copy of the resident's discharge summary and any other documentation, as applicable, to ensure a safe and effective transition of care.

**POLICY/PROCEDURE**

**SUBJECT:** Notice Requirements before Transfer/Discharge

**DATE:**

**INTENT:**

It is the policy of the facility to notify the resident and or their legal guardian of the before transfer and/or discharge according to state and federal regulations.

**PROCEDURE:**

1. Before the facility transfers or discharges a resident, the facility will:
    a. Obtain a physician's order for the transfer and or discharge.
    b. Notify the resident and, if known, a family member or the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
    c. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
    d. Record the reasons for the transfer or discharge in the resident's medical record; and
    e. Include in the notice the following items:
    i. The reason for transfer or discharge;
    ii. The effective date of transfer or discharge;
    iii. The location to which the resident is transferred or discharged;
    iv. A statement that the resident has the right to appeal the action to the State;
    v. The name, address and telephone number of the State long term care Ombudsman;
    vi. For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
    vii. For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

2. The facility will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer and or discharge from the facility.

3. If the information in the notice changes prior to effecting the transfer or discharge, the facility will update the recipients of the notice as soon as practicable once the updated information becomes available.

4. A resident may challenge a decision by the facility to discharge or transfer the resident.

5. In the case of facility closure, the individual who is the administrator of the facility will provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

**Timing of Notice:**

1. At least 30 days prior to any proposed transfer or discharge, the facility will provide advance notice of the proposed transfer or discharge to the resident and, if known to a family member or the resident's legal guardian or representative, except in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:
    a. The transfer or discharge is necessary for the welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical record by the resident's physician; or
    b. The health or safety of other residents or facility employees would be endangered, and the resident's physician or the medical director documents the circumstances in the resident's medical record if the resident's physician is not available.

**Written Notice:**

1. The notice will be in writing and will contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings.

2. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form shall state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form shall clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council to review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within five business days after signature by the resident or resident designee.

3. The facility will provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

**POLICY/PROCEDURE**

**SUBJECT:** Notice of Bed Hold Policy Before/Upon Transfer

**DATE:**

**INTENT:**

It is the policy of the facility to notify the resident and or their legal guardian of the Bed Hold Policy according to state and federal regulations.

**PROCEDURE:**

1. Before the facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies:
    a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
    b. The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; and
    c. The nursing facility's policies regarding bed-hold periods.

2. At the time of transfer of a resident for hospitalization or therapeutic leave, the facility will provide to the resident and the resident representative written notice, which specifies the duration of the bed-hold policy.

**POLICY/PROCEDURE**

**SUBJECT:** Bed Hold Policy

**DATE:**

**INTENT:**

It is the policy of the facility to notify the resident and or their legal guardian of the before the Bed-Hold Policy and Readmission according to state and federal regulations.

**PROCEDURE:**

**A. MEDICAID RESIDENTS**

If hospitalized, the Department of Children and Family Services will pay to reserve a bed for eight (8) days for each medically necessary hospitalization. If a resident is hospitalized for more than eight days, the resident will be discharged. Should a bed be unavailable when the resident is discharged from the hospital and an admission to another facility is necessary, the resident will be notified of the first Medicaid bed available at this facility. The resident or family members may pay privately to hold a bed after the eight paid days run out. The patient is still responsible for their portion of the patient responsibility during the bed hold period. Medicaid will not pay for a bed hold when a resident goes to the hospital or on a home leave if 5 percent or more of the Medicaid certified beds are available. The percentage of occupancy is determined by the facility's occupancy for the previous quarter. You will be notified within 24 hours if this rule applies or you may see the Administrator.

Additionally, Medicaid will pay for sixteen (16) days annually for therapeutic home visits. Residents who wish to have more than sixteen days may pay privately for them, in advance.

**B. MEDICARE PART A RESIDENTS**

Beds are not reserved. If a Medicare resident is admitted to the hospital, a discharge from the facility is necessary. When the resident is discharged from the hospital, they may be admitted to the facility according to bed availability. The Medicare Bed may be held privately, see "C" below.

**C. PRIVATE PAY RESIDENTS/HOSPICE**

The Nursing Facility will reserve the resident's bed for a period of up to thirty (30) days for any hospitalization, provided the Nursing Facility receives reimbursement, and arrangements to hold the bed are made at the time of transfer to the hospital.

Hospice does not pay for bed holds.

In order to return to the facility, the resident must need the services provided by the facility. If the resident was transferred with the expectation of returning and cannot

return to the facility, the facility will comply with its policy on notice of transfer and discharge.

When the facility to which a resident returns is a composite distinct part the resident will be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon first availability of a bed there.

**ALL QUESTIONS REGARDING THE BED HOLD POLICY ARE TO BE DIRECTED TO THE ADMINISTRATOR OR OFFICE MANAGER.**

**POLICY/PROCEDURE**

**SUBJECT:** Permitting Resident to Return to Facility

**DATE:**

**INTENT:**

It is the policy of the facility to permit the resident to return to facility according to state and federal regulations.

**PROCEDURE:**

1. A facility will establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave.

2. The policy will provide for the following:
   a. A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident:
      i. Requires the services provided by the facility; and
      ii. Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
   b. If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

3. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

PLACE TAB FOR RESIDENT ASSESSMENTS HERE

**POLICY/PROCEDURE**

**SUBJECT:** Resident Assessment

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Resident Assessment/Instrument and Process in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Admission Physician orders for Immediate Care
2. Comprehensive assessments & Timing
3. Comprehensive assessment after significant change
4. Quarterly assessment at least every 3 months
5. Maintain 15 months of resident assessments
6. Encoding/Transmitting Resident Assessment
7. Accuracy of Assessments
8. Coordination/Certification of Assessment
9. Coordination of PASARR and Assessments
10. PASARR Screening for MD & ID
11. MD/ID Significant Change Notification

**POLICY/PROCEDURE**

**SUBJECT:** Admission Orders

**DATE:**

**INTENT:**

It is the policy of the facility to provide a care and services related to admission orders, according to state and federal regulations.

**PROCEDURE:**

1. The facility will have physician orders for the resident's immediate care, at the time of a resident's admission.
2. The admitting nurse will call the attending physician and clarify all orders on admission.
3. The admitting orders will be transcribed to the admission Physician Order Sheets (POS) once the orders are clarified or entered into the facility electronic medical record.
4. The POSs will be faxed or transmitted electronically to the pharmacy in a timely manner to ensure receipt of the resident's medications on the next pharmacy delivery.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Assessment Instrument (RAI)

**DATE:**

**INTENT:**

It is the policy of the facility to adhere to the following procedures related to the proper documentation and utilization of a resident's Minimum Data Set (MDS) to ensure a comprehensive and accurate assessment of residents will be completed in the format and in accordance with time frames stipulated by the Department of Health and Human Services Center for Medicare and Medicaid Services. This assessment system will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development.

**PROCEDURE:**

Completion of the Minimum Data Set:

1. Resident Assessment Instrument. A facility will complete a comprehensive assessment of a resident's needs, functional and health status, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
    a) Identification and demographic information
    b) Customary routine.
    c) Cognitive patterns.
    d) Communication.
    e) Vision.
    f) Mood and behavior patterns.
    g) Psychological well-being.
    h) Physical functioning and structural problems.
    i) Continence.
    j) Disease diagnosis and health conditions.
    k) Dental and nutritional status.
    l) Skin Conditions.
    m) Activity pursuit.
    n) Medications.
    o) Special treatments and procedures.
    p) Discharge planning.
    q) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

r) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

2. A resident's Minimum Data Set (MDS) is completed by an interdisciplinary team. During the initial assessment period, data is collected by resident observation and communication as the primary source of information. The following disciplines will be responsible to complete these sections:
    a. Resident Master Information, Section AA and A completed by the MDS Coordinator on day of admission.
    b. Background section, AB-AC completed by the MDS Coordinator.
    c. Sections B, C, E, and Q completed by the Social Services Department.
    d. Section K completed by the Certified Dietary Manager (CDM).
    e. Section F completed by the Activities Department.
    f. Section O, P, GG and G (partial) completed on the work-sheet MDS by the MDS Coordinator.
    g. Sections C, D, GG, G (partial), H, I, J, L, M, N, O, P, Q (partial) and S, are entered into the computer software, Matrix by the MDS Coordinator.

3. All sections of the assessment are encoded and closed by each interdisciplinary team (IDT) member as assigned above. The computer software has standardized edits defined by CMS and the State. Any information on the encoded MDS that does not pass CMS – specified edits are made prior to the completion. Computerized CAA's are confirmed, utilizing a section "V" worksheet. The MDS Coordinator completes Section V listing the location and date of the CAA assessment documentation. The completed MDS is verified and signed by the MDS Coordinator. Staff members who complete portions of the assessment attest to the accuracy of their sections by signature. Interdisciplinary care planning is completed within seven (7) days of the completion of the MDS admission assessment.

4. Assessments are also completed for residents who have experienced a "Significant Change." Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) A significant change in status MDS is required when a resident elects, and revokes the hospice benefit, and if decline or improvement from baseline in 2 or more areas of the resident's functional status.
5. Quarterly assessments are also done for residents every 3 months, at least every 92 days following a comprehensive assessment. Annual, entry, discharge and re-

entry assessments are completed following the guidelines indicated in the Final Rule and the RAI MDS Version 3.0 Guidelines.

6. The assessment will accurately reflect the resident's status.
7. A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals.
8. A registered nurse will sign and certify that the assessment is completed.
9. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Electronic Transmission and Validation:

1. PPS and Quarterly Assessments will be transmitted within 14 days of completion date.
2. Comprehensive assessments will be transmitted within 14 days of the Care Plan completion date.
3. The MDS Coordinator will transmit the file and print the initial and final Validation Report.
4. The MDS Coordinator will facilitate the correction of any fatal errors immediately and retransmit the assessment until an accepted Validation Report is received.
5. The MDS Coordinator will also address non-fatal errors using the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system MDS 3.0 Provider User's Guide.
6. The MDS Coordinator will maintain Validation Reports in a transmittal notebook to be organized by month.
7. The MDS Coordinator will provide a copy, the same day to the business office designee of the initial and final Validation Report that acknowledges acceptance of the MDS into the QIES ASAP for all PPS Assessments.
8. The Validation Report will be confirmed by the Business Office designee prior to billing the RUG for dates of service on the UB (Uniform Bill) to include:
    a. Confirmed RUG
    b. Acceptance
    c. Accuracy of ARD Per assessment billed
    d. Accuracy of number of days billed per assessment/claim
9. Copies of the PPS Assessment Validation Reports will be maintained in the business office, organized chronologically for three (3) years. Copies of OBRA Assessment Validation Reports will be maintained in the MDS office for a one-year time period or from certification survey to certification survey.

10. To facilitate receiving Validation Reports on a timely basis, the MDS Coordinator will transmit as frequently as necessary to obtain timely Validation of MDS acceptance into the QIES ASAP database.

Maintenance of Assessment Data:

1. Fifteen (15) months of assessment data will be maintained on site in the resident's active clinical record or in a location easily accessible to the nursing staff and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. The form of storage may be electronic or hard copy. The most recent comprehensive assessment with CAA's will be maintained as a hard copy in the resident's/patient's clinical record. Computer MDS software (Answers on Demand "AOD") has the capacity to print all assessments for the period upon request. Backup for MDS data is done nightly to servers located both on site at the facility and off site at a cyber-secure location selected by the facility's Information Technology vendor. For more detailed information concerning the facility's data back-up procedures, please see the facility's IT Manual.

Training:

1. MDS documentation overview is provided at a new hire's orientation along with a copy of the MDS for review.

Program Security:

1. Passwords to the computer MDS Software are issued by the Assistant Director of Nursing (ADON).

2. Computers with the MDS program are located in the following offices: Healthcare Administrator, Director of Nursing, MDS Coordinator, Admission Coordinator, Social Services Coordinator, Dietary, Activity Director and Medical Records. Each of these computers are password protected, thus limiting access to approved users.

3. Additionally, the following security measures are in place:
    a. The Health Care Administrator, the MDS Coordinator and the computer software vendor (Enter facility software vendor here) coordinate the administrative aspect of the MDS.
    b. When "Creating a new user" special consideration will be given to determine assigned privileges ("Read Only," "Read and Edit," "Full Administrative Privileges" etc.)
    c. A register of MDS program users is kept locked in the Healthcare Administrator's office for necessary access.

Confidentiality/Resident Identifiable Information:

1. Automated RAI information, as part of the clinical record, is safeguarded as confidential information. The facility will not release information that is resident identifiable to the public. The facility may release information that is resident

identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. All resident's health information will be handled in a safe, secure, and confidential manner.

Resident Consent:

1. Each resident will be informed upon admission and consent will be obtained for electronic transmission of the MDS.

Date Backup and Restore Process:

1. Backup – The MDS software is located on the facility's server. The program and data are backed up to both on site and off site servers nightly by the facility's Information Technology Vendor. Restore and test restore functions are also completed by the facility's Information Technology Vendor. For more detailed information concerning the facility's data back-up and data restoration procedures, please see the facility's IT Manual.

**POLICY/PROCEDURE**

**SUBJECT:** Coordination - Pre-Admission Screening and Resident Review (PASRR) program

**DATE:**

**INTENT:**

It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort.

2. Coordination includes:
    a. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.
    b. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

3. Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. The facility will not admit, on or after January 1, 1989, any new residents with:
    a. Mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission:
        i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
        ii. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
    b. Exceptions for purposes of this section include:
        i. The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
        ii. The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a

nursing facility of an individual: who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, who requires nursing facility services for the condition for which the individual received care in the hospital, and whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

c. Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission:
    i. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
    ii. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

4. Definitions for purposes of this section:
    a. An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b) (1).
    b. An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b) (3) or is a person with a related condition as described in 435.1010 of this chapter.

5. A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

INSERT COMPREHENSIVE RESIDENT CENTERED CARE PLANS
TAB HERE

**POLICY/PROCEDURE**

**SUBJECT:** Comprehensive Resident Centered Care Plans

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Comprehensive Resident Centered Care Plans in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Baseline Care Plan
2. Develop/Implement Comprehensive Care Plan
3. Care Plan Timing and Revision
4. Services Provided Meet Professional Standards
6. Qualified Persons
7. Discharge Planning Process
8. Discharge Summary

**POLICY/PROCEDURE**

**SUBJECT:** Baseline Care Plan

**DATE:**

**INTENT:**

It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident.

Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning.

The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate.

The Interim Interdisciplinary Care Plan will be located in the care plan section of the Medical Record.

It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care.

**PROCEDURE:**

The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will:

1. Be developed within 48 hours of a resident's admission.

2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    a. Initial goals based on admission orders.
    b. Physician orders.
    c. Dietary orders.
    d. Therapy services.
    e. Social services.
    f. PASARR recommendation, if applicable.

3. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan:
    a. Is developed within 48 hours of the resident's admission.
    b. Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

4. The facility will provide the resident and their representative with a summary of the baseline care plan prior to the completion of the comprehensive care plan, that includes but is not limited to:
    a. The initial goals of the resident.
    b. A summary of the resident's medications and dietary instructions.
    c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
    d. Any updated information based on the details of the comprehensive care plan, as necessary.

**POLICY/PROCEDURE**

**SUBJECT:** Comprehensive Resident Centered Care Plans

**DATE:**

**INTENT:**

It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident.

Every resident will have an Interdisciplinary Care Plan, with the Interim Interdisciplinary Care Plan initiated within 24 hours of admission. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning.

The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate.

The Interim Interdisciplinary Care Plan will be located in the care plan section of the Medical Record.

It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care.

**PROCEDURE:**

1. The following health care professionals contribute to the Interdisciplinary Care Plan by collaboration and direct documentation: RN, LPN, CNA, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist, Activity Director, Social Services Coordinator, Dietitian, Physician and other appropriate members of the Care Plan Team. Other specialty areas available for consultation when needed include, but are not limited to diabetic, pain, wound, psychological, hospice and pharmacy professionals.

2. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:
    a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
    b. Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c) (6).
    c. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
    d. In consultation with the resident and the resident's representative (s):
        i. The resident's goals for admission and desired outcomes.
        ii. The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
        iii. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

3. The resident will have the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
    a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
    b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
    c. The right to receive the services and/or items included in the plan of care.
    d. The right to see the care plan, including the right to sign after significant changes to the plan of care.

4. The facility will inform the resident of the right to participate in his or her treatment and shall support the resident in this right.

5. The planning process will:
    a. Facilitate the inclusion of the resident and/or resident representative.
    b. Include an assessment of the resident's strengths and needs.

c. Incorporate the resident's personal and cultural preferences in developing goals of care.

Developing the Care Plan:

1. A comprehensive care plan will be:
    a. Developed within 7 days after completion of the comprehensive assessment.
    b. Prepared by an interdisciplinary team, that includes but is not limited to:
        i. The attending physician.
        ii. A registered nurse with responsibility for the resident.
        iii. A nurse aide with responsibility for the resident.
        iv. A member of food and nutrition services staff.
        v. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
        vi. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
    c. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
2. The services provided or arranged by the facility, as outlined by the comprehensive care plan, will meet professional standards of quality.
3. Each discipline will check and/or add interventions/approaches to include but not limited to:
    a. The intervention statements describe those measures performed by the staff to help the resident achieve the expected outcomes
    b. Interventional entries reflect activities that incorporate observations, assessments, management and teaching components that will restore, maintain and/or promote the resident's well-being.
    c. Each planned intervention will be specific and include parameters for frequency and time schedule.
4. Each discipline will check or add expected outcomes and goals. Expected outcomes describe the realistic short-range goals to be achieved by the resident within a specific time frame.
5. These activities will be completed for each patient problem.
6. Computer generated plans of care are completed within seven (7) days of the comprehensive MDS assessment. The individualized care plan based on the interdisciplinary assessment is therefore completed within twenty-one (21) days of admission. The care plan will be maintained in the care plan section of the resident's medical record.

Updating Care Plans:

1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals.
2. Stand-up meetings of the Director of Nursing, Social Services Coordinator (if appropriate), MDS Coordinator, Registered Dietician, Activities Director and Therapy Professional are held to review the current status of skilled residents and determine needed interventions to meet resident goals.
3. The Care Plan will be updated and/or revised for the following reasons:
    a. Significant change in the resident's condition.
    b. A change in planned interventions.
    c. Goals are obtained and new goals established to meet current resident needs and/or goals
    d. New diagnosis, new medications, or abnormal labs.
4. Any revision, additions, or deletion to the plan of care will be dated and initialed.
5. Revisions involving the care of other disciplines are done through consultative and collaborative efforts and documented as above.
6. Discharge planning concerns will be identified by all disciplines through ongoing assessment. The licensed nurse will make appropriate referrals to interdisciplinary team members as necessary.
7. All residents are discussed with the Interdisciplinary Team to provide continued appropriate interventions based on the resident's goals, care needs, and discharge planning.

Resolution of Problems:

1. When outcomes/goals are attained, an evaluation of the problem will be documented, dated and initialed by the interdisciplinary (ID) team members.

Resident/Resident Representative Involvement:

1. Residents are involved in decisions regarding the provision of care.
2. Discussions with resident/representative may occur during admission, during resident care conferences, and anytime a new diagnosis is established and/or the plan of care is significantly altered.
3. Regularly scheduled resident care conferences are held by the 21st day after admission, quarterly, annually, or if a significant change in status occurs.
4. The resident, resident representative and health care providers are invited to attend and provide input into the planning process.

CAA's provide further assessment of triggered MDS areas, and enables staff to further analyze assessment findings to develop a comprehensive plan of care.

**POLICY/PROCEDURE**

**SUBJECT:** Discharge Planning Process

**DATE:**

**INTENT:**

It is the policy of the facility to assure that the discharge planning process is implemented in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

2. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and:
    a. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
    b. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
    c. Involve the interdisciplinary team, as defined by §483.21(b) (2) (ii), in the ongoing process of developing the discharge plan.
    d. Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
    e. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
    f. Address the resident's goals of care and treatment preferences.
    g. Document that a resident has been asked about their interest in receiving information regarding returning to the community.
    h. If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
    i. Facilities will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
    j. If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
    k. For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in

selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility will ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

l. Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

**PROCEDURE**

**SUBJECT:** Discharge Planning

**DATE:**

**INTENT:**

It is the policy of the facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility's discharge planning process will be consistent with the discharge rights set forth at 483.15(b) as applicable.
2. The facility will ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
3. The facility will include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
4. The facility will involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
5. The facility will consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
6. The facility will involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
7. The facility will address the resident's goals of care and treatment preferences.
8. The facility will document that a resident has been asked about their interest in receiving information regarding returning to the community.
9. If the resident indicates an interest in returning to the community, the facility will document any referrals to local contact agencies or other appropriate entities made for this purpose.

10. The Facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

11. If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

12. For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

13. Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

14. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.

15. The post-discharge plan of care will indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

**POLICY/PROCEDURE**

**SUBJECT:** Discharge Summary

**DATE:**

**INTENT:**

It is the policy of the facility to assure that a discharge summary is completed in accordance to State and Federal requirements.

**PROCEDURE:**

1. When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
    a. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.
    b. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

2. When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
    a. A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
    b. A final summary of the resident's status to include items in paragraph (b) (1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
    c. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

PLACE TAB FOR QUALITY OF LIFE HERE

**POLICY/PROCEDURE**

**SUBJECT:** Quality of Life

**DATE:**

**INTENT:**

It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

**PROCEDURE:**

This policy will include:

1. Quality of Life
2. Activities of Daily Living (ADLs)/Maintain Abilities
3. ADL Care Provided for Dependent Residents
4. Cardio-Pulmonary Resuscitation (CPR)
5. Activities Meet Interest/Needs of Each Resident
6. Qualifications of Activity Professional

**POLICY/PROCEDURE**

**SUBJECT:** Quality of Life

**DATE:**

**INTENT:**

It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

**PROCEDURE:**

Quality of life is a fundamental principle that applies to all care and services provided to facility residents.

Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

**POLICY/PROCEDURE**

**SUBJECT:** Activities of Daily Living (ADLs)/Maintain Abilities

**DATE:**

**INTENT:**

It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

**PROCEDURE:**

1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.

2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.

3. The facility will provide care and services for the following activities of daily living:
    a. Hygiene –bathing, dressing, grooming, and oral care,
    b. Mobility—transfer and ambulation, including walking,
    c. Elimination-toileting,
    d. Dining-eating, including meals and snacks,
    e. Communication, including:
        i. Speech,
        ii. Language, and
        iii. Other functional communication systems.

4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, if and when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

5. The facility will ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities by:
    a. Making appointments, and

b. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

**POLICY/PROCEDURE**

**SUBJECT:** Activities Meet Interest/Needs of Each Resident

**DATE:**

**INTENT:**

It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

**PROCEDURE:**

1. The facility will provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

2. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:
    a. Is licensed or registered, if applicable, by the State in which practicing; and
    b. Is:
        i. Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
        ii. Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or
        iii. Is a qualified occupational therapist or occupational therapy assistant; or
        iv. Has completed a training course approved by the State.

PLACE TAB FOR QUALITY OF CARE HERE

**POLICY/PROCEDURE**

**SUBJECT:** Quality of Care

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

This policy will include:

1. Quality of Care
2. Treatment/Devices to Maintain Hearing/Vision
3. Treatment/Services to Prevent/Heal Pressure Ulcers
4. Foot Care
5. Increase/Prevent Decrease in ROM/Mobility
6. Free of Accident Hazards/Supervision/Devices
7. Bowel/Bladder Incontinence, Catheter, UTI
8. Colostomy, Urostomy, or Ileostomy Care
9. Nutrition/Hydration Status Maintenance
10. Tube Feeding Management/Restore Eating Skills
11. Parenteral/IV Fluids
12. Respiratory/Tracheostomy Care and Suctioning
13. Prostheses
14. Pain Management
15. Dialysis
16. Bedrails

**POLICY/PROCEDURE**

**SUBJECT:** Quality of Care

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that each resident receive and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, in accordance with State and Federal Regulations.

**DEFINITIONS:**

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

**PROCEDURE:**

1. The facility will ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process.

2. The facility will ensure that the resident receives proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

3. Based on the comprehensive assessment of the resident, the facility will ensure that the resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

4. The facility will ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility will provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s); and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.

5. The facility will ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

6. The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

7. The facility will ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility will ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

8. The facility will ensure that residents, who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

9. The facility will ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; is offered sufficient fluid intake to maintain proper hydration and health; and is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

10. The facility will ensure that a resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,

diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

11. The facility will ensure that parenteral fluids will be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

12. The facility will ensure that a resident, who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.

13. The facility will ensure that a resident who has a prosthetic device is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

14. The facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

15. The facility will ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

16. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility will ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.
    a. Assess the resident for risk of entrapment from bed rails prior to installation.
    b. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
    c. Ensure that the bed's dimensions are appropriate for the resident's size and weight.
    d. Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

17. The facility will provide care to residents with the diagnosis of Dementia.

18. The facility will provide training to staff related to the above mentioned programs as well as training required by state and federal regulations related to the above mentioned areas. Staff training may be facilitated through any combination of in-person instruction, webinars and or supervised practical training hours and will be competency based.

**POLICY/PROCEDURE**

**SUBJECT:** Treatment/Devices to Maintain Hearing/Vision

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

1. The facility will ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility will, if necessary, assist the resident:
    a. In making appointments, and
    b. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

2. The Director of Social Services or Designee will coordinate the care and services related to vision and hearing needs of our residents.

3. When identified the vision and or hearing needs of a resident will be communicated to the Director of Social Services or Designee.

4. This communication will be documented in the resident's clinical record.

5. Once the Director of Social Services or Designee has made arrangements for vision and or hearing needs of the resident, they will document the arranged services in the resident's clinical record.

6. The facility utilizes outside service providers for Vision and Hearing Services.

7. Residents are seen within the facility.

8. Documentation of services provided will be maintained within the resident's medical record.

**POLICY/PROCEDURE**

**SUBJECT:** Treatment/Services to Prevent/Heal Pressure Ulcers

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

1. The facility will ensure that based on the comprehensive Assessment of a resident:
    a. A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
    b. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
2. Upon admission, the resident will receive a head to toe skin check to identify any skin issues.
3. Interventions will be implemented in the resident's plan of care to prevent pressure sore development, when the resident has no areas of concern.
4. When the resident is admitted with a pressure sore(s) the admitting nurse will document the size, location, odor (if any), drainage (if any), and current treatment ordered.
5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure sore.
6. The admitting nurse will notify the attending physician as well as the resident and or resident's representative of the condition of the pressure sore on admission.
7. The pressure sore(s) will be evaluated weekly and the nurse will document the size, location, odor (if any), drainage (if any), and current treatment ordered.
8. The nurse will notify the physician anytime the pressure sore is showing signs of non-healing or infection and request treatment order changes.
9. The nurse will notify the resident and or the resident's representative of any changes related to the improvement, deterioration and/or treatment changes on an on-going basis.

**WOUND PREVENTION PROGRAM**

**SUBJECT:** Wound Prevention

**DATE:**

**PURPOSE:**

The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds.

**PROCESS:**

1. Upon admission and in conjunction with the Resident Assessment Instrument (RAI) and when a significant change in the resident status occurs, the resident's skin will be evaluated head-to-toe by licensed nurse utilizing a Braden Scale Observation.

2. Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's Electronic Medical Record (EMR).

3. Daily, during routine care, the Certified Nursing Assistant (CNA) will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse and the licensed nurse will proceed as mentioned in step 2 and complete a Wound Event.

4. All residents will have the following nursing care procedures implemented:
    a. Skin Hygiene –
        i. Daily with cleanser, rinse and dry thoroughly
        ii. As needed to keep local areas of skin clean, dry and free of body wastes such as urine, feces, perspiration and wound drainage
        iii. Daily with care lubricate the skin with lotion, to keep it soft and pliable
        iv. During care inspect the skin for signs and symptoms of skin breakdown

    b. Activity –
        i. As tolerated by the resident encourage ambulation and out of bed activity

    c. Pressure Relief –
        i. All residents will have a pressure redistribution mattress
        ii. As tolerated by the resident encourage mobility
        iii. As needed position and reposition the resident with pillows and other supportive devices,
        iv. As needed keep foundation sheets dry and stretch to avoid wrinkles
        v. Wheel chair cushion as indicated

    d. Skin Protection –

i. Avoid shearing forces by keeping the head of bed less than 45 degrees (unless contraindicated)
ii. Use a lift sheet when lifting the resident in bed, do not slide
iii. When the resident requires incontinence brief, check for moisture frequently and apply house stock barrier cream after each incontinent episode
iv. Provide padding for casts, splints and braces and check for redness
v. Apply Skin Prep to:
    1. Skin before applying adhesives
    2. Ears to protect from oxygen cannula irritation
    3. Bony prominences in areas of high friction
    4. Every morning and evening to heels, when applicable.

e. Nutrition/Hydration –
    i. Provide a well-balanced diet
    ii. Encourage fluids, unless contraindicated

**Point of Emphasis:**

**The facility complies with State and Federal guidelines as it relates to wound prevention and definitions. Adherence to this program is under the direction of the DON.**

**WOUND MANAGEMENT PROGRAM**

**SUBJECT:** Wound Management

**DATE:**

**PURPOSE:**

The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds.

**PROCESS:**

1. All residents admitted to facility will have a Braden Scale Observation completed at the time of admission, in conjunction with each quarterly and annual assessment, with any significant change assessment and as deemed necessary by the Interdisciplinary Team; this includes the development of a newly identified pressure ulcer. The admitting nurse is responsible for completing the form. The admitting nurse will then be responsible for initiating the appropriate interventions such as ensuring treatment order(s) are in place, pressure reduction devices are ordered and or requested, i.e. specialty mattress and wheel chair cushion, and that the interim/baseline care plan is initiated.

2. The admitting nurse will then initiate and complete the Initial Wound Exam for each wound that has been identified.

3. The admitting nurse will be responsible for informing the Unit Manger or other designated supervisor of the wound so that the wound can be then documented on the appropriate tracking log. The Unit Manager or other designated supervisor will be responsible for updating the log and every Thursday turning the completed tracking logs to the Director of Nursing, the MDS Department and the Dietary Department

4. The Unit Managers will be responsible for the creation of the monthly cumulative report of all wounds on their individual units and present this report at the monthly Risk Management/Quality Assurance Meeting.

5. The facility utilizes an outside wound care specialist, to assist with wound management and treatment, who provides weekly visits to residents with wounds. The wound description information obtained from this provider will be scanned into the electronic medical record and maintained under the documents section.

6. The Unit Manager or designee will be responsible for completing the Wound Exam Observation utilizing the information obtained during that week's visit.

7. Once the wound has been identified as being healed, the physician as well as the resident and/or resident's representative will be notified and this notification will be documented in the resident's clinical record.

8. The nurse identifying the wound as being healed will notify the Unit Manager or designee that the wound is healed and the Unit Manager or designee will document on the appropriate wound log that the wound is healed.

**Point of Emphasis:**

**The facility complies with State and Federal guidelines as it relates to wound prevention and definitions. Adherence to this program is under the direction of the DON.**

**PROCEDURE**

**SUBJECT:** Clean Dressing Change

**DATE:**

**INTENT:**

It is the policy of the facility to ensure change dressings in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Verify and review physician's order for procedure.
2. Perform hand hygiene and assemble equipment and supplies needed for dressing change.
3. Identify the resident and explain the procedure.
4. Evaluate resident's pain and the need for pain medication.
5. Put on gloves. Adjust bedside stand/table to waist level. Clean bedside stand/table with germicidal disposable cloth. Establish a clean field.
6. Place the resident's trash can within easy reach.
7. Remove gloves and perform hand hygiene.
8. Set-up supplies on barrier.
9. Position the resident for comfort.
10. Perform hand hygiene.
11. Put on clean gloves.
12. Remove dressing and place in the resident's trash can.
13. Remove gloves and perform hand hygiene.
14. Put on clean gloves
15. Cleanse wound with gauze and prescribed cleaning solution using single outward strokes. Use separate gauze for each cleansing wipe.
16. Use dry gauze to pat the wound dry.
17. Remove gloves and preform hand hygiene.
18. Put on clean gloves.

19. Apply clean dressing as ordered and ensure the dressing is dated.
20. Remove gloves and perform hand hygiene.
21. Reposition the resident and ensure the call light is in place.
22. Discard all disposable items into the appropriate receptacle.
23. Clean the bedside stand/table with germicidal disposable cloth.
24. Remove trash from resident's room.
25. Wash and dry hands thoroughly.
26. Document the completion of dressing change on the treatment record.

**PROCEDURE**

**SUBJECT:** Skin Prep Application

**DATE:**

**PROCEDURE:**

The purpose of this procedure is to provide guidelines for the application of skin prep.

1. Assemble equipment and supplies needed.
2. Identify the resident and explain the procedure.
3. Place the resident's trash can within easy reach.
4. Position the resident for comfort.
5. Wash and dry hands thoroughly.
6. Put on clean gloves.
7. Remove the barrier wipe from wrapping and wipe over area(s) of bony prominence and/or high friction.
8. Reposition the resident for comfort as needed.
9. Remove gloves and perform hand hygiene.
10. Document and report any changes to resident's skin integrity.

**POLICY/PROCEDURE**

**SUBJECT:** Foot Care

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

1. Provide foot care and treatment, in accordance with professional standards of practice, including preventing complications from the resident's medical condition(s).
2. If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
3. The Director of Social Services or Designee will coordinate the care and services related to foot care and treatment for our residents.
4. When identified the foot care and treatment needs of a resident will be communicated to the Director of Social Services or Designee.
5. This communication will be documented in the resident's clinical record.
6. Once the Director of Social Services or Designee has made arrangements for foot care and treatment for the resident, they will document the arranged services in the resident's clinical record.
7. Documentation to include but may not be limited to:
    a. Services needed;
    b. Date and time of appointment;
    c. Transportation Services, (What transportation company)
    d. Pick up time; and
    e. Who will be accompanying the resident?

**POLICY/PROCEDURE**

**SUBJECT:** Increase/Prevent Decrease in ROM/Mobility

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

The facility will ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

1. A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
2. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

**POLICY/PROCEDURE**

**SUBJECT:** Specialized Rehabilitative and Restorative Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide Specialized Rehabilitative and Restorative Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will provide specialized rehabilitative services such as, but not limited to physical therapy, speech language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care.

2. The facility will:
   a. Provide the required services; or
   b. In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

3. The facility will ensure that specialized rehabilitative services are provided under the written order of a physician by qualified personnel.

4. The facility will provide restorative services such as but not limited to walking, transfer training, bowel and or bladder training, bed mobility, Range of Motion (ROM), splint and brace, eating and/or swallowing, amputation/prostheses care and communication, when necessary as indicated by the assessment of the interdisciplinary team.

**PROCEDURE**

**SUBECT:** Restorative Nursing Program

**DATE:**

**INTENT:**

It is the policy of the facility to assist each Resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal Regulations.

**PROCEDURE:**

1. Each resident will be screened and or evaluated by the Nurse designated to oversee the restorative nursing process for inclusion into the appropriate facility restorative nursing program(s) when it has been identified by the interdisciplinary team that the resident is in need or may benefit from such program(s).

2. The screening will include the resident or their representative's input, choices, and expectations related to participating in the restorative nursing program.

3. The facility restorative nursing program will include but not be limited to the following programs:
    a. Hygiene –bathing, dressing, grooming, and oral care,
    b. Mobility—transfer and ambulation, including walking, prosthetic and or splint application with or without active and or passive range of motion, bed mobility,
    c. Elimination-toileting, bowel and bladder,
    d. Dining-eating, including meals and snacks,
    e. Communication, including:
        i. Speech,
        ii. Language,
        iii. Other functional communication systems

4. The above programs will be documented on the facility designated restorative care forms/tools in the resident's electronic medical record.

5. Based on clinical evaluation and ongoing consideration residents may be placed in one or more of the above listed programs at one time.

6. The designated nurse will be responsible for the following:
    a. Obtaining orders for the resident's restorative program,
    b. Documentation on a monthly basis (at a minimum), and
    c. Initiation and updating restorative care plans.

7. Once in an appropriate restorative nursing program, the designated nurse will continue to monitor the resident's progress.

8. The designated nurse will evaluate the restorative documentation monthly to determine if there are any changes needed to the existing program and make a monthly progress note, in the resident's electronic medical record related to this evaluation.

9. For active programs, the resident would normally be expected to reflect progress within a four-week period.

10. For maintenance programs, the resident would normally be expected to have already reached their highest level of potential and the therefore be supported to maintain their level and if clinically possible stave off further decline.

11. In the event that it is clinically contraindicated for a resident to participate in a restorative care program, the designated nurse will discuss with the physician or extender and if that is medically determined, the physician or extender will provide an order to direct the staff accordingly.

**POINT OF EMPHASIS:**

It is recognized that there are occasions when residents may have unavoidable declines which may not be reversible which might not be under the control of the facility.

Furthermore, it is recognized that some residents may not wish to participate in restorative care programming which will be respected as election of choice and documented accordingly.

**POLICY/PROCEDURE**

**SUBJECT:** Restorative Nursing Bed Mobility Program

**DATE:**

**POLICY:**

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process. The Nursing Restorative Bed Mobility Program will assist the resident to become more independent in repositioning and moving himself/herself in bed.

**PROCEDURE:**

1. Identifying Residents Who Could Benefit from a Restorative Bed Mobility Program.

    a. The residents admitted from the community (home or hospital) who expects/or plans to return home after rest and/or rehabilitation.

| | | |
|---|---|---|
| Examples: | Recent Surgery | Accident Victim |
| | Pneumonia | Heart Attack |
| | Hip or other Fracture | Mild Stroke |
| | Fall with Injury | Amputee |

    b. The resident who had a recent exacerbation of a chronic disease who desires to return to their prior level of function, or at least maintain this new level.
    Examples: Arthritis, Parkinson's disease, COPD

    c. Any resident with a recent cardiovascular accident (CVA) who has a fair level of alertness and is participating in physical therapy.

    d. Any resident with cognitive impairment, who is alert, follow simple directions, has functional motor skills, is cooperative and demonstrates the potential to increase bed mobility skills.

    e. Any resident who the staff feels has the ability to increase their level of bed mobility ability regardless of the resident's physical or mental limitations.

    f. As a rule of thumb, any resident with a deficit in bed mobility abilities should be evaluated for possible restorative programming or, at a minimum, hand over hand assistance.

2. General Restorative Approaches**:**

    a. A factor critical to the success of restorative programming in these areas is the resident's beliefs and expectations concerning their ability for bed mobility. The

residents must be motivated and believe they can and will progress. At the same time, staff must also believe that the resident can achieve the goals set.

b. Provide daily routine and structure for both the resident and staff on a seven-day basis.

c. Administrative nursing staff must be interested and feel this program is valuable and convey this to the CNAs carrying out the daily program or it will not be successful. The charge nurse sets the tone.

d. Allow CNAs to spend extra time and effort with those residents in restorative bed mobility programs. Allow the resident time and effort to do as much as they can, thereby improving their skills gradually.

e. Activities can promote exercise groups, hug therapy, and movement games to assist in increasing general strength and endurance.

f. Refer any resident to Occupational Therapy (OT) for screening if there is any question on protocol or need for adaptive devices or techniques. Ask OT to write a bed mobility program protocol to follow. The therapist may pick the resident up for direct services before starting the restorative program.

g. Use your occupational therapist (OT) as consultant to the restorative bed mobility program. The therapist can instruct nursing staff on useful techniques to try with the resident. Just as the therapist observes and makes recommendations for restorative programs, the therapist can also observe and monitor the bed mobility program on a weekly or monthly basis.

h. Social services should visit restorative residents weekly to encourage and motivate them to continue participation and efforts. Encourage the residents to express their goals.
    - "I want to sit up in bed by myself"
    - "I want to sit on the side of the bed by myself"
    - "I want to turn over by myself"

i. Residents who should be referred to OT for screening and are usually treated directly for bed mobility training in OT are residents with recent hip and arm fractures, CVAs, acute arthritis and back surgery.

3. The Restorative Care Process:

a. Resident identified for need of program:
    I. By physician order
    II. From Minimum Data Set or Resident Assessment Protocol Trigger (ADL Functional/Rehabilitation Potential)
    III. During initial care plan or care plan review
    IV. By recommendation from physical or occupational therapy
    V. By nursing per monthly review
    VI. By activities when noting activity level

VII. By social service when noting change in emotional or self-esteem level

b. Documentation:

Example of monthly progress note, which would be written in the appropriate space on the Nursing/Rehab Restorative Program Record.

*"Mrs. Cahn is participating well in her daily restorative program for bed mobility. She has progressed from dependent to turning side to side, going from prone to sitting position and dangling legs off bed with minimal assist and active participation. She is motivated but still tires easily. Continue four more weeks."*

*B. Garlin, RN*

c. Discontinue formal programming when the resident reaches independence or maintenance status. The highest goal (bed mobility) reached may be established as a maintenance plan.

d. As a reminder, the care plan should always be updated to reflect current resident status.

4. Bed Mobility Guidelines:

a. Scooting up in Bed

I. Explain to the resident what they are going to do.
II. Take the pillow out from under their head.
III. Have the resident bend their/her hips and knees so they can position their feet flat on bed.
IV. Have the resident bend their elbows and position their hands flat on the bed between waist and hips.
V. Assist resident in stabilizing their legs by gently holding their ankles.
VI. Instruct the resident that on the count of three they are to lift their head and at the same time push down with their feet and arms resulting with them scooting up in bed.
VII. If resident is successful in scooting a sufficient distance, have them straighten their legs out on the bed. If not, have the resident reposition his legs and arms and repeat step 6.

Note: IF a trapeze is on the bed, have the resident hold onto the bar overhead and when they pushes up with their legs pull up with their arms.

b. Scooting Side to Side

I. Explain to the resident what they are going to do.
II. Have the resident bend their hips and knees so they can position their feet flat on bed.
III. Depending on which side the resident is going to scoot toward, have the resident place that foot closer to this side of bed.

IV. Have the resident either reach toward the side of the bed or grasp the rail of the side they will be moving toward. Bend the resident's other elbow and place their hand flat on the bed between their hip and waist.
V. Stabilize legs by gently holding onto the ankles.
VI. On the count of 3, have the resident lift their hips off the bed and swing them sideways. At the same time pull with the hand grasping the side of bed/rail and push with opposite hand.
VII. If scooting the opposite direction, then reposition feet and arms and repeat the step above.

**POLICY/PROCEDURE**

**SUBJECT:** Mobility

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the residents receive range of motion, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will ensure that based on the comprehensive assessment of a resident:
    a. that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and
    b. a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
    c. a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
2. The facility will ensure that the resident reaches and maintains his or her highest level of range of motion and to prevent avoidable decline of range of motion.

**POLICY/PROCEDURE**

**SUBJECT:** Free of Accident Hazards/Supervision/Devices

**DATE:**

**INTENT:**

It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

**PROCEDURE:**

1. The facility must ensure that:
    a. The resident environment remains as free of accident hazards as is possible; and
    b. Each resident receives adequate supervision and assistance devices to prevent accidents.

**POLICY/PROCEDURE**

**SUBJECT:** Reporting Accidents and Incidents

**DATE:**

**INTENT:**

It is the policy of the facility to report Accidents and Incidents in accordance to State and Federal regulations.

**PROCEDURE:**

1. The Incident and Accident Reporting System will include a comprehensive process which will allow for:
    a. Collection of the incident and accident occurrence
    b. Investigate incidents and accidents
    c. Evaluate injuries of unknown source (IUS)
    d. Track and Trend incidents and accidents

2. The Event Report will be completed by Nurse assigned to the resident at the time of the event or a designated Nurse.

3. The Investigation will be initiated by the Nurse Manager or designee within 72 calendar hours from the event.

4. The Risk Manager or Designee will complete the investigation to include the IUS Tool when indicated.

5. The Unit Manager or designee will add the investigation results into the Event and close it after 72 hours.

6. The Risk Manager or designee will track incidents and accidents on the facility surveillance log to determine patterns and trends.

7. Monthly during the facility Risk Management Quality Assurance Meeting the results of the Incident and Accident Tracking System will be evaluated.

8. The facility will ensure that:
    a. The resident environment remains as free from accident hazards as is possible; and
    b. Each resident receives adequate supervision and assistance devices to prevent accidents.
    c. Every attempt is made to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.
        I. Assess the resident for risk of entrapment from bed rails prior to installation.

II. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
III. Ensure that the bed's dimensions are appropriate for the resident's size and weight.

9. The facility will provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
    a. Identifying hazard(s) and risk(s);
    b. Evaluating and analyzing hazard(s) and risk(s);
    c. Implementing interventions to reduce hazard(s) and risk(s); and
    d. Monitoring for effectiveness and modifying interventions when necessary.

10. The facility will identify each resident at risk for accidents and/or falls, and adequately plan care and implement procedures to prevent accidents.

11. The facility will ensure each resident receives adequate supervision and assistance devices to prevent accidents.

12. The facility will development and implement an accident and incident reporting system that will report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

13. The reporting system will consist of:
    a. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation;
    b. Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and
    c. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.

14. The facility will develop and implement written policies and procedures that:
    a. Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Social Security Act. The policies and procedures must include but are not limited to the following elements:
        i. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will:
            - Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility

and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
- Have evidence that all alleged violations are thoroughly investigated.
- Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
- Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

15. The facility will develop appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all non-physician personnel, as follows:
    a. Risk Management Training at orientation
    b. Risk Management Training - 1 Hour Annually

16. The facility will conduct an internal risk management and quality assurance program will include the use of incident reports to be filed with the risk manager and facility administrator. The risk manager shall have free access to all resident records of the licensed facility. The incident reports are part of the work papers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As part of the each internal risk management and quality assurance program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

17. The facility will for purposes of reporting to the agency will use the term "adverse incident" which means: An event over which facility personnel could exercise control and which is associated in whole or in part with the facility's intervention, rather than the condition for which such intervention occurred, and which results in one of the following:
    a. Death;
    b. Brain or spinal damage;
    c. Permanent disfigurement;
    d. Fracture or dislocation of bones or joints;
    e. A limitation of neurological, physical, or sensory function;
    f. Any condition that required medical attention to which the resident has not given his or her informed consent, including
    g. failure to honor advanced directives; or
    h. Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather that the resident's condition prior to the adverse incident; or

i. An event reported to law enforcement or its personnel for investigation; or
j. Resident elopement, if the elopement places the resident at risk of harm or injury.

18. The facility will ensure the risk manager:
    a. Investigates every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact when the allegation is that the sexual misconduct occurred at the facility or at the grounds of the facility;
    b. Reports every allegation of sexual misconduct to the administrator of the licensed facility; and
    c. Notifies the resident representative or guardian of the victim that an allegation of sexual misconduct has been made and that an investigation is being conducted.

19. The facility will initiate an investigation and notify the risk manager if the facility determines the event to meet the definition of an “adverse event”. The risk manager will submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence.

**PROCEDURE**

**SUBJECT:** Medical Errors Occurrence Reporting

**APPROVED:**

---

**INTENT:**

It is the policy of the facility to evaluate any concerns related to medical and or medication errors.

**PROCEDURE:**

1. In the event that a medical and or medication error is detected, the individual detecting it will complete the Medication Variance Event.
2. This report will be based on the type of error and will be reported to the appropriate supervisor or designee if that supervisor is unavailable.
3. The completed Medical Error Occurrence Record will be reviewed the next business day by and signed by the Risk Manager, Administrator and Director of Nursing.
4. The completed Medical Error Occurrence Record will be reviewed by the Medical Director.
5. Based on the error outside reporting may be required to include but not limited to:
   a. 1-800-96-ABUSE, and or
   b. Federal Abuse Neglect Exploitation, and or
   c. State Adverse Incident, and or
   d. Federal Elder Justice Act Suspicion of a Crime
   e. Federal Occupational Safety and Health Administration
   f. Professional Licensure and Certification Boards
   g. Other

**POINT OF EMPHASIS:**

All errors will be reviewed and evaluated with the goal of identification of risk and or a gap analysis to determine correction, systematic changes when indicated, in-service and education, and appropriate follow-up with monitoring.

**PROCEDURE**

**SUBJECT:** Fall Reduction Program

**DATE:**

**INTENT:**

All residents will receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. Each resident will be evaluated for safety risks including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in the prevention of falls.

All Falls are to be investigated and monitored. The facility will maintain a record that contains a list of all incidents and falls. The recording trends are reported and discussed at Quality Assurance Risk Management Committee Meetings monthly and quarterly. The Risk Manager is responsible for coordinating all investigations. If the Incident/Fall meets the Adverse Incident criteria, the Adverse Reporting procedure will be followed according to State Laws.

It is the policy of the facility to report Accidents and Incidents in accordance to State and Federal regulations.

**DEFINITIONS:**

An "accident" is an unexpected, unintended event that can cause a resident bodily injury.

A "fall" is the unintentional coming to rest on a lower surface, such as a chair, the bed or the floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).

An "intercepted fall" occurs when a resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person (this is still considered a fall regardless if the resident does not hit the floor).

A "fracture related to a fall" is any documented bone fracture (in a problem list from a medical record, an x-ray report, or by a history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

Falls are **NOT** a result of an overwhelming external force (e.g., a resident pushes another resident).

**PROGRAM STEPS:**

**I. INVESTIGATIVE GUIDELINES**

A. Check resident for injuries.
   i. Vital Signs

ii. Neuro-checks, for head injuries or un-witnessed fall and resident unable to communicate if he hit his/her head.
iii. Visual check for cuts, bruises, abrasions, redness or deformities.

B. Secure resident
C. Call Post-Fall Huddle and complete form
D. If injury is serious, contact physician or call 911 immediately
E. Contact NHA
F. Contact DON
G. Contact Supervisor, or Unit Manager
H. Notify physician ,family/responsible party of fall
I. Complete Incident/Event Report
J. Update the Fall Evaluation tool in Matrix
K. Start Investigative Report
L. Obtain detailed statements from *ANY* witnesses. Statements must be signed with the correct date and time for falls with serious injuries.
M. Document in the Nurses Notes:
    i. Observed circumstances; resident fell, slid from chair, found on floor, etc.
    ii. Note if any injuries
    iii. Physician contacted
    iv. Resident Representative contacted
    v. Vital Signs
    vi. Neuro-checks
    vii. Any medications taken
    viii. Time of Toileting (if pertinent)
    ix. Any other pertinent observations
    x. Implement any directions given by the Administrator and/or RN on call.
    xi. Use the Fall Intervention form for possible immediate approaches to use in care of the resident.
N. Continue to observe resident throughout shift and provide a thorough report for the next oncoming shift(includes Nurses and C.N.A.s)
O. Each nurse, each shift will observe resident and document for **72** hours in the resident's medical record.
    i. Vital Signs
    ii. Neuro-checks (for unwitnessed falls)
    iii. Behavior changes
    iv. Physical changes
    v. Neurological changes
P. If resident has to be sent out of the facility, initiate the Abuse and or Adverse Incident investigation process. Notify the Risk Manager.
Q. Use the Fall Intervention form for possible immediate approaches to implement status post incident/fall.
R. Risk Manager is to add the resident to the Incident/Fall follow up log.

## II. Quality Assurance/Risk Management Guidelines

A. Responsibility of Risk Manager/Designee
    - Review Incident report for completeness

- Ensure Fall Evaluation Tool has been updated
- Complete Investigative Report
- Take the incident to Stand up meeting for review and care plan review the next business day.
- Therapy to screen resident that falls as referred and recommend appropriate interventions.
- Care plan is to be updated with any new interventions.
- Nursing staff is to document Q shift for 72 hours.
- Trending and Tracking to be completed at end of month and report given at the QAPI monthly/quarterly meetings.
- The Abuse and Adverse Reporting Protocol to be initiated when appropriate.

B. The Interdisciplinary Plan of Care (IPOC) team will meet within the same period of time and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary and revise the care plan if necessary.

C. Rehabilitation therapy will screen referred resident within 24 hours after a fall, unless the fall occurs on a weekend, then the screen will be done on Monday. They will then obtain an order for the appropriate course of treatment or write a restorative program that will assist in reducing further falls.

D. When a resident has more than one fall in a 24-72 hour period of time, one screening and recommendation will suffice unless the IPOC team deems otherwise.

E. If the resident sustained an injury requiring care that you cannot provide or Abuse is suspected or alleged, then initiate the appropriate reporting requirements for State and Federal reporting.

**III. Fall Reduction Program "Falling Star Program"**

A. Program Goal:

The Falling Star Program is a comprehensive program designed to identify and address residents 'actively at risk' for falls. This is in accordance to assisting residents maintain a safe and comfortable environment while residing in the facility. By creating such a program, our goals will be to reduce the number of falls and or falls with injury on a monthly, quarterly, and annual basis.

B. Staff Involvement:

The Falling Star Program will be a full facility program including all disciplines 24 hours a day, seven days a week. The Falling Star Program will be in-serviced to all facility staff on hire, annually, and PRN as dictated by Department Heads and/or the Administrator.

C. Criteria:
The criteria for inclusion in the Program include:

1. Resident has been identified as a fall risk (fall score of 15 or greater)on their admission Safety Risk Evaluation or on their admission minimum data set (MDS), and/or
2. The resident is on an **anticoagulant** and/or
3. Has **moderate to severe Osteoporosis**.
4. Resident has a new fall from standing, sitting, lying position.

The criteria for discontinuance of a resident in the Program:

1. Resident was placed on program as a new admit with a FRA of 15 or higher and has remained fall free for 30 days,
2. Resident is no longer identified as a moderate/high fall risk for 30 or more days,
3. Resident was placed on program after 2 or more falls in 30 days and has remained fall free for 60 days,
4. Resident who was placed on program for being on anticoagulant with FRA of 10 or higher and has remained fall free for 30 days, and or
5. Resident was placed on program due to fall with major injury and has remained fall free for 90 days.
6. Resident is capable of following safety instructions and/or remembers to use the call bell. (IDT) discussion.
7. The Inter Disciplinary Team decision.

D. The Falling Star Identification:

1. Residents who are included in the Falling Star Program will be identified with a Star. The Star will be placed outside resident's room (with the resident's bed number written neatly off center for identification when in semi-private rooms), wheelchairs, walkers, and/or canes.

E. Program description will include:

1. Monitor shower rooms for non-slip surfaces,
2. Monitor all assistive equipment (e.g., wheelchairs, walkers, etc.) for broken or loose parts,
3. Keep floors in the hallways and rooms dry and clutter-free,
4. Identify all residents at risk for falls,
5. Monitor medications for side-effects that can cause dizziness,
6. Monitor handrails and other objects for sharp edges, broken parts, etc.,
7. Remove items that are out of place in rooms and resident common areas to avoid tripping (e.g., trash cans, linen carts, etc.),
8. Check residents who are using alarms (bed, chair),
9. Monitor lighting for burnt out light bulbs, and
10. STOP, LOOK, and LISTEN

## IV. FORMS

- **Incident Report**

- **Fall Investigation Report**
- **Incident/Fall follow-up log**
- **Fall Review and Interventions – Possible Immediate Approaches**
- **Accident/Incident Surveillance Tracking Log**

**Point of Emphasis:**

Each time an employee (any department) walks past a resident room or resident identified with a STAR the employee will **STOP, LOOK**, and **LISTEN** to assure that the resident is safe and not in an unsafe situation.

**POLICY/PROCEDURE**

**SUBJECT:** Missing Resident

**DATE:**

**INTENT:**

It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable. This is with the intent of not invading privacy but to identify a possible missing resident.

**PROCEDURE:**

1. In the event that any staff member identifies that they cannot find a resident in a place that the resident is anticipated to be, the staff member will alert their supervisor for assistance once affirming that the resident was not signed out on leave, and if not, inform the Nurse.

2. The Nurse on the Unit will assume control of the search and gather all available staff and begin an immediate preliminary search of the area and immediate premises. Areas to be searched include but are not limited to resident rooms, bathrooms, utility rooms, shower rooms, activity rooms, and locked areas normally not accessible to residents.

3. Staff will also search the unit in order to identify any other residents that may be missing.

4. While staff are conducting the search, the Nurse assigned to the Unit will make phone calls to alert the Administrator, Director of Nursing and Risk Manager of the missing resident.

5. The facility has designated the term "MR" as the universal page for those residents who are determined to be missing and unable to be located at that time.

6. The Nurse will notify the Receptionist and a "MR" will be paged throughout the campus supervisor would alert staff of the identity of the resident and direct designated staff to participate in the search.

7. Staff on the unit will make copies of the resident's photograph to be distributed.

8. The Nurse in charge of the search will not assume that the resident has left the facility and will:
    a. Re-affirm if the resident could be out of the facility on an authorized leave or pass by reviewing the facility sign out process;
    b. Determine if it is prudent to call the Residents family or other visitors if there is a possible concern that the resident was taken out and potentially they did not sign the resident out;

c. If the resident is not authorized to leave the facility independently, initiate a search of the facility and premises by assigning staff to look in various areas;
d. If the resident is not located in a reasonable amount of time, the Administrator and the Director of Nursing (DON), the resident's representative, the Attending Physician, and law enforcement officials will be notified as indicated; and
e. If the resident remains unable to be located and or is not authorized to leave the facility independently; Initiate an extensive search of the surrounding area.

9. When a missing resident is not located within the confines of the facility building, then the Nurse in charge would direct designated staff to participate in an outside facility grounds search, which may include but is not limited to the roof of the building, the parking lot, and any outside parked vehicles, etc.

6. In the event that a staff member observes a resident attempting to leave the premises without supervision and is concerned that the resident would not normally be appropriate to do so independently, the staff member will:
   a. Call for assistance then calmly approach the resident, (attempt to initiate a friendly chat as possible), and in a courteous manner attempt to re-direct or guide the resident back into the facility;
   b. If the resident is upset or agitated and is not easily re-directed or guided, the staff member will continue walking with the resident either next to or behind them to provide support, supervision, and safety; and
   c. If the resident is not able to be re-directed or guided and is out of the facility, the staff member will alert another staff member or supervisor for assistance while staying with the resident (e.g., use of cellular phone, tell the next person the staff member see's to please get assistance, may need to verbally yell out, etc.).

7. When a resident who was missing is found, unless they were with their family or other supporting individual, the nurse will:
   a. Examine the resident for possible injuries;
   b. Notify the Attending Physician for consultation;
   c. Notify the facility Administrator or designee;
   d. Notify the resident's designated representative;
   e. Discuss with the Administrator, DONS, or designee if it is prudent to provide the resident with 1:1 or other level of supervision;
   f. Complete the facility appropriate report to document the event; and
   g. Complete appropriate documentation in the resident's medical record.

8. The supervisor or designee will also instruct staff members to verify any other resident that has been identified as at risk of wandering is in the building to affirm their safety.

If the facility utilizes signaling devices proceed to #9

9. If the resident uses an electronic device that alarms, the supervisor or designee will:
   a. Determine if an electronic protection device normally used by the resident, if any, is present and, if so, the location of the device on the resident's body;

b. Test any used electronic protection device both on the resident and attached to or associated with any doorways;
c. Alert the Maintenance Director or their designee's in the event that there is a mechanical device involved in the situation;
d. In the event that there is any doorway equipment malfunction supervision of that area will be provided unless there is only one resident at risk in which case the assigned staff member will provide 1:1 or other frequency of observation to the resident as determined by the physician and or supervisor; and
e. Re-evaluate the resident's risk for possible elopement regardless if this event may constitute an elopement or not.

**POLICY/PROCEDURE**

**SUBJECT:** Elopement

**DATE:**

**INTENT:**

It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable. This is with the intent of not invading privacy but to identify possible elopement.

**DEFINITION:**

Elopement includes when a resident leaves the premises or a safe area without authorization and/or necessary supervision placing the resident at risk for harm or injury.

**PROCEDURE:**

1. In the event that any staff member identifies that they cannot find a resident in a place that the resident is anticipated to be, the staff member will alert their supervisor for assistance once affirming that the resident was not signed out on leave.

2. The supervisor would assume control of the search.

3. The supervisor would alert staff of the identity of the resident and direct designated staff to participate in the search.

4. The supervisor in charge of the search will not assume that the resident has left the facility and will:
    a. Re-affirm if the resident could be out of the facility on an authorized leave or pass by reviewing the facility sign out process;
    b. Determine if it is prudent to call the Residents family or other visitors if there is a possible concern that the resident was taken out and potentially they did not sign the resident out;
    c. If the resident is not authorized to leave the facility independently, initiate a search of the facility and premises by assigning staff to look in various areas;
    d. If the resident is not located in a reasonable amount of time, the Administrator and the Director of Nursing (DON), the resident's representative, the Attending Physician, and law enforcement officials will be notified as indicated; and
    e. If the resident remains unable to be located and or is not authorized to leave the facility independently; Initiate an extensive search of the surrounding area.

5. When a missing resident is not located within the confines of the facility building, then the supervisor in charge would direct designated staff to participate in an outside facility grounds search, which may include but is not limited to the roof of the building, the parking lot, and any outside parked vehicles, etc.

6. In the event that a staff member observes a resident attempting to leave the premises without supervision and is concerned that the resident would not normally be appropriate to do so independently, the staff member will:
    a. Call for assistance then calmly approach the resident, (attempt to initiate a friendly chat as possible), and in a courteous manner attempt to re-direct or guide the resident back into the facility;
    b. If the resident is upset or agitated and is not easily re-directed or guided, the staff member will continue walking with the resident either next to or behind them to provide support, supervision, and safety; and
    c. If the resident is not able to be re-directed or guided and is out of the facility, the staff member will alert another staff member or supervisor for assistance while staying with the resident (e.g., use of cellular phone, tell the next person the staff member see's to please get assistance, may need to verbally yell out, etc.).

7. When a resident who was missing is found unless they were with their family or other supporting individual, the nurse will:
    a. Examine the resident for possible injuries;
    b. Notify the Attending Physician for consultation;
    c. Notify the facility Administrator or designee:
    d. Notify the resident's designated representative;
    e. Discuss with the Administrator, DONS, or designee if it is prudent to provide the resident with 1:1 or other level of supervision;
    f. Complete the facility appropriate report to document the event; and
    g. Complete appropriate documentation to include in the resident's medical record.

8. The supervisor or designee will also instruct staff members to verify any other resident that has been identified as at risk of wandering is in the building to affirm their safety.

If the facility utilizes signaling devices proceed to #9

9. If the resident uses an electronic device that alarms, the supervisor or designee will:
    a. Determine if an electronic protection device normally used by the resident, if any, is present and, if so, the location of the device on the resident's body;
    b. Test any used electronic protection device both on the resident and attached to or associated with any doorways;
    c. Alert the Maintenance Director or their designee's in the event that there is a mechanical device involved in the situation;
    d. In the event that there is any doorway equipment malfunction supervision of that area will be provided unless there is only one resident at risk in which case the assigned staff member will provide 1:1 or other frequency of observation to the resident as determined by the physician and or supervisor; and
    e. Re-evaluate the resident's risk for possible elopement regardless if this event may constitute an elopement or not.

**POLICY/PROCEDURE**

**SUBJECT:** Incontinence

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

2. For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility will ensure that:
    a. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
    b. A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and
    c. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

3. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility will ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

**PROCEDURE**

**SUBJECT:** Bowel and Bladder Program

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. All residents admitted to facility will have a Bowel and Bladder Continence Evaluation preformed at the time of admission, in conjunction with each quarterly and annual assessment, with any significant change assessment and as deemed necessary by the Interdisciplinary Team; this includes the removal of an indwelling urinary catheter.
2. The admitting nurse or designee is responsible for completing the initial evaluation.
3. The admitting nurse or designee will then be responsible for initiating the 3-Day Resident Tracking/Trending Bowel and Bladder Pattern with the resident's name, room number and date for all new admissions.
4. The C.N.A. responsible for the resident at the time of admission will begin the tracking and trending documentation on the form.
5. After the 3 days the Unit Manager or designee will review the documentation looking for an established pattern.
6. The Unit Manager or designee along with the Interdisciplinary Team will evaluate the appropriate program for the resident and refer to Restorative if appropriate.
7. When appropriate, the Unit Manager or designee will initiate the Restorative Bowel and/or Bladder Retraining Program. This is a 14 day program.
8. The C.N.A. responsible for the resident will document on the Restorative Bowel and Bladder Form.
9. After 14 days the Unit Manager or designee will reevaluate the appropriateness to continue with current plan or change the current plan.

**PROCEDURE**

**SUBJECT:** Indwelling Catheter Justification and Removal

**DATE:**

**POLICY:**

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. When a resident is admitted with an indwelling catheter, the admitting nurse will complete the Indwelling Urinary Catheter Justification Form.
2. The admitting nurse will document the indwelling catheter size and obtain an order from the physician or physician extender to change the catheter as needed for blockage, as well as obtain a supporting diagnosis for use of the catheter.
3. The admitting nurse will also obtain orders to perform catheter care on each shift, to irrigate the catheter as needed for occlusion or blockage, and may change indwelling urinary catheter to obtain urinalysis when catheter has been in place for greater than 14 days.
4. When there is no supporting diagnosis for the use of the indwelling urinary catheter, the admitting nurse will obtain an order from the physician or physician extender to remove, along with orders for notification when the resident does not void.
5. Once the indwelling urinary catheter has been removed the nurse removing the catheter will document this in the electronic medical record and initiate the 3-day tracking and trending Form for the nursing assistant to document voiding.
6. Update the care plan as indicated based on outcome.

**POLICY/PROCEDURE**

**SUBJECT:** Colostomy, Urostomy, or Ileostomy Care

**DATE:**

**INTENT:**

It is the policy of the facility to provide Colostomy, Urostomy, or Ileostomy Care Services in accordance to State and Federal regulations.

**PROCEDURE:**

The facility will ensure that a resident who requires colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

**POLICY/PROCEDURE**

**SUBJECT:** Nutrition/Hydration Status Maintenance

**DATE:**

**INTENT:**

It is the policy of the facility to provide Nutrition/Hydration Status Maintenance Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. Based on a resident's comprehensive assessment, the facility will ensure that a resident:
   a. Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;
   b. Is offered sufficient fluid intake to maintain proper hydration and health;
   c. Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

2. Based on a resident's comprehensive assessment, the facility will ensure that a resident:
   Enteral Nutrition:
   a. A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and
   b. A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

**POLICY/PROCEDURE**

**SUBJECT:** Assisted Nutrition and Hydration

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the residents receive care and services related to Naso-Gastric Tubes or gastrostomy tube, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will ensure that based on the comprehensive assessment of a resident:

    a. A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and
    b. A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers..

2. The facility will ensure that a naso-gastric tube or gastrostomy tube feeding is utilized only after adequate assessment, and the resident's clinical condition makes this treatment necessary.

3. Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

4. Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

5. Is offered sufficient fluid intake to maintain proper hydration and health.

*Note - This Policy includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic, Jejunostomy, and enteral fluids.

**POLICY/PROCEDURE**

**SUBJECT:** Enteral Feeding

**DATE:**

**INTENT:**

It is the policy of the facility to provide adequate nutrition and hydration to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance to State and Federal regulation.

**PROCEDURE:**

Residents Admitted to Facility Without Tube Feedings:

A resident who has been able to eat enough alone or with assistance is not fed by gastric tube unless the resident's clinical condition demonstrates that use of a gastric tube was unavoidable. Clinical conditions demonstrating that nourishment via a gastric tube is unavoidable include:

- The inability to swallow without choking or aspiration (i.e., in cases of Parkinson's disease, pseudo bulbar palsy, Advanced stages of Dementia or esophageal diverticulum).
- Lack of sufficient alertness for oral nutrition (i.e., comatose), and
- Malnutrition not attributable to a single cause or causes that can be isolated and reversed.
- There is documented evidence the facility has not been able to maintain or improve the resident's nutritional status through oral intake.

1. Physician should document the clinical conditions demonstrating the need for a tube feeding, and the resident, his/her family or legal representative should be consulted regarding the use of a feeding tube.

2. Documentation in the medical record should reveal identification of the risk for malnutrition, and what the facility did to maintain oral feeding, prior to inserting a feeding tube.

3. Where swallowing difficulties are identified, the resident should receive appropriate therapies to improve or enhance swallowing skills, as appropriate.

4. Documentation in the medical record should reveal consultation with the dietitian.

Residents Admitted to Facility With Tube Feedings Already In Place:

A resident who is fed by a gastrostomy tube shall receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting,

dehydration, metabolic abnormalities and to restore, if possible, normal eating skills.

5. Admitting Nurse will obtain Physician Orders for Tube Feeding Formula.

6. The Dietitian will be notified of the tube feeding orders and assess nutrition/hydration needs of the resident. Based on the outcome of assessment the dietitian will make recommendations for tube feeding type, rate, volume and water flushes.

7. The Nurse will review the Dietitian's recommendations with the Physician and obtain orders.

8. A Feeding Pump will be utilized for all Enteral Feedings, unless otherwise contraindicated.

9. Proper elevation of the Resident's head will be maintained according to Resident's condition.

10. Prior to the flushing of a feeding tube, the administration of medication via a feeding tube, or the providing of tube feedings, the nurse performing the procedure ensures the proper placement of the feeding tube.

11. Universal precautions and clean technique will be utilized when stopping, starting, flushing, and giving medications through the feeding tube.

12. The plan of care should address tube-feeding use, strategies to prevent complications including, but not limited to: aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and to restore, if possible, normal eating skills.

**PROCEDURE**

**SUBJECT:** Enteral Tube Feeding via Bolus

**DATE:**

**INTENT:**

It is the policy of the facility to provide enteral feeding as ordered by the physician via bolus to ensure adequate nutrition for residents that are unable to maintain their nutrition orally.

**PROCEDURE:**

1. Obtain a physician order to include the following information:
   a. Resident's name, and room number
   b. Type of formula
   c. Route of delivery Access site
   d. Method (Bolus)
   e. Number of cans/or number of CC's for administration
   f. Flushes before and after bolus feeding
   g. Free water flush order
   h. HOB elevation
   i. Changing syringe and tubing every 24 hours

2. Check the Enteral Administration Record.

3. Place your supplies on a clean over bed table/bedside stand and arrange so they can be easily reached.

4. Position head of bed at 30-45 degrees unless medically contraindicated.

5. Wash hands and dry thoroughly.

6. Donne gloves.

7. Provide barrier to protect resident's clothing.

8. Verify placement of the tube using the facility's procedure.

9. Check gastric residual volume using the facility's procedure.

10. If the placement is positive and gastric residual volume is within the amount acceptable for that resident, proceed to initiating the enteral feeding.

11. Attach a 60 ml large tip syringe without the barrel to the tube and unclamp the tube. Elevate the syringe approximately Twelve to Eighteen (12-18) inches above the residents head if length of tube allows.

12. Fill the syringe with the prescribe amount of water (room temperature) flush as ordered. Unclamp the tube and allow flush to flow by gravity.

13. Fill the syringe with the formula and allow to flow by gravity until the prescribe amount is administered.

14. Follow the feeding with the prescribed amount of water flush (room temperature)

15. Plug the end of the enteral tube and secure it.

16. Instruct the resident to remain upright or leave head of bed elevated for approximately one (1) hour to prevent aspiration

17. Discard disposable supplies in the designated containers.

18. Clean reusable equipment.

19. Clean over bed table and return to proper position.

20. Make the resident comfortable.

21. Place call light in easy reach for resident.

22. Remove gloves and wash hands.

23. Document on the resident's medical record to include any complication and notify the physician as needed.

**PROCEDURE**

**SUBJECT:** Enteral Tube Feeding via Pump

**DATE:**

**INTENT:**

It is the policy of the facility to provide enteral feeding as ordered by the physician via pump to ensure adequate nutrition for residents that are unable to maintain their nutrition orally.

**PROCEDURE:**

1. Obtain a physician order to include the following information:
    j. Resident's name, and room number
    k. Type of formula
    l. Route of delivery Access site
    m. Method (pump)
    n. Rate of administration (number of cans/or number of CC's)
    o. Number of hours to administer
    p. Time to start and end
    q. Free water flush order
    r. HOB elevation
    s. Changing syringe and tubing every 24 hours

2. Check the Enteral Administration Record

3. Label the enteral feeding bag/bottle, to include the tubing, with the following information:
    a. Resident's name and room #
    b. Type of formula (if using bags)
    c. Date and time formula is being hung
    d. Rate of administration

4. Place your supplies on a clean over bed table/bedside stand and arrange so they can be easily reached.

5. Position head of bed at 30-45 degrees unless medically contraindicated.

6. Wash hands and dry thoroughly

7. Donne gloves

8. Attach the enteral tubing to the pump and prime the tubing

9. Verify placement of the tube using the facility's procedure.

10. Check gastric residual volume using the facility's procedure.

11. If the placement is positive and gastric residual volume is within the amount acceptable for that resident, proceed to initiating the enteral feeding.

12. Clamp the enteral tube and remove the plug.

13. Connect the primed feeding pump set to the enteral tube (G-Tube, NGT, Jejunostomy tube) and unclamp the tube. Set rate and press start for continuous feeding

14. Discard disposable supplies in the designated containers.

15. Clean reusable equipment.

16. Clean over bed table and return to proper position.

17. Make the resident comfortable

18. Place call light in easy reach for resident

19. Remove gloves and wash hands

20. Document on the resident's medical record to include any complication and notify the physician as needed.

**PROCEDURE**

**SUBJECT:** Enteral Tube Feeding via Gravity Bag

**DATE:**

**INTENT:**

It is the policy of the facility to provide enteral feeding as ordered by the physician via gravity bag to ensure adequate nutrition for residents that are unable to maintain their nutrition orally.

**PROCEDURE:**

1. Obtain a physician order to include the following information:
   a. Resident's name, and room number
   b. Type of formula
   c. Route of delivery Access site
   d. Method (Gravity Bag)
   e. Number of cans/or number of CC's for administration
   f. Flushes before and after gravity feeding
   g. Free water flush order
   h. HOB elevation
   i. Changing syringe and tubing every 24 hours

2. Check the Enteral Administration Record.

3. Place your supplies on a clean over bed table/bedside stand and arrange so they can be easily reached.

4. Maintain head of bed at 30-45 degrees unless medically contraindicated.

5. Preform hand hygiene.

6. Donne gloves.

7. Provide barrier to protect resident's clothing.

8. Verify placement of the tube using the facility's procedure.

9. Check gastric residual volume using the facility's procedure.

10. If the placement is positive and gastric residual volume is within the amount acceptable for that resident, proceed to initiating the enteral feeding.

11. Pour prescribed amount of enteral feeding into enteral feeding bag and prime tubing. Clamp tubing.

12. Remove the plug from the enteral feeding tube and flush as order.

13. Hang enteral feeding bag on IV pole approximately eighteen (18) inches above resident's head. Connect to enteral tube and allow feeding to flow by gravity.

14. Follow feeding with prescribed flush order.

15. When flush completed, disconnect bag from enteral tube

16. Instruct the resident to remain upright or leave head of bed elevated for approximately one (1) hour to prevent aspiration.

17. Discard disposable supplies in the designated containers.

18. Clean reusable equipment.

19. Clean over bed table and return to proper position.

20. Make the resident comfortable.

21. Place call light in easy reach for resident.

22. Remove gloves and wash hands.

23. Document on the resident's medical record to include any complication and notify the physician as needed.

**PROCEDURE**

**SUBJECT:** Changing a Gastrostomy Tube

**DATE:**

**INTENT:**

It is the policy of the facility to maintain nutritional support for residents unable to obtain nourishment orally

**PROCEDURE:**

1. Obtain a physician's order for the procedure
2. This procedure is performed by a Registered Nurse only.
3. Assemble equipment and supplies
   a. Towel or other barrier
   b. Gastrostomy tube (size ordered by physician)
   c. Water soluble lubricant
   d. Two (2) 10 ml syringes
   e. Normal saline;
   f. Sterile water
   g. Personal protective equipment (Gown, gloves, mask, eve shield).
4. Place protective barrier on a clean bedside
5. Place equipment on bedside table and arrange supplies so they can be easily reached.
6. Wash hands
7. Put on gloves
8. Open package with new gastrostomy tube and check for proper inflation by inflating the balloon with (10) ml of sterile water, then deflate balloon.
9. Leave new tube in package
10. Deflate balloon in existing gastrostomy tube using (10) ml syringe.
11. Apply gentle pressure with non-dominant hand and then pull gastrostomy tube upward with dominant hand until out of the abdomen.

12. Clean the stoma site with normal saline.

13. Remove the new tube from the package by the large end of the tube

14. Apply lubricant to the tip of the tube and gently insert six (6) to eight (8) inches into the stoma site

15. Inflate the balloon with five (5) ml (or as recommended by the manufacturer) of sterile water

16. Pull gastrostomy tube upward until balloon is resting against the inside of the stomach and secure

17. If tube not in use then clamp until needed

18. Stop for any resistance and attempt again.

19. If replacing a tube that was removed traumatically, ensure an abdominal X-RAY id completed prior to use.

20. Discard disposable supplies.

21. Clean over bed table and return to its proper position.

22. Ensure resident is comfortable with call light access.

23. Document procedure in the resident's medical record and notify the physician as needed.

**PROCEDURE**

**SUBJECT:** Gastrostomy/Jejunostomy Site Care

**DATE:**

**INTENT:**

It is the policy of the facility to provide Gastrostomy and Jejunostomy site care to decrease the risk of infection.

**PROCEDURE:**

1. Obtain a physician order to include the following information:
    t. Resident's name, and room number
    u. Type of solution for cleansing
    v. Frequency of treatment

2. Arrange supplies so they can be easily reached on a clean surface

3. Wash hands and put on clean gloves

4. For **New Sites only:**
    a. Evaluate for pain and medicate as indicated prior to procedure.
    b. Using gauze pads with normal saline, gently clean the area immediately surrounding the tube and continue working outward in a circular fashion. Be sure you clean under the bolster.
    c. If the resident has a "Button", use a cotton-tipped applicator to clean the area and rotate the device once everyday
    d. Pat dry after cleaning
    e. Apply ointment if ordered
    f. Cover with dressing as ordered

5. For established sites:
    a. Evaluate for pain and medicate as indicated prior to procedure.
    b. Using gauze pads, soap and water, gently clean the area immediately surrounding the tube and continue working outward in a circular motion. Be sure to clean under the bolster.
    c. If the resident has a 'Button", use a cotton- tipped applicator to clean the area and rotate the device daily.
    d. Pat dry after cleaning
    e. Do not place a dressing over the site unless otherwise ordered
    f. Evaluate stoma site for signs of redness, pain or soreness, swelling or drainage. Document if present and notify the resident's physician.
    g. Discard disposable supplies in designated containers
    h. Clean surface used for supplies
    i. Make resident comfortable

j. Ensure resident can reach call bell
k. Remove gloves and discard in appropriate container
l. Wash hands

6. Document the procedure in the resident's medical record.

**PROCEDURE**

**SUBJECT:** Cleaning and Storing Reusable Syringe Used During Enteral Feeding

**DATE:**

**INTENT:**

It is the policy of the facility to clean and store syringes used during enteral feeding in a manner that decreases the risk of infection.

**PROCEDURE:**

1. With gloves on, separate the barrel and the plunger
2. Rinse both pieces with warm until clean
3. Use a clean paper towel and dry the barrel thoroughly, dry plunger also
4. Store separately in a zip lock bag or a sealed container
5. Remove gloves
6. Wash hands
7. Replaced syringe every 24 hours

**PROCEDURE**

**SUBJECT:** Enteral Feeding Medication Administration

**DATE:**

**INTENT:**

It is the policy of the facility to provide appropriate medication administration to residents who receive their medications via an enteral feeding tube to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance to State and Federal regulation.

**PROCEDURE:**

Residents Admitted to Facility With An Enteral Feeding Tube:

1. The admitting nurse will obtain the medication orders upon admission to the facility.
2. Documentation in the medical record admission orders will identify the route of administration for those medications.
3. Residents who are able to take medications by mouth will be encouraged to do so.
4. For those residents who are to receive “Nothing by Mouth” (NPO) all applicable medication will be administered via the enteral feeding tube.
5. The admitting nurse will notify the pharmacy that the resident is NPO and all medications are to be administered via the enteral feeding tube and request a Pharmacist review of medications for compatibility.
6. Prior to the flushing of a feeding tube, the administration of medication via a feeding tube, or the providing of tube feedings, the nurse performing the procedure ensures the proper placement of the feeding tube.
7. Prior to medication administration flush the tube with 30ml of water, mix each crushed medication with 5-10ml of water and flush with 10ml of water between each medication and flush with 30ml of water after last medication.
8. Universal precautions and clean technique will be utilized when stopping, starting, flushing, and giving medications through the feeding tube.
9. The plan of care will address tube-feeding use, strategies to prevent complications including, but not limited to: aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and to restore, if possible, normal eating skills.

**PROCEDURE**

**SUBJECT:** Placement and Residual Volume Check for Enteral Feeding Tubes

**DATE:**

**INTENT:**

It is the policy of the facility to verify placement of the feeding tube and appropriate levels of gastric residual to decrease the risk of aspiration, nausea and or vomiting during feeding administration.

**PROCEDURE:**

1. Obtain a physician order to include the following:
    a. Frequency to check placement and residual (recommendations for new Gastrostomy tube residual check is every 2-4 hrs. until resident demonstrate the ability to empty stomach).
    b. Parameter for gastric residual volume before feeding and or medications are held.

2. Place your supplies on a clean over bed table/bedside stand and arrange so they can be easily reached.

3. Position head of bed at 30-45 degrees unless medically contraindicated.

4. Wash hands and dry thoroughly

5. Put on gloves

6. Using the auscultory method (for gastrostomy tube)
    a. Protect the resident's clothing
    b. Attach a large tip 60cc syringe with approximately 10cc of air to the feeding tube.
    c. Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing.
    d. Listen for the "whooshing" sound to check placement of the tube in the stomach

7. Aspirate the stomach content:
    a. If there is **100 cc or more** of gastric residual volume, hold the feeding and recheck in one (1) hour. If still **100 cc or more** notify the physician.
    b. Replace aspirated stomach contents.

8. If acceptable placement and Gastric Residual Volume verified, flush feeding tube with 30 cc of water or as ordered by the physician.

9. Administered feeding and or medications as ordered.
10. Discard disposable supplies in the designated containers.
11. Clean reusable equipment.
12. Clean over bed table and return to proper position.
13. Make the resident comfortable
14. Place call light in easy reach for resident
15. Remove gloves and wash hands
16. Document on the resident's medical record to include any complication and notify the physician as needed.

**POLICY/PROCEDURE**

**SUBJECT:** Parenteral/IV Fluids

**DATE:**

**INTENT:**

It is the policy of the facility to provide Parenteral/IV Fluids Services in accordance to State and Federal regulations.

**PROCEDURE:**

Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

**PROCEDURE**

**SUBJECT:** PICC Line Removal Procedure

**DATE:**

**PURPOSE:**

The purpose of this procedure is to assist the facility in the care, services and documentation related to the removal of Peripherally Inserted Central Catheter.

**PROCEDURE:**

1. Verify doctor's orders to remove PICC line.
2. Gather supplies needed:
   a. 1 pair - non-sterile gloves
   b. 2 Moisture- proof drapes
   c. Alcohol pad or swab
   d. Suture removal kit (scissors, forceps), if line is sutured in
   e. PPE's- mask, gloves
   f. 1 pair - sterile gloves
   g. Chlorhexidine skin prep
   h. Sterile 4x4 gauze
   i. Occlusive dressing
   j. Tape measure
   k. Hemostat
3. Introduce self to resident and provide privacy.
4. Explain doctor's orders and the PICC line removal process; answer any questions the resident may have about the procedure.
5. Perform hand hygiene and don non-sterile gloves.
6. Turn off infusion pump, disconnect and clamp lumens, if present.
7. Position the resident in a supine position with the insertion arm extended.
8. Place moisture-proof drape under resident's arm.
9. Instruct resident to turn head away (opposite direction) from PICC line site and avoid moving arm.
10. Cleanse old PICC line dressing with alcohol swab to release transparent dressing.

11. Remove the old dressing by carefully lifting the distal edge of the dressing toward the proximal edge.
12. Remove all catheter securing device{s,) if present:
    a. If sutures are securing the PICC line in place, carefully use the sterile scissor to cut, then use the sterile forceps to remove the loosened suture and pull the thread from the skin
13. Remove and dispose of gloves and old dressing.
14. Don standard precautions personal protective equipment (PPE):
    a. Mask
    b. Gown, as indicated
    c. Protective eyewear
15. Place moisture-proof drape onto clean work surface and open sterile supplies onto drape.
16. Don sterile gloves.
17. Assess PICC line insertion site.
18. Apply chlorhexidine skin prep to insertion site and at least three (3) inches around.
19. Use two (2) fingers of the non-dominant hand to hold the sterile 4x4 gauze just above insertion site.
20. Instruct resident to take a deep breath and hold.
21. Grasp the catheter near the insertion site using dominant hand and while keeping the catheter parallel to the arm, slowly withdraw about one (1) inch (2.5cm) at a time; continue the procedure until the catheter is completely removed.
    a. If there is resistance when withdrawing, STOP! Do not remove PICC line using force or pulling against resistance.
    b. If resistance occurs, taking the following measures that may resolve issue:
        i. Release any pressure along catheter path
        ii. Wait a few minutes to allow vein to relax; venous spasm can cause resistance
        iii. Apply warm packs proximal to the insertion site; warmth may help to relax the vein walls
        iv. Reposition the arm and try again
    c. If resistance continues - STOP!
        i. Clean site, re-prep, secure the catheter, re-dress the site and notify the physician immediately
    d. If the catheter breaks while withdrawing:

        i. Clamp catheter using a sterile hemostat, if enough projects from the insertion site
        ii. Carefully consider the option to continue withdrawal
22. Use sterile 4x4 gauze to apply pressure for a few minutes to site after catheter removal.

23. Instruct resident to exhale and breathe normally.

24. Assess site, if no bleeding is present, leave the sterile 4x4 gauze in place and cover with an occlusive dressing.
    a. If bleeding continues, continue to hold for a few more minutes.

25. Evaluate condition of catheter - measure with a paper tape measure and confirm that it is fully intact.
    a. A non-intact catheter is an emergent situation!
    b. Breakage and retained fragments of the catheter can become dislodged and cause an embolism
        i. Immobilize the limb and instruct the resident to avoid moving the arm
        ii. Carefully apply dressing, avoid dislodging fragments
        iii. Measure removed catheter to determine how much is retained
        iv. Save all catheter pieces for subsequent report of medical device failure
        v. Notify physician of potential embolus
        vi. Prepare patient for possible transport

26. Reposition resident in a comfortable position.

27. Document the following:
    a. Initial resident assessment
    b. Description of the procedure: resident's position, insertion site, aseptic technique, standard precautions, draping, safety measures, hemostasis, dressing
    c. Resident's tolerance of the procedure
    d. Condition and disposition of the removed catheter

**POLICY/PROCEDURE**

**SUBJECT:** Respiratory/Tracheostomy Care and Suctioning

**DATE:**

**INTENT:**

The intent of this policy is that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan, and the resident's choice.

**PROCEDURE:**

The facility will ensure that a resident, who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.

**POLICY/PROCEDURE**

**SUBJECT:** Prostheses

**DATE:**

**INTENT:**

The intent of this policy is that each resident receives necessary care and services that is in accordance with professional standards of practice, the resident's care plan, and the resident's choice.

**PROCEDURE:**

The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

**POLICY/PROCEDURE**

**SUBJECT:** Pain Management

**DATE:**

**INTENT:**

The intent of this policy is that each resident receives necessary care and services that is in accordance with professional standards of practice, the resident's care plan, and the resident's choice.

**PROCEDURE:**

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

**PROCEDURE**

**SUBJECT:** Pain Management Program

**DATE:**

**POLICY:**

The facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.

**PROCEDURE:**

1. Evaluate the resident for pain upon admission, during periodic scheduled assessments, and with change in condition or status (e.g., after a fall, with change in behavior or mental status).

2. Behavioral signs and symptoms that may suggest the presence of pain include but are not limited to:
    a. Change in gait
    b. Loss of function
    c. Decline in activity level
    d. Resisting care, striking out
    e. Bracing, guarding or rubbing
    f. Fidgeting, increased or recurring restlessness
    g. Facial expressions: grimacing, frowning, fear, grinding of teeth
    h. Change in behavior: depressed mood, decreased participation in usual activities of daily living
    i. Loss of appetite
    j. Sleeping poorly
    k. Sighing, groaning, crying, breathing heavily

3. Assessment and evaluation by the appropriate members of the interdisciplinary team may include:
    a. Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual descriptor that is appropriate and preferred by the resident.
    b. Review of the resident's diagnoses or conditions and any additional factors that may be causing or contributing to pain.
    c. Identifying key characteristics of the pain (Examples: Duration, Frequency, Location, Onset, Pattern and Radiation)
    d. Obtaining descriptors of the pain (Examples: Aching, Burning, Throbbing, Tingling, Stabbing)
    e. Determining factors that make the pain better or worse
    f. Identifying recent exacerbations of chronic pain
    g. Impact of pain on quality of life
    h. Current prescribed pain medications, dosage and frequency

i. Note all treatments the patient is receiving for pain including non-pharmacologic therapies.
j. The resident's goals for pain management and his/her satisfaction with the current level of pain control
k. The effectiveness of specific drugs and other treatments used in the past to treat pain.

4. If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified.

5. The interdisciplinary team and the resident collaborate to arrive at pertinent, realistic and measurable goals for treatment.

6. Factors influencing the choice of treatments include:
    a. The patient's underlying diagnoses or conditions that are causing or contributing to pain
    b. The causes, location, nature and severity of pain
    c. The patient's preferences expressed either directly or in an advance directive
    d. Possible adverse medication effects

7. Non-pharmacological pain management interventions include but are not limited to:
    a. Adjusting room temperature
    b. Smoothing linens
    c. Turning and repositioning to a comfortable position
    d. Loosen any constrictive bandage or device
    e. Apply splinting (e.g., pillow or folded blanket)
    f. Physical modalities (e.g., cold compress, warm shower or bath)
    g. Exercises to address stiffness
    h. Cognitive/behavioral interventions (e.g., music, diversions, pain education)

8. Pharmacological interventions should follow a systematic approach.

9. The interdisciplinary team is responsible for developing a pain management regimen.

10. The following are general principles for prescribing analgesics in the long-term care setting:

    a. Evaluate the patient's medical condition and current medication regimen to determine the most appropriate therapy for pain
    b. Consider whether the medical literature contains evidence-based recommendations for specific regiments to treat identified causes of pain
    c. Use the least invasive route of administration possible
    d. For chronic pain, begin with a low dose and titrate carefully until comfort is achieved
    e. For acute pain, begin with a low or moderate dose as needed and titrate more rapidly than for chronic pain

    f. Reassess and adjust the dose to optimize pain relief while monitoring and trying to minimize or manage side effects
    g. Some clinical conditions may require several analgesics or adjuvant medications, documentation should help clarify the rationale for a treatment regimen and to acknowledge associated risks

11. Reassess patients with pain regularly based on the facility's established intervals.

12. If when re-evaluated, findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated.

13. If pain has resolved or there is no longer an indication for pain medication, the interdisciplinary team should work to discontinue or taper (as needed to prevent withdrawal symptoms) analgesics.

**PROCEDURE**

**SUBJECT:** Dialysis

**DATE:**

**POLICY:**

The facility shall provide adequate management of Dialysis Services to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.

**PROCEDURE:**

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

**PROCEDURE**

**SUBJECT:** Bedrails

**DATE:**

**POLICY:**

The facility shall provide adequate management of Bedrails to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.

**PROCEDURE:**

1. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail.
2. If a bed or side rail is used, the facility will ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.
    a. Assess the resident for risk of entrapment from bed rails prior to installation.
    b. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
    c. Ensure that the bed's dimensions are appropriate for the resident's size and weight.
    d. Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
3. The admitting nurse will evaluate the resident for the use of bed/side rails.
4. When bed/side rails are requested by the resident/resident representative, the admitting nurse will complete the Side Rail Evaluation.
5. When bed/side rails are deemed to be appropriate for the resident, upon completion of the Side Rail Evaluation, the admitting nurse will review risks and benefits and obtain informed consent.

PLACE PHYSICIAN SERVICES TAB HERE

**POLICY/PROCEDURE**

**SUBJECT:** Physician Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Physician Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Residents' Care Supervised by a Physician
2. Physician Visits – Review Care/Notes/Orders
3. Physician Visits – Frequency/Timeless/Alternate NPPs
4. Physician for Emergency Care, Available 24 Hours
5. Physician Delegation of Tasks to NPP
6. Physician Delegation to Dietitian/Therapist

**POLICY/PROCEDURE**

**SUBJECT:** Physician Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide Physician Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. Each resident or resident representative will be allowed to select his or her own private physician.
2. A physician will approve in writing a recommendation that an individual be admitted to the facility.
3. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.
4. Each resident will remain under the care of a physician.
5. All physician or other health care professional verbal orders, including telephone orders, will be immediately recorded, dated, and signed by the person receiving the order.
6. All verbal treatment orders will be countersigned by the physician or other health care professional on the next visit to the facility.
7. Physician orders may be transmitted by facsimile machine. It is not necessary for a physician to re-sign a facsimile order when he visits a facility.
8. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift.
9. The facility will ensure that another physician supervises the medical care of residents when their attending physician is unavailable.
10. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.
11. The physician will:
    a. Review the resident's total program of care, including medications and treatments, at each visit;
    b. Write, sign, and date progress notes at each visit; and

c. Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

12. The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

13. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

14. All required physician visits will be made by the physician personally.

15. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance to federal and state laws.

16. A physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who:
    a. Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;
    b. Is acting within the scope of practice as defined by State law; and
    c. Is under the supervision of the physician.

17. A resident's attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who:
    a. Is acting within the scope of practice as defined by State law; and
    b. Is under the supervision of the physician.

18. A resident's attending physician may delegate the task of writing therapy orders, consistent with §483.65, to a qualified therapist who:
    a. Is acting within the scope of practice as defined by State law; and
    b. Is under the supervision of the physician.

19. A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

20. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

INSERT NURSING SERVICES TAB HERE

**POLICY/PROCEDURE**

**SUBJECT:** Nursing Services, General

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Nursing Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Sufficient Nurse Staff
2. Competent Nursing Staff
3. RN 8 Hours/7 Days/Week Full Time DON
4. Facility Hiring and Use of Nurse
5. Nurse Aide Registry Verification, Retraining
6. Nurse Aide Perform Review – 12 Hour/Year In-service
7. Waiver-Licensed Nurses 24 Hour/Day and RN Coverage
8. Posted Nurse Staffing Information

**POLICY/PROCEDURE**

**SUBJECT:** Nursing Services

**DATE:**

**INTENT:**

It is the policy of the facility to assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.

**POLICY:**

1. The facility will have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

2. The facility will provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

    a. Except when waived under paragraph (e) of this section, licensed nurses; and
    b. Other nursing personnel, including but not limited to nurse aides.

3. Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

4. The facility will have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.

5. The facility will ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

6. Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

7. The facility will ensure that nurse aides are able to demonstrate competency in

skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
9. Except when waived, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.
10. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

**POLICY/PROCEDURE**

**SUBJECT:** Nursing Services - Requirement for Facility Hiring and Use of Nurse Aides

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Nursing Services in accordance to State and Federal regulation.

**POLICY:**

1. The facility will not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:
    a. That individual is competent to provide nursing and nursing related services;
        i. That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State; or
        ii. That individual has been deemed or determined competent as provided in §483.150(a) and (b).

2. The facility will not use on a temporary, per diem, leased or any basis other than a permanent employee any individual who does not meet the requirements of a certified nursing assistant.

3. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual:
    a. Is a full-time employee in a State-approved training and competency evaluation program;
    b. Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or
    c. Has been deemed or determined competent as provided in §483.150(a) and (b).

**POLICY/PROCEDURE**

**SUBJECT:** Nursing Services - Registry Verification and Retraining

**DATE:**

**INTENT:**

It is the policy of the facility to verify nursing registry and provide in-service training in accordance to State and Federal regulation.

**POLICY:**

1. Before allowing an individual to serve as a nurse aide, the facility will receive registry verification that the individual has met competency evaluation requirements unless:
   a. The individual is a full-time employee in a training and competency evaluation program approved by the State; or
   b. The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

2. Before allowing an individual to serve as a nurse aide, the facility will seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.

3. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

4. The facility will complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training will comply with the requirements of §483.95(g).

**POLICY/PROCEDURE**

**SUBJECT:** Nursing Services - Nurse Staffing Information

**DATE:**

**INTENT:**

It is the policy of the facility to make staffing information readily available in a readable format to residents and visitors at any given time..

**POLICY:**

1. The facility will post the following information on a daily basis:
    a. Facility name.
    b. The current date.
    c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
        i. Registered nurses.
        ii. Licensed practical nurses or licensed vocational nurses (as defined under State law).
        iii. Certified nurse aides.
    d. Resident census.

2. The facility will post the nurse staffing data on a daily basis at the beginning of each shift.

3. Data must be posted as follows:
    a. Clear and readable format.
    b. In a prominent place readily accessible to residents and visitors.

4. The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

5. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

PLACE TAB FOR BEHAVIORAL HEALTH SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Behavioral Health Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide Mental Health Services in accordance to State and Federal regulations.

**PROCEDURE:**

This policy will include:

1. Behavioral Health Services
2. Sufficient/Competent Staff-Behavioral Health Needs
3. Treatment/Services for Mental/Psychosocial Concerns
4. No Pattern of Behavioral Difficulties Unless Unavoidable
5. Treatment/Service for Dementia
6. Provision of Medically Related Social Services

**POLICY/PROCEDURE**

**SUBJECT:** Behavioral Health Services

**DATE:**

**INTENT:**

The intent of this policy is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans.

**PROCEDURE:**

1. Each resident will receive and the facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

2. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

3. The facility will have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population.

4. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
    a. Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment, and
    b. Implementing non-pharmacological interventions.

**POLICY/PROCEDURE**

**SUBJECT:** Treatment/Services for Mental/Psychosocial Concerns

**DATE:**

**INTENT:**

It is the policy of the facility to provide Behavioral Health Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will ensure that, a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; and

2. The facility will ensure that, a resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable.

3. A resident, who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

4. If rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility will:
    a. Provide the required services, including specialized rehabilitation services; or
    b. Obtain the required services from an outside resource or from a Medicare and/or Medicaid provider of specialized rehabilitative services.

5. The facility will not admit any new residents with mental illness unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission that:
    a. because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
    b. If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

6. The facility will provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

**PROCEDURE**

**SUBJECT:** Behavior and Psychoactive Management Program

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services to promote our resident's quality of life. It is the philosophy of the facility that all resident behavior has meaning. Our facility will work diligently to minimize the use of psychoactive medications in its resident population.

**PROCEDURE:**

**Philosophy:** The Facility believes that all resident behavior has meaning. It is the pledge of our Facility to work to identify the cause and meaning of behaviors that are distressing and affect negatively on the resident's quality of life. Our Facility will work diligently to minimize use of psychoactive medications in its resident population.

**Facility's Behavior Management Program will consist of:**

1. An effective Interdisciplinary Behavior Management Committee.
2. Ensuring a thorough and comprehensive assessment of the resident's needs, behaviors, and prior medication and medical history.
3. Monitoring the resident's behavior(s) to establish patterns, determine intensity and behavior frequency, and identifying the specific ("targeted") behavior(s) that are distressing to the resident which are decreasing the resident's quality of life.
4. Thoroughly assessing the need for the inclusion of psychoactive medications into the resident's medication regime.
5. Along with the resident and their representative, weighing the risks and benefits of adding or eliminating psychoactive medications.
6. Planning and implementing appropriate interventions into the resident's plan of care.
7. Evaluating the effectiveness of Pharmacological and non-pharmacological interventions.
8. Monitoring for any adverse side effects of medications, which includes completion of Abnormal Involuntary Movement Scale (AIMS) as per recognized standards of practice.

**Purpose:**

1. To implement the most desirable and effective interventions that meet both the known and unknown needs of the resident, to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or impacting on the residents' quality of life.

2. To increase desired behaviors, promote resident safety and security, and to enhance the resident's ability to interact positively with his/her environment.

**Behavior Management Team Care Process:**

1. Medications are an integral part of resident care. The Behavior Management Team will effectively manage the psychoactive medication process for the residents by:
    a. Recognizing and Identifying problems which affect the resident's behavior,
    b. Evaluating and defining causative factors of the identified behaviors and any related diagnosis,
    c. Managing, treating, developing, and implementing effective approaches,
    d. Monitoring on a regular basis, and with change in the approaches implemented for effectiveness; and
    e. Re-evaluating, assessing, and modifying approaches as needed.

**Role of the Behavior Management Team: Medication Management**

1. The Behavior Management Team will meet monthly to review those residents receiving psychoactive medications.

2. The Behavior Management Team will review Residents receiving psychoactive medications at least quarterly for need to continue use, whether the dose continues to be appropriate, and when the following occurs:
    - A clinically significant change in condition/status*
    - A new or recurrent clinically significant symptom*
    - A worsening of an existing problem or condition*
    - An unexplained decline in function or condition*
    - Acute onset of psychiatric disorders or distressed behavior*

    *A licensed nurse and Social Service representative familiar with the resident will initially evaluate the resident who is experiencing any of the above changes, will document the evaluation in the resident's medical record. The licensed nurse will inform the resident's physician and representative, and will communicate this information to a member of the Behavior Management Committee.

3. The Behavior Management Committee will review the admissions and, readmissions of residents who are admitted with a psychoactive medication.

4. The Behavior Management Committee will educate themselves and appropriate Staff to understand the indications and goals for using the medication by obtaining a thorough resident history related to use of psychoactive medication.

5. The Behavior Management Committee will ensure that the facility staff provide Effective monitoring to include:
    a. Evaluating resident's progress towards achieving therapeutic goals
    b. Recognizing when adverse consequences may be may be or have already emerged

c. Evaluating whether the medication may be implicated in an adverse consequence, and
d. Modifying the medication regime if indicated

6. The Director of Nursing or Designee will make a request to discontinue medications that have a "black box" warning, or medications which have the potential to cause significant adverse consequences when identified on admission and requests will be made for alternate medication therapy.

7. The Behavior Management Committee will consist of at least the following:
    a. Director of Nursing/designee
    b. Social Services
    c. Consulting Pharmacist
    d. Nurse Manager(s)
    e. Activity Department Representative
    f. Dietary Representative (As determined by Committee)
    **The committee chair will be the Director of Social Services

8. The Behavior Management Committee will ensure the prescriber's order for the Dose of medication is based on the following:
    a. Resident's diagnosis
    b. Resident signs and symptoms
    c. Resident's current condition, age, labs, and other related tests
    d. Co-existing medication regime
    e. Duplicate therapy does not occur unless current standards of clinical practice and documented clinical rationale confirm the benefit

**Tapering and Gradual Dose Reduction (GDR)**

**Definition:** GDR is defined as "the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued."

Goals of Gradual Dose Reduction are to achieve the lowest effective dose; to discontinue the medications that no longer benefit the resident; and to minimize exposure to increased risk of adverse consequences.

Gradual Dose Reduction is indicated when the resident's clinical condition has improved or stabilized or the underlying causes of symptoms have resolved and the type of medication requires gradual reduction of the dosage in order to avoid adverse consequences that could occur if the medication is stopped abruptly.

The resident's response to medications is not only evaluated by the Behavior Management Team. Evaluation and consideration of the resident's medication to continue, reduce or discontinue must also take place during:

a. Monthly medication regimen review by the consulting pharmacist
b. Review of care plan and monthly renewal of orders
c. Quarterly MDS review

d. Daily behavior monitoring every shift
e. Resident and family staffing meetings

**Guidelines for Gradual Dose Reduction:**

1. During the first year if receiving an antipsychotic or other psychopharmacologic medication, at least one attempt at GDR or dose tapering.

2. A second attempt, in a subsequent quarter the same year (12 month period) unless the first attempt demonstrated that GDR or tapering was clinically contraindicated. The attempts should be at least a month apart.

3. After the first year, GDR or tapering should be attempted once a year.

4. GDR or tapering may be considered clinically contraindicated if the resident's targeted symptoms worsened or returned during the reduction. If this occurs the physician must document the clinical rationale why further GDR attempts should not be done (further attempts may cause impairment of resident function, increase distressed behavior(s), cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

5. Residents receiving sedative/hypnotic medication routinely must have attempts to taper the medication during each quarter. Before tapering a dose of sedative/hypnotic is considered contraindicated for the remainder of that year, tapering must have been attempted during the previous 3 quarters and documented by the physician as unsuccessful.

**Regulatory Language of F-757 (Unnecessary Medications)**

1. F-757 CRF 483.45(d) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
    a. In excessive dose (including duplicate drug therapy); or
    b. For excessive duration; or
    c. Without adequate monitoring; or
    d. Without adequate indications for its use; or
    e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
    f. Any combinations of the reasons above.

2. F-758 CFR 483.45(c) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
    a. Anti-psychotic;
    b. Anti-depressant;
    c. Anti-anxiety; and
    d. Hypnotic

3. Based on the regulatory mandates of CMS related to unnecessary drugs; an anti-psychotic, antidepressant, antianxiety, and a hypnotic medication will not be

initiated unless the Behavior Management Committee has determined the medication is necessary to treat a specific condition. The targeted behaviors causing the resident distress must be clearly identified.

4. Non-pharmacological interventions previously attempted without success must be documented. The condition must be comprehensively assessed and the rationale clearly documented in the resident's medical record. A comprehensive care plan must be in place with the problem/condition identified, measurable goals determined, and interventions in place to manage/decrease/eliminate the behaviors.

**Goals for use of Psychoactive Medications: To maintain or improve function and wellbeing.**

1. The Behavior Management Committee and the resident's physician will ensure that psychoactive medications are administered for the following reasons only:
    a. To prevent a disease or a symptom
    b. Diagnose a condition or a disease
    c. Cure an illness
    d. Slow or arrest a disease process
    e. Reduce or eliminate symptoms
    f. To achieve a positive physical, mental, and psychosocial outcome.

2. The Behavior Management Committee will ensure the following has been completed before a psychoactive medication is administered:
    a. An accurate and complete assessment of the resident's condition and goals for treatment.
    b. Monitoring for the anticipated response to the medication.
    c. Consideration of clinical standards of practice and manufacturer's guidelines regarding dose and duration, and consideration of the resident's age and possible systems failure related to aging.
    d. Consideration of the type or characteristics of the medication, in conjunction with the resident's present medication regime.
    e. Consideration of administering the lowest possible dose for the shortest, yet effective duration.
    f. The root cause of the resident's condition, symptom, or disease has been assessed and considered/identified and the resident's plan of care reflects this assessment.
    g. Contributing factors and triggers for the symptom/behavior have been assessed/identified and approaches put in place to reduce/eliminate the impediments, triggers, and causes.
    h. Appropriate non-pharmacological interventions have been identified and implemented based on an individual resident assessment that include:
        i. Modification of the resident's environment;
        ii. Modification/elimination of psychological stressors to accommodate the resident's previous lifelong activities, habits, or roles;
        iii. Modification of staff/resident interactions; and

iv. Behavioral interventions.

NOTE: This program is based on the following recognized Standards of Clinical Practice and References:


1. Centers for Medicare & Medicaid (CMS) F-329; Unnecessary Medications Guidance Training Instructors Guide 42 CFR 483.45;
2. Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline. APA Presidential Task Force on the Assessment of Age-Consistent Memory Decline and Dementia.
3. American Psychological Association, February 1998;
4. Clinical Practice Guidelines-The American Geriatrics Society 2001;
5. Behavior Associated with Dementia, M. Smith, MS, ARNP, CS and K. Buckwalter, PhD, RN, FAAN AJN, American Journal of Nursing, July 2005, Vol.107 Number 7;
6. CDC-Health Information for Older Adults-Mental Health http://www.cdc.gov/aging/info.htm;
7. Appropriate Use of Antipsychotics for Residents with Dementia in the Long-Term Care Setting L.J. Cohen W.J. Burke 1999

PLACE TAB FOR PHARMACY SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Pharmacy Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Pharmacy Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Pharmaceutical Services – Procedures, Registered Pharmacist (RPH), Records
2. Drug Regimen Review, Report Irregular, Act on
3. Drug Regimen is Free From Unnecessary Drugs
4. Free from Unnecessary Psychotropic Meds/PRN Use
5. Free of Medication Error Rates of 5% or More
6. Residents Are Free of Significant Med Errors
7. Label/Store Drugs & Biologicals

**POLICY/PROCEDURE**

**SUBJECT:** Pharmacy Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide Pharmacy Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will employ or obtain the services of a licensed pharmacist who:
   a. Provides consultation on all aspects of the provision of pharmacy services in the facility.
   b. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
   c. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

2. The facility will honor the right to freedom of choice in selecting a pharmacy; to obtain pharmaceutical supplies and services, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record.

3. When a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents.

4. The facility will provide routine and emergency drugs and biological to its residents or obtain them under an agreement.

5. The facility will provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each resident.

6. The facility utilizes only persons authorized under state requirements to administer medications.

7. If ordered by the resident's physician, the resident may, upon discharge, take all current prescription drugs with him. An inventory of the drugs released shall be completed, will be dated and signed by both the person releasing the drugs and the person receiving the drugs, and will be placed in the resident's record.

8. The facility will maintain an Emergency Medication Kit, the contents of which shall be determined in consultation with the Medical Director, Director of Nursing and Pharmacist, and it will be in accordance with facility policies and procedures. The kit will be readily available and will be kept sealed. All items in the kit will be properly labeled. The facility will maintain an accurate log receipt and disposition of each item in the Emergency Medication Kit. An inventory of the contents of the Emergency Medication Kit will be attached to the outside of the kit. If the seal is broken, the kit will be resealed the next business day after use.

9. The facility will ensure that it is free of medication error rates of 5 percent or greater and that residents are free of any significant medication errors.

10. Drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

11. In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

12. The facility will provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

**POLICY/PROCEDURE**

**SUBJECT:** Pharmacy Services – Drug Regimen Review

**DATE:**

**INTENT:**

The intent of this policy is that the facility maintains the resident's highest practicable level of physical, mental and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON).

**PROCEDURE:**

1. The drug regimen of each resident will be reviewed at least monthly by a licensed pharmacist and the pharmacist will report any irregularities to the attending physician, the facility's medical director and the director of nursing and these reports will be acted upon.

2. Irregularities include, but are not limited to, any drug that meets the following criteria:
   a. Excessive dose (including duplicate drug therapy); or
   b. Excessive duration; or
   c. Without adequate monitoring; or
   d. Without adequate indications for its use; or
   e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   f. Any combinations of the reasons above.

3. This review will include a review of the resident's medical chart.

4. The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports will be acted upon.

5. Any irregularities noted by the pharmacist during this review will be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

6. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

7. The facility will develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

**POLICY/PROCEDURE**

**SUBJECT:** Pharmacy Services – Drug Regimen Free From Unnecessary Drugs

**DATE:**

**INTENT:**

The intent of this policy is each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing; the facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

**PROCEDURE:**

1. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
   a. In excessive dose (including duplicate drug therapy); or
   b. For excessive duration; or
   c. Without adequate monitoring; or
   d. Without adequate indications for its use; or
   e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   f. Any combinations of the reasons stated

2. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
   a. Anti-psychotic;
   b. Anti-depressant;
   c. Anti-anxiety; and
   d. Hypnotic

3. Based on a comprehensive assessment of a resident, the facility will ensure that:
   a. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
   b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
   c. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
   d. PRN orders for psychotropic drugs are limited to 14 days. Except, if the attending physician or prescribing practitioner believes that it is appropriate for

the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

e. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

PLACE TAB FOR LABORATORY, RADIOLOGY, AND OTHER DIAGNOSITC SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Laboratory, Radiology, and Other Diagnostic Services

**DATE:**

**INTENT:**

It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource.

**PROCEDURE:**

This policy will include the following:

1. Laboratory Services
2. Blood Bank and Transfusion Services
3. Lab Services Not Provided On-Site
4. Lab Services Physician Order/Notify of Results
5. Assist with Transport Arrangements to Lab Services
6. Lab Reports in Record-Lab Name Address
7. Radiology/Other Diagnostic Services
8. Radiology/Diagnostic Services Ordered/Notify of Results
9. Assist with Transportation Arrangements to Radiology
10. X-ray/Diagnostic Report In Record – Sign/Dated

**POLICY/PROCEDURE**

**SUBJECT:** Diagnostic Services

**DATE:**

**INTENT:**

It is the policy of this facility to ensure that laboratory, radiology, and other diagnostic services meet the needs of residents, that results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, and treatment, and that the facility has established policies and procedures, and is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource.

**PROCEDURE:**

1. The facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for the quality and timeliness of the services.
2. The facility does not provide laboratory services on site. It has an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of the Federal Regulations.
3. The facility will provide or obtain laboratory services only when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law, including scope of practice laws.
4. The facility will promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.
5. The facility will assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
6. The facility will file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
7. The facility will provide or obtain radiology and other diagnostic services to meet the needs of its residents.
8. The facility does not provide its own diagnostic services. It has an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.
9. The facility will provide or obtain radiology and other diagnostic services only when ordered by a physician, physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.

10. The facility will promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.
11. The facility will file in the resident's clinical record x-ray and diagnostic reports that are signed and dated.

PLACE TAB FOR DENTAL SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Dental

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Dental Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Routine/emergency dental services in Skilled Nursing Facilities and Nursing Facilities

**POLICY/PROCEDURE**

**SUBJECT:** Dental Services

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that residents obtain needed dental services, including routine dental services; to ensure the facility provides the assistance needed or requested to obtain these services; to ensure the resident is not inappropriately charged for these services; and if a referral does not occur within three business days, documentation of the facility's to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

**PROCEDURE:**

1. The facility will provide from an outside source routine and 24-hour emergency dental services to meet the needs of each resident.

2. The facility will, if necessary or if requested, assist the resident;:
   a. Making appointments; and
   b. Arranging for transportation to and from the dental services location; and
   c. Will promptly, within 3 days, refer residents with lost or damaged dentures for dental services.
   d. If a referral does not occur within 3 days, the facility will provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

3. The facility may charge a Medicare resident an additional amount for routine and emergency dental services.

4. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.

PLACE TAB FOR FOOD AND NUTRITION SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Food and Nutrition Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Dietary Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Provided Diet Meets Needs of each Resident
2. Qualified Dietary Staff
3. Sufficient Dietary Support Personnel
4. Menus Meet Resident Needs/Prepared in Advance/Followed
5. Nutritive Value/Appearance, Palatable/Preferred Temperature
6. Food in Form to Meet Individual Needs
7. Resident Allergies, Preferences and Substitutes
8. Drinks Available to Meet Needs/Preferences/Hydration
9. Therapeutic Diet Prescribed by Physician
10. Frequency of Meals/Snacks at Bedtime
11. Assistive Devices – Eating Equipment/Utensils
12. Feeding Assistant – Training/Supervision/Resident
13. Food Procurement, Store/Prepare/Serve – Sanitary
14. Personal Food Policy
15. Dispose Garbage & Refuse Properly

**POLICY/PROCEDURE**

**SUBJECT:** Food and Nutrition Services

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet.

**PROCEDURE:**

1. The facility will provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

2. The facility will employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.

3. A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who:
    a. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
    b. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
    c. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
    d. For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

4. If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who:
    a. For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
        i. A certified dietary manager; or
        ii. A certified food service manager; or
        iii. Has similar national certification for food service management and safety from a national certifying body; or
        iv. Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
    b. In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
    c. Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

5. A member of the Food and Nutrition Services staff must participate on the interdisciplinary team.

6. The residents will receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team, which maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that it is not possible and received a therapeutic diet when there is a nutritional problem.

7. The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.

8. Each resident will receive and the facility will provide at least three meals daily at regular times comparable to normal mealtimes in the community, or in accordance with resident needs, preferences, requests, and plan of care.

9. There will be no more than 14 hours between substantial evening meal and breakfast the following day except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

10. Suitable, nourishing alternative meals and snacks will be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

11. The facility will maintain a one-week supply of non-perishable food and supplies that represents a good diet.

12. The facility will provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.

13. The facility will procure food from sources approved or considered satisfactory by the Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of foodborne illness.
    a. This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
    b. This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
    c. This provision does not preclude residents from consuming foods not procured by the facility.

14. The facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety.

15. The facility will have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.

16. The facility will dispose of garbage and refuse properly, garbage and refuse containers will be maintained in good condition, and garbage receptacles will be covered when transported to the dumpster from the kitchen.

**POLICY/PROCEDURE**

**SUBJECT:** Dietary Services – Menus and Nutritional Adequacy

**DATE:**

**INTENT:**

It is the policy of the facility to assure that menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.

**PROCEDURE:**

Menus will:

1. Meet the nutritional needs of residents in accordance with established national guidelines.;

2. Be prepared in advance;

3. Be followed;

4. Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

5. Be updated periodically;

6. Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

7. Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

**POLICY/PROCEDURE**

**SUBJECT:** Dietary Services – Food and Drink

**DATE:**

**INTENT:**

It is the policy of the facility To assure that the nutritive value of food is not compromised and destroyed because of prolonged; food storage, light, and air exposure; or cooking of foods in a large volume of water; or holding on steam table.

**PROCEDURE:**

The facility will provide to each resident:

1. Food prepared by methods that conserve nutritive value, flavor, and appearance;

2. Food and drink that is palatable, attractive, and at a safe and appetizing temperature.

3. Food prepared in a form designed to meet individual needs.

4. Food that accommodates resident allergies, intolerances, and preferences.

5. Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice.

6. Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.

**POLICY/PROCEDURE**

**SUBJECT:** Dietary Services – Paid Feeding Assistants

**DATE:**

**INTENT:**

It is the policy of the facility to provide assistance with meals by utilizing Paid Feeding Assistants whenever necessary in accordance to State and Federal regulation.

**PROCEDURE:**

1. A facility may use a paid feeding assistant, as defined in § 488.301 if:
    a. The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and
    b. The use of feeding assistants is consistent with State law.

2. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

3. In an emergency, a feeding assistant must call a supervisory nurse for help.

4. The facility will ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.

5. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

6. The facility will base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.

7. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants.

**POLICY/PROCEDURE**

**SUBJECT:** Dietary Services – Food Brought in the Facility by Family or Visitors

**DATE:**

**INTENT:**

It is the right of the residents of this facility to have food brought in by family or other visitors. The food will be handled in a way to ensure the safety of the resident.

**PROCEDURE:**

1. Family members or other visitors may bring the resident food of their choosing.
2. All food items that are already prepared by the family or visitor brought in will be labeled with name and dated.
    a. The facility will refrigerate label and dated prepared items in the nourishment refrigerator.
    b. The prepared food must be consumed within 3 days.
    c. If not consumed within 3 days, food will be thrown away.
    d. The facility will not be responsible for maintaining any reusable items.
3. All food items brought in that are manufactured and do not require refrigeration, may be kept in the resident room inside a closed container that is provided by the resident.
4. It is the responsibility of the resident and/or resident representative to maintain said container and items in the container.
5. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative.

**PROCEDURE**

**SUBJECT:** Weight Management

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to weight management in accordance to State and Federal regulation.

**PROCEDURE:**

1. All Residents admitted to the facility will be weighed according to the following schedule: **day one on admission**, **day two**, and then **weekly x 4 weeks.**
2. All residents will be weighted on a **monthly** basis unless otherwise ordered by the physician or deemed necessary by the dietician and or the interdisciplinary team.
3. Monthly weights will be completed by the **fifth** of each month.
4. Dietary will evaluate all weights by the **seventh** of each month.
5. A re-weight will be obtained for any weight change of +/- (3) lbs. from the previous weight unless other parameters have been ordered by the physician.
6. All re-weights will be obtained immediately. The re-weight process will be visualized by a license nurse.
7. All weights will be documented in the resident's electronic medical record.
8. Weights will be obtained at the same time of day preferably in the morning and with the same scale to ensure consistency.
9. The scale will be zeroed out prior to weighing the resident by the staff member obtaining the weight.
10. For residents being weighed in a wheelchair, be sure to obtain the wheelchair weight first, including any cushions/devices in use and subtract weight from total weight, each time the resident is weighed.
11. Once a resident is cleared by therapy for safe transfer and standing by contact guard assist of one person, weights may be obtained by standing the resident.
12. The physician and the resident or resident representative will be notified by the resident's nurse of any significant unexpected and or unplanned weight changes. The nurse will document the notification in the resident's electronic medical record by completing the Event Report.

PLACE TAB FOR SPECIALIZED REHAB SERVICES HERE

**POLICY/PROCEDURE**

**SUBJECT:** Specialized Rehab Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Specialized Rehab Services in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Provide/Obtain Specialized Rehab Services
2. Rehab Services – Physician Order/Qualified Person

**POLICY/PROCEDURE**

**SUBJECT:** Specialized Rehabilitative and Restorative Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide Specialized Rehabilitative and Restorative Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will provide specialized rehabilitative services such as, but not limited to physical therapy, speech language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care.

2. The facility will:
   a. Provide the required services; or
   b. Obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

3. The facility will ensure that specialized rehabilitative services are provided under the written order of a physician by qualified personnel.

4. The facility will provide restorative services such as but not limited to walking, transfer training, bowel and or bladder training, bed mobility, Range of Motion (ROM), splint and brace, eating and/or swallowing, amputation/prostheses care and communication, when necessary as indicated by the assessment of the interdisciplinary team.

PLACE TAB FOR ADMINISTRATION HERE

**POLICY/PROCEDURE**

**SUBJECT:** Administration

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Administration in accordance to State and Federal regulation.

**PROCEDURE:**

The Administration of the facility will ensure the following:

1. Administration
2. License/Comply with Fed/State/Local Law/Professional Standards
3. Governing Body
4. Facility Assessment
5. Staff Qualifications
6. Use of Outside Resources
7. Responsibilities of Medical Director
8. Resident Records - Identifiable Information
9. Transfer Agreement
10. Disclosure of Ownership Requirements
11. Facility closure-Administrator
12. Facility closure
13. Hospice Services
14. Qualifications of Social Worker >120 Beds
15. Payroll Based Journal

**POLICY/PROCEDURE**

**SUBJECT:** Administration

**DATE:**

**INTENT:**

It is the policy of the facility to be Administered, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

2. The facility will be licensed under applicable State and local law.

3. The facility will operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

4. The facility will meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.

5. The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

6. The governing body appoints the administrator who is:
    a. Licensed by the State where licensing is required;
    b. Responsible for the management of the facility; and
    c. Reports to and is accountable to the governing body.

**POLICY/PROCEDURE**

**SUBJECT:** Facility Assessment

**DATE:**

**INTENT:**

The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.

2. The facility will review and update that assessment, as necessary, and at least annually.

3. The facility will also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

4. The facility assessment will address or include:
    a. The facility's resident population, including, but not limited to:
        i. Both the number of residents and the facility's resident capacity;
        ii. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
        iii. The staff competencies that are necessary to provide the level and types of care needed for the resident population;
        iv. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
        v. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

    b. The facility's resources, including but not limited to:
        i. All buildings and/or other physical structures and vehicles;
        ii. Equipment (medical and non-medical);
        iii. Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;

iv. All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
v. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
vi. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

c. A facility-based and community-based risk assessment, utilizing an all-hazards approach.

**POLICY/PROCEDURE**

**SUBJECT:** Staff Qualifications

**DATE:**

**INTENT:**

It is the policy of the facility to employ Nursing Aides, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. The facility will provide employ on a full-time, part-time or consultant basis professionals necessary to carry out the provisions of these requirements.
2. The facility will ensure that professional staff are licensed, certified, or registered in accordance with applicable state laws.
3. The facility will ensure that when services are not able to be provided by a current employee then the facility will have that service furnished to its residents by a person or agency outside the facility under a written arrangement that the facility assumes responsibility for that includes:
    a. Obtaining services that meet professional standards and principles that apply to professionals providing services in the facility, and
    b. Ensuring the timeliness of such services.

**POLICY/PROCEDURE**

**SUBJECT:** Medical Director

**DATE:**

**INTENT:**

It is the policy of the facility to provide Medical Director Services in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will have only one Medical Director who will be a licensed physician in accordance to State and Federal guidelines.
2. A Medical Director who does not have hospital privileges will be certified or credentialed through a recognized certifying or credentialing body, such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
3. A physician will have his/her principal office within 60 miles of the Facility and may be Medical Director of a maximum of 10 nursing homes at any one time.
4. The facility shall appoint a Medical Director who shall visit the facility at least once a month and review:
    a. all new policies and procedures,
    b. all new incident and accident reports
    c. the most recent grievance logs
5. The Medical Director will, in collaboration with the facility, coordinate the medical care and the implementation of resident care policies, within the facility.
6. The Medical Director appointed by the facility will meet at least monthly with the risk management committee and no less than quarterly with the quality assessment and assurance committee of the facility. The facility may combine both committees.

**Point of Emphasis:**
The Medical Director duties are separate from the responsibilities of resident attending physician.

**POLICY/PROCEDURE**

**SUBJECT:** Medical Records

**DATE:**

**INTENT:**

It is the policy of the facility to maintain Medical Records in accordance to State and Federal regulations.

**PROCEDURE:**

This policy will include:

1. The facility will designate a full-time employee as being responsible and accountable for the facility's medical records. If this employee is not a qualified Medical Record Practitioner, then the facility shall have the services of a qualified Medical Record Practitioner on a consultant basis.

2. The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, systematically organized and include:
    a. The resident's admissions and discharges;
    b. Medical and general health status;
    c. Personal and Social history;
    d. Identity and address of next of kin or responsible party;
    e. The resident's comprehensive care plan;
    f. The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
    g. Physician's, nurse's, and other licensed professional's progress notes; and
    h. Laboratory, radiology and other diagnostic services reports.

3. The facility will retain medical records for the time period required by state law or:
    a. Five years from the date of discharge when there is no requirement in state law; and
    b. For a minor, three years after the resident reaches legal age under state law.

4. The facility will not release information to the public that is resident-identifiable to the public.

5. The facility may release information that is resident-identifiable to an only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

6. The facility will safe guard clinical record information against loss, destruction or unauthorized use.

7. Unless expressly prohibited by a legally competent resident, the facility will furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records which are in the possession of the facility. Such records will include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records will not be considered part of a deceased resident's estate and may be made available prior to the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact.

8. The facility may charge a reasonable fee for the copying of resident records. Such fee will not exceed $1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages.

9. The facility will allow any such spouse, guardian, surrogate, proxy, or attorney in fact, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help assure that the records are not damaged, destroyed, or altered.

**POLICY/PROCEDURE**

**SUBJECT:** Record Retention

**APPROVED:**

**INTENT:**

It is the policy of the facility to retain all records in accordance to State and Federal Regulations or as outlined in payer contracts, whichever is longer. In the absence of regulations, the state General Records Schedule (GS4) for Public Hospitals, Health Care Facilities and Medical Providers will be utilized for guidance as to record retention timeframes.

**PROCEDURE:**

**Retention Periods**

***Medical Records***

1. Will be retained for a period of seven (7) years from the date of discharge or period outlined by payer contracts, whichever is longer.
2. Minors
    a. Records will be retained for three (3) years after a resident reaches eighteen (18) years old.

***Survey and Inspection Reports*** – *including but not limited, to inspection reports, notice of corrections, in-house surveys, correction of deficiencies.* (Florida Record Retention Schedule GS-4)

1. Retain for five (5) years following next survey report issued.

***Biomedical Waste Records*** – *including but not limited to, training records, signed biomedical tracking forms or mail receipts, and logs.*

1. Retain for three (3) calendar years

***Dietary Recipe Records*** – *standardized recipe records used for resident meal preparation that may include nutritional analysis, ingredients, and serving size.*

1. Retain until obsolete or superseded

***Menus*** *– includes but is not limited to, list of food choices available for specific meals and snacks on specific days at specific times.*

1. Retain for six (6) months

***Dietitian Consultant Reports/Summaries***

1. Retain for two (2) years

***Infection Control Program Reports*** *– including but not limited to, training materials, and records used to identify, evaluate and report infections.*

1. Retain for five (5) calendar years

***Medication Inventory Records*** *– including but not limited to, inventory sheets for controlled class I-V substances, logs for emergency drug kit, etc.*

1. Retain for two (2) years

***Manuals, Policies, and Procedures (Revised)***

1. Retain for seven (7) years from date of revision

***Medicare/Medicaid Records*** *- including all financial and administrative records regarding Medicare and Medicaid claims, reimbursement and any other activities.*

1. Retain for five (5) years, unless audit issues are pending.
2. If audit issues are pending, retain until audits are resolved.

***Risk Management Records*** *– includes but not limited to, staff education and training, patient grievance reviews, committee meeting minutes, investigations, etc.*

1. Retain for seven (7) calendar years

***Incident Reports/Records*** *– including but not limited to, incident forms and logs. May include security and/or injury incidents or any work place disturbance (i.e. fire alarms, electronic medical record system outages, etc.)*

1. Retain for seven (7) years from date of incident

***Payroll and Supporting Documents*** *– Including but not limited to attendance and leave records, deduction authorizations, ledgers, etc.*

1. Three (3) fiscal years

***Personnel Records*** *– including volunteers and temporary staff*

1. Three (3) fiscal years after separation or termination of employment

***Schedules (Daily, Weekly, or Monthly)***

1. Retain original documents for seven (7) years.

***Resident Contracts*** *– including but not limited to admission agreements and any addendums to such contracts.*

1. Retain for five (5) years after contract expiration.

**Record Destruction**

1. Records to be destroyed will be entered onto a Record Disposal Log
2. Record Disposal Approval Form will be completed by Health Information Management Coordinator, or Other Department Manager/Coordinator responsible for record destruction.
3. The Record Disposal Log and Record Disposal Approval Form will be submitted with to Administrator for review and signature.
4. Once Record Disposal is approved, Preparer will contact Disposal Company to schedule record disposal.
    a. Proper Disposal Methods for Paper Records
        i. Shredding
        ii. Incinerating
        iii. Pulping
        iv. Pulverizing
    b. Proper Disposal Methods for Electronic Media
        i. Degaussing
        ii. Pulverizing
        iii. Shredding
        iv. Incinerating
5. Upon disposal of records, Preparer will obtain Receipt of Disposal/Destruction from the Disposal Company.
6. Record Disposal Log, Record Disposal Approval and Receipt of Disposal will be retained indefinitely.

**REFERENCES:**

General Records Schedule for Public Hospitals, Health Care Facilities and Medical Providers; Florida Department of State Division of Library and Information Services; February 19,2015 (http://dos.myflorida.com/media/693585/gs04.pdf )

Recordkeeping Requirements; U.S. Equal Employment Opportunity Commission; Retrieved: January 26, 2017 from https://www.eeoc.gov/employers/recordkeeping.cfm

**POLICY/PROCEDURE**

**SUBJECT:** Transfer Agreement

**DATE:**

**INTENT:**

It is the policy of the facility to maintain a Transfer Agreement in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that:

    a. Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and
    b. Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers.

2. The facility will attempt in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

**POLICY/PROCEDURE**

**SUBJECT:** Disclosure of Ownership

**DATE:**

**INTENT:**

It is the policy of the facility to maintain Disclosure of Ownership in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in:
    a. Persons with an ownership or control interest;
    b. The officers, directors, agents, or managing employees;
    c. The corporation, association, or other company responsible for the management of the facility; or
    d. The facility's administrator or director of nursing.
2. The notice will include the identity of each new individual or company.

**POLICY/PROCEDURE**

**SUBJECT:** Facility Closure

**DATE:**

**INTENT:**

It is the policy of the facility to handle a facility closure, should it occur, in accordance with State and Federal Regulations.

**PROCEDURE:**

1. Any individual who is the administrator of the facility will:
    a. Submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:

        i. At least 60 days prior to the date of closure; or
        ii. In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;

2. Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

3. Include in the notice the plan, that has been approved by the State, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

**POLICY/PROCEDURE**

**SUBJECT:** Hospice Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide collaborative care with Hospice providers to ensure that our resident's end of life preferences and choices are honored.

**PROCEDURE:**

1. The facility will do either of the following:
    a. Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices; or
    b. Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.
2. When hospice care is furnished in the facility through an agreement the following requirements will be met:
    a. The facility will ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
    b. The facility will have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
        i. The services the hospice will provide;
        ii. The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this regulation;
        iii. The services the LTC facility will continue to provide based on each resident's plan of care;
        iv. A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day; and
        v. A provision that the LTC facility immediately notifies the hospice about the following;
            - A significant change in the resident's physical, mental, social, or emotional status,

- Clinical complications that suggest a need to alter the plan of care,
- A need to transfer the resident from the facility for any condition, and
- The resident's death.

c. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
d. An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
e. A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
f. A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
g. A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries if unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
h. A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

3. Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff.

4. The interdisciplinary team member must have a clinical background, within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

5. The designated interdisciplinary team member is responsible for the following:

a. Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services;
b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family;
c. Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians; and
d. Obtaining the following information from the hospice;

    i. The most recent hospice plan of care specific to each patient,
    ii. Hospice election form,
    iii. Physician certification and recertification of the terminal illness specific to each patient,
    iv. Names and contact information for hospice personnel involved in hospice care of each patient,
    v. Emergency Instructions on how to access the hospice's 24-hour on-call system,
    vi. Hospice medication information specific to each patient, and
    vii. Hospice physician and attending physician (if any) orders specific to each patient.

6. Ensure that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

7. Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required.

**POLICY/PROCEDURE**

**SUBJECT:** Social Services

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to social services, according to state and federal regulations.

**PROCEDURE:**

1. The facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

2. Medically related social services means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include:

    a. Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;
    b. Maintaining contact with facility (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;
    c. Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications;
    d. Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);
    e. Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
    f. Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);
    g. Providing or arranging provision of needed counseling services;
    h. Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs;
    i. Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality;

j. Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;
k. Finding options that most meet the physical and emotional needs of each resident;
l. Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;
m. Meeting the needs of residents who are grieving; and
n. Finding options, which most meet their physical and emotional needs.

3. The facility with more than 120 beds must employ a qualified social worker on a full-time basis.

4. A qualified social worker is an individual with:

    a. A minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, gerontology, special education, rehabilitation counseling, and psychology; and
    b. One year of supervised social work experience in a health care setting working directly with individuals.

**POLICY/PROCEDURE**

**SUBJECT:** Mandatory Submission of Uniform Format Staffing Information

**DATE:**

**INTENT:**

It is the policy of the facility to complete submission of staffing information based on payroll data in a uniform format as specified by CMS.

Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

**DIRECT CARE STAFF DEFINTION:**

Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

**PROCEDURE:**

1. The facility must submit to CMS complete and accurate direct care staffing data, to
   Include:

    a. The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
    b. Resident census data; and
    c. Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

2. The facility will distinguish employees from agency and contract workers.

3. The facility will report information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

4. The facility will submit as directed by CMS to CMS during the established staffing reporting periods.

We anticipate revision to this policy as some will submit internally and some externally through a 3rd party provider.

INSERT QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT TAB HERE

**POLICY/PROCEDURE**

**SUBJECT:** Quality Assurance and Performance Improvement

**DATE:**

**INTENT:**

These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

**POLICY:**

This policy will include:

1. QAPI Program/Plan, Disclosure/Good Faith Attempt
2. QAPI/QAA Improvement Activities
3. QAA Committee

**POLICY/PROCEDURE**

**SUBJECT:** Quality Assurance and Performance Improvement

**DATE:**

**INTENT:**

These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

**POLICY:**

The facility, will develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

The facility will:

1. Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

2. Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

3. Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

4. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility.

5. It must:
    a. Address all systems of care and management practices;
    b. Include clinical care, quality of life, and resident choice;
    c. Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

    d. Reflect the complexities, unique care, and services that the facility provides.

6. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:
    a. An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.
    b. The QAPI program is sustained during transitions in leadership and staffing;
    c. The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;
    d. The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.
    e. Corrective actions address gaps in systems, and are evaluated for effectiveness; and
    f. Clear expectations are set around safety, quality, rights, choice, and respect.

7. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee.

8. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

**POLICY/PROCEDURE**

**SUBJECT:** QAA Committee

**DATE:**

**INTENT:**

These policies are intended to ensure the facility develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

**POLICY:**

The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI Program.

The committee will:

1. Develop and implement appropriate plans of action to correct identified quality deficiencies;

2. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

3. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:
    a. The director of nursing services;
    b. The Medical Director or his/her designee;
    c. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role.

4. The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program.

5. The committee must:
    a. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.

PLACE TAB FOR INFECTION CONTROL HERE

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control, General

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Infection Control in accordance to State and Federal regulation.

**PROCEDURE:**

1. Infection prevention and control program
2. Antibiotic Stewardship Program
3. Influenza and Pneumococcal Immunization

**POLICY/PROCEDURE**

**SUBJECT:** Infection Prevention and Control and Surveillance Program

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the Infection Control Program is designed to prevent, identify, report, investigate, and control the spread of infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection, in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. The facility will establish and maintain an infection prevention and control program under which it:
    a. Prevents, identifies, reports, investigates, and controls the spread of infections and communicable disease in the facility;
    b. Conducts surveillance for early detection of infections, clusters/ outbreaks, and reportable diseases and to track and trend surveillance data;
    c. Decides when and how isolation should be applied to an individual resident;
    d. Prohibits staff with a communicable infection or disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease/infection; and
    e. Maintains a record of incidents and corrective actions related to infection prevention and control.

2. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident using the least restrictive option given current circumstances. (Please see the Standard and Transmission-based Precautions Policy for more detailed information regarding isolation.)

3. The facility will provide personal protective equipment (PPE) to support compliance with standard and transmission-based precautions and ensure that it is readily available for staff use. Staff are required to adhere to standard precautions and use PPE according to standard precautions.

4. The facility will prohibit staff with a communicable disease/infection or has infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

a. The CDC guidelines for isolation and CDC guidelines for infection control in healthcare personnel, 1998 will be used to determine employee exclusion. Employees are to report signs and symptoms of illness to their supervisor. The supervisor will report to the infection prevention designee who will determine work exclusions as needed per CDC guidelines.
b. All skin lesions must be covered and dressings must be dry.
c. Staff that are symptomatic of influenza-like-illness are not to provide direct resident care for 7 days after symptom onset or until 24 hours after resolution of symptoms, whichever is longer.

5. The facility will require staff to perform hand hygiene as indicated by national guidelines (See hand hygiene policy for more details).

6. The facility will ensure linens are properly handled, stored, processed, and transported in a way to prevent the spread of infection (See linens management policy for more details).

7. The facility will provide infection prevention and control training upon hire and ongoing throughout the year as needed in the following areas:
    a. Hand hygiene;
    b. Standard precautions;
    c. Transmission-based precautions;
    d. Personal protective equipment;
    e. Proper cleaning and disinfection of equipment;
    f. Proper handling of linens;
    g. Biomedical waste;
    h. Tuberculosis risk factors, signs, and symptoms;
    i. HIV/AIDS/blood borne pathogens; and
    j. Other infection prevention and control topics as determined by program needs (i.e. per surveillance data) and opportunities for improvement.

8. The facility is to maintain a surveillance system with the capacity to identify possible communicable disease and infections before they can spread to other persons in the facility.
    a. To identify infections the following information regarding residents is reviewed on an ongoing basis and information is to be communicated by staff in meetings (e.g. morning meeting) to the person responsible for infection prevention and control:
        i. Signs and symptoms (newly developed or ongoing and observations made by staff providing wound care);
        ii. Laboratory and other diagnostic testing orders;
        iii. Laboratory and other diagnostic testing results;
        iv. New antibiotic starts; and
        v. New admission records.

b. The person responsible for infection prevention and control will use the information gathered through these various means to identify who requires isolation precautions and to what extent as well as which medical records need to be reviewed for surveillance purposes.
c. Nationally recognized surveillance case definitions, known as the McGeer criteria, and the criteria set forth by the CDC's National Healthcare Safety Network will be used to identify infections for surveillance purposes. Only those infections meeting these criteria will be recorded. The facility will use (*insert name of form that will be used for collecting surveillance data)* forms to support data collection and evaluation of medical record for documenting infections for surveillance and data analysis.
d. Surveillance data and process measure data, such as hand hygiene compliance and compliance with isolation precautions, will be analyzed on a monthly basis. Surveillance data will be tracked and trended as necessary to identify clustering of infections, increasing or decreasing incidence and prevalence of infections, and identifying opportunities for improvement in current practices and events/incidents needing corrective action plans or process improvement action plans.
e. Surveillance reports will include infection (i.e. outcome) data and process measure data (i.e. hand hygiene compliance) to the director of nursing and medical director on a monthly basis. Reports will also be reviewed by the Quality Assurance and Advisory committee.
f. Any staff who suspect an infection or communicable disease that may warrant isolation is to notify the person responsible for infection prevention and control or their designee or the director of nursing to ensure isolation is appropriately implemented when necessary.
g. The local health department will be notified of all reportable diseases identified and of any clusters or outbreaks of any disease in accordance with state law. All clusters and or outbreaks will be investigated to identify breaches in infection control and or opportunities to improve current practices.

9. Any staff member that suspects a breach in infection prevention and control practice or policy is to report this to the person responsible for the infection prevention and control program or the director of nursing as soon as possible.

10. All shared medical equipment will be cleaned using an EPA-approved disinfectant wipe effective against TB and Hepatitis B.

11. The facility will review its infection prevention and control program annually, evaluate effectiveness, and update the program as needed.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Antibiotic Stewardship

**DATE:**

**INTENT:**
It is the policy of the facility to support the judicious use of antibiotics in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. The facility will establish protocols for antibiotic prescribing in accordance with national guidelines and treatment protocols.
2. The facility will establish algorithms for appropriate diagnostic testing (i.e. obtaining cultures) for specific infections.
3. The facility will summarize antibiotic use on a quarterly basis and use the data to evaluate adherence to antibiotic prescribing protocols and appropriate diagnostic testing protocols.
4. The facility will provide an antibiogram annually to medical staff to support prescribing practices.
5. Prescribers are to document dose, duration, and indication for all antibiotic prescriptions.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Influenza and Pneumococcal Immunizations for Residents

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the resident receives Influenza and Pneumococcal immunizations, in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

**Influenza Immunization**

1. Before offering the influenza immunization, each resident and or the resident representative receives education regarding the benefits and potential side effects of the immunization;

2. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

3. The resident and or the resident representative has the opportunity to refuse immunization; and

4. The resident's medical record includes documentation that indicates, at a minimum, the following:
    i. That the resident or resident representative was provided education regarding the benefits and potential side effects of influenza immunization; and
    ii. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

**Pneumococcal Immunization**

1. Before offering the pneumococcal immunization, each resident and or resident representative receives education regarding the benefits and potential side effects of the immunization;

2. Each resident is offered pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

3. The resident and or resident representative has the opportunity to refuse immunization; and

4. The resident's medical record includes documentation that indicates, at a minimum, the following:
    i. That the resident or resident representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
    ii. That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

5. Pneumococcal immunization will be offered in accordance with CDC immunization algorithm for PCV13 and PPS23. http://www.cdc.gov/vaccines/vpd-vac/pneumo/downloads/adult-vax-clinician-aid.pdf

**POLICY/PROCEDURE**

**SUBJECT:** Influenza and Pneumococcal Immunization Policy for Staff

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. All facility staff are to be offered influenza vaccination each year in accordance with the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations.
2. Staff who are not vaccinated are required to sign a vaccination declination form.
3. Staff who are not vaccinated are required to properly wear a mask at all times in the facility when there are medium – high levels/local, regional, or widespread levels of influenza circulating in the community per public health reports.
4. All facility staff and residents are to be offered pneumococcal vaccination in accordance with the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations.

**PROCEDURE**

**SUBJECT:** Infection Control - Standard and Transmission-based Precautions

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

**Standard Precautions**

1. All staff are to adhere to standard precautions.
    a. Personal protective equipment is to be worn to protect health care workers (i.e. have a barrier) from contact with body fluids.
    b. Personal protective equipment includes gloves, gowns, masks, goggles and or face shield.
    c. The personal protective equipment worn will vary by task being performed and likelihood of exposure to body fluid.
2. Standard precautions apply to all residents.

**Transmission-based Precautions**

1. Transmission-based precautions include airborne, contact, and droplet precautions. Residents requiring airborne precautions will be transferred to a hospital or other health care facility with airborne precaution capability. Residents that require contact and or droplet precautions may remain at this facility.
2. Transmission-based precautions are applied in addition to standard precautions and in accordance with nationally recognized guidelines such as those from the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control (APIC), and or the Society for Healthcare Epidemiology of America (SHEA). The Centers for Disease Control and Prevention Isolation Guidelines are the primary resource for determining the type and duration of isolation precautions.
3. When a resident is placed on transmission-based precautions (i.e. isolation), the least restrictive option for isolation given current circumstances will be used.

4. Transmission-based precautions are applied presumptively or upon first suspicion that a resident may have an infection that requires transmission-based precautions.

5. The duration of transmission-based precautions/isolation will be based on nationally recognized guidelines and determinations to remove residents from isolation precautions will be made on a case-by-case basis by the infection preventionist/persons responsible for infection prevention and control program or their designee and or the director or nursing. At a minimum, residents must be asymptomatic and all body fluids must be contained in order to discontinue isolation precautions.

    a. When there is an increase in the prevalence of a certain type of infection or infections due to the same organism, isolation precautions may need to be extended until colonization pressure (i.e. bioburden) decreases in the facility.

6. All staff including environmental services staff are to comply with transmission-based precautions.

7. To designate a room for transmission-based precautions, a sign will be placed in the pocket of the caddy and is yellow in color for all infections except C-Diff. Staff will be notified of the type of transmission-based precautions a resident is place on and the reason. Staff are notified during shift report.

8. An isolation caddy with personal protective equipment and other supplies will be placed at the entrance of the resident room. At a minimum, this caddy will include appropriate personal protective equipment and disinfecting wipes.

9. Disinfectant wipes are an EPA-registered hospital disinfectant effective against HBV or have a tuberculocidal claim. (Please see section below for requirements for rooms of residents with *C. difficile*.)

10. All shared medical equipment used in (transmission-based precautions) resident room will be wiped down with disinfecting wipe upon exit of the room. When possible, equipment will be dedicated to the resident while on precautions or disposable equipment will be used.

11. When a resident is placed on transmission-based precautions, the resident and their family members and visitors are educated about transmission-based precautions.

12. Contact precautions are implemented most often for residents who have an infection due to an epidemiologically important organism such as multi-drug resistant organism (MDRO).
    a. Staff are to put on gowns and gloves upon room entry and remove gowns and gloves upon exit of resident room.

b. A private room is preferred for residents on contact precautions. Cohorting residents on contact precautions will be made on a case-by-case basis based on risk of transmission between roommates.
c. Residents are to remain in their rooms while on contact isolation precautions. Exceptions, for specified activity/time-limited activity that does not put other resident's health at risk, may be made on a case-by-case basis by the infection control designee or director of nursing.
d. Residents with urinary tract infections due to MDRO (i.e. ESBL) are not required to be placed on contact precautions as long as all body fluids can be contained. Staff are to wear gowns and gloves when providing care in the resident's room.
e. Residents with wound infections due to MDRO (i.e. MRSA) are not required to be placed on contact precautions as long as all body fluids are contained (i.e. wound can remain covered and dressing remains dry). Staff are to wear gowns and gloves when providing care in the resident's room.
f. A terminal/deep room cleaning is to be completed when a resident is removed from contact precautions.

13. Residents with *C. difficile* infection will be placed on special contact precautions.
    a. Special contact precautions require the use of gowns and gloves upon entry to room, soap and water for hand hygiene after contact with the resident or their care environment. Gowns and gloves should be removed and discarded at room exit.
    b. Special contact precautions also require the use of an EPA-approved sporicidal or bleach based product with EPA-approved claim for killing *C. difficile* spores for cleaning and disinfection of the resident room and equipment.
    c. Resident rooms for special contact precautions will be designated with a blue sign.
    d. A resident requiring special contact precautions is given priority for a private room. If a private room is not available, room placement will be evaluated and determined by the infection control designee. At a minimum, residents with *C. difficile* infection will not share a commode with any other resident (e.g. may require use of bedside commode).
    e. The resident will remain on special contact precautions as long as they are symptomatic. To discontinue precautions, the resident must be asymptomatic (i.e. no diarrhea). Occasionally, special contact isolation may need to be extended beyond the duration of diarrhea and should be reviewed on a case-by-case basis with infection control designee.
    f. Residents are to remain in their rooms while on special contact precautions.
    g. When possible, therapy services will be provided in the resident's room. If therapy cannot be provided in the resident's room, and all of the resident's body fluids can be contained, then the resident may be the last patient scheduled for the day in the therapy room. A terminal cleaning (using appropriate disinfectant) of the therapy area and all equipment used during

therapy session will be completed immediately after the resident completes therapy.

h. If resident must be transported for therapy services, prior to transport to clean clothes must be put on the resident. Hands must be washed with soap and water. All equipment (i.e. wheelchairs, walkers, etc.) must be wiped down with appropriate disinfecting wipe upon exit of the room.
i. A terminal/deep room cleaning is to be completed using an EPA-approved sporicidal or bleach solution of 1:10 when a resident is removed from special contact precautions.

14. Droplet precautions are implemented most often for residents who have respiratory illness.
    a. Staff are to put on a mask upon room entry and removed upon room exit of resident placed on droplet precautions.
    b. A private room is preferred for residents placed on droplet precautions. Cohorting residents on droplet precautions will be made on a case-by-case basis based on risk of transmission of infection.
    c. If a resident on droplet precautions must share a room, the curtain between residents is to remain pulled across room (to serve as a barrier between residents) at all times while resident is on droplet precautions.
    d. Residents requiring droplet precautions may leave their room if they wear a mask at all times while out of their room and hand hygiene can be performed prior to room exit. If the resident cannot tolerate a mask, then the resident is to stay in their room while on droplet precautions.
    e. Droplet precautions may be implemented in addition to contact precautions for some respiratory infections such as (but not limited to) pneumonia due to MDRO, Adenovirus, and RSV (Please see CDC Isolation Guidelines for complete list.
    f. A terminal/deep room cleaning is to be completed when a resident is removed from droplet precautions.

**Respiratory Hygiene/Etiquette**

1. Staff are to perform respiratory hygiene by coughing and sneezing into arm, sleeve, or tissue.

2. Hand hygiene is to be performed after discarding soiled tissue or after soiling hands.

3. Staff are to educate residents and visitors on the importance of respiratory hygiene.

4. Staff that are symptomatic of influenza-like-illness are not to provide direct resident care for 7 days after symptom onset or until 24 hours after resolution of symptoms, whichever is longer.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Cleaning and Disinfection/Non-critical care and shared equipment

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to provide a safe, sanitary, and comfortable environment to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Cleaning and disinfection of the facility including resident rooms is completed in accordance with environmental services policies and procedures.

2. Resident rooms, including rooms of residents on transmission-based precautions, are cleaned daily.
    a. Rooms of residents with *Clostridium difficile* infection are cleaned and disinfected in accordance with transmission-based precautions policy.

3. When residents are in their room at time of cleaning, staff are to be careful not to disturb dust or clean above a resident's head.

4. Environmental services staff is to focus on cleaning and disinfection of high-touch surfaces such as TV remotes, call buttons, over-bed tables, etc.

5. Non-critical medical equipment (equipment that only comes in contact with intact skin) is to be wiped down with a disinfectant wipe once per shift and as needed when soiled. Any equipment used in rooms while a resident is on transmission-based precautions is to be cleaned with a disinfectant wipe immediately after use/upon exit of room.
    a. Wheelchairs that are dedicated to one resident are cleaned and disinfected on a regular schedule and as needed when soiled.
    b. Wheelchairs that are not dedicated should be wiped down after use/prior to removal from resident room.

6. Workstation on wheels/computer on wheels are to be wiped with disinfectant wipe by resident care staff once per shift, as needed when soiled, and immediately after use in the room of a resident on transmission-based precautions.

7. Disinfectant wipes are an EPA-registered hospital disinfectant with tuberculocidal claim (i.e. intermediate level disinfectant). Floors may be cleaned with low-level disinfectant.

8. Terminal/Deep room cleaning is to be completed when a resident is removed from transmission-based precautions.

9. Privacy curtains are removed and laundered on a regular schedule, as needed when soiled, and when a resident is removed from transmission-based precautions.

**Blood and Body Fluid Spills**

1. Staff cleaning up blood and body fluid spills are to wear appropriate personal protective equipment (based on size and location of spill and disinfectant product used).

2. An absorbent material such as cotton mop head or paper towels should be used to soak up blood/body fluid prior to cleaning area with disinfectant. An EPA-registered disinfectant effective against blood borne pathogens including Hepatitis B or bleach solution is used to clean area.

3. Materials contaminated with blood or body fluids (except urine and feces without the presence of blood) are discarded into biohazardous waste containers.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Central Venous Catheter/Central Line Access and Maintenance

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Perform hand hygiene prior to accessing a central line or performing a dressing change and don a mask and clean or sterile gloves.
2. Any time the central line is accessed, the access port or hub is scrubbed with an appropriate antiseptic (e.g. chlorhexidine, povidone iodine, an iodophor, or 70% alcohol).
3. Only sterile devices may be used when accessing a central line.
4. Dressings that are wet, soiled, or dislodged should be replaced using aseptic technique with sterile or clean gloves. Otherwise, transparent dressings are changed every seven (7) days and sterile gauze dressings are changed every two (2) days.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Clean Dressing Change

**DATE:**

**INTENT:**

It is the policy of the facility to ensure change dressings in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Verify and review physician's order for procedure.
2. Perform hand hygiene and assemble equipment and supplies needed for dressing change.
3. Identify the resident and explain the procedure.
4. Evaluate resident's pain and the need for pain medication.
5. Put on gloves. Adjust bedside stand/table to waist level. Clean bedside stand/table with germicidal disposable cloth. Establish a clean field.
6. Place the resident's trash can within easy reach.
7. Remove gloves and perform hand hygiene.
8. Set-up supplies on barrier.
9. Position the resident for comfort.
10. Perform hand hygiene.
11. Put on clean gloves.
12. Remove dressing and place in the resident's trash can.
13. Remove gloves and perform hand hygiene.
14. Put on clean gloves
15. Cleanse wound with gauze and prescribed cleaning solution using single outward strokes. Use separate gauze for each cleansing wipe.
16. Use dry gauze to pat the wound dry.
17. Remove gloves and preform hand hygiene.
18. Put on clean gloves.

19. Apply clean dressing as ordered and ensure the dressing is dated.
20. Remove gloves and perform hand hygiene.
21. Reposition the resident and ensure the call light is in place.
22. Discard all disposable items into the appropriate receptacle.
23. Clean the bedside stand/table with germicidal disposable cloth.
24. Remove trash from resident's room.
25. Wash and dry hands thoroughly.
26. Document the completion of dressing change on the treatment record.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Food Handling

**DATE:**

**INTENT:**

It is the policy of the facility to procure, store, prepare, distribute, and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of foodborne illness in accordance with State and Federal Regulations.

**PROCEDURE:**

1. Food services staff are to wash hands when: entering a food preparation area; before putting on gloves; before preparing food; when changing tasks (i.e. switching from working with raw foods to ready to eat foods); after handling soiled dishes, utensils, and equipment; after using the bathroom; after coughing, sneezing, eating or drinking; and after handling shellfish.
2. Hands are to be washed in sinks designated for handwashing only.
3. Ready-to-eat foods should not be touched with bare hands.
4. Single-use gloves are not to be used for more than one task. Change gloves and perform hand hygiene between tasks.
5. The facility will prohibit employees with signs or symptoms of infection (i.e. vomiting, diarrhea, jaundice, sore throat with fever) that may be transmitted to residents or any exposed boil or open, infected wound or cuts on the hands or arms from contact with residents or their food.
6. Food services staff are to eat and drink in designated areas away from exposed food, food equipment, utensils, or items that require protection.
7. Temperatures of refrigerators and freezers will be monitored daily and documented. Refrigerators should be < $40^{o}$F and the freezer at $0^{o}$F or below.
8. Foods are to be cooked to appropriate temperatures.
9. Food are to be held at appropriate temperatures while being served. Monitoring of food temperatures using food thermometer should be performed regularly.
10. Food should be properly labeled and expired foods will be discarded.
11. Food left out at room temperature for more than two (2) hours will be discarded.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Hand Hygiene

**DATE:**

**INTENT:**

It is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers for Disease Control and Prevention and the World Health Organization.

**PROCEDURE:**

1. Soap and water is required for hand hygiene when:
   a. Hands are visibly soiled;
   b. After caring for resident with diarrheal infection such as *C. difficile*;
   c. After potential exposure to body fluid;
   d. Before and after eating or handling food; and
   e. After personal use of toilet.

2. Alcohol-based hand rub may be used for all other hand hygiene opportunities (e.g. when soap and water is not indicated per #1 above). According to the World Health Organization, hand hygiene is to be performed:
   a. Prior to caring for a resident;
   b. Prior to performing a procedure such as blood glucose monitoring or catheter care;
   c. When moving from a contaminated body site to a clean body site such as when changing a brief or wound dressing;
   d. After caring for a resident including after removing gloves; and
   e. After contact with the resident environment.

3. The Centers for Medicare and Medicaid State Operations Manual indicates that hand hygiene should be performed:
   a. When coming on duty;
   b. Before and after performing any invasive procedure (e.g. finger stick blood sampling);
   c. Before and after entering isolation precaution settings;
   d. Before and after assisting a resident with meals;
   e. Before and after assisting a resident with personal care;
   f. Before and after handling peripheral vascular catheters and other invasive devices;
   g. Before and after inserting indwelling catheters;
   h. Before and after changing a dressing;
   i. Upon and after coming in contact with a resident's intact skin (e.g. when taking a pulse or blood pressure, and lifting a resident);

j. Before and after assisting a resident with toileting;
k. After blowing or wiping nose;
l. After contact with a resident's mucous membranes and body fluids or excretions;
m. After handling soiled or used linens, dressing, bedpans, catheters, and urinals;
n. After handling soiled equipment or utensils;
o. After removing gloves or aprons; and
p. After completing duty.

4. Resident care staff must keep fingernails short, no longer than ¼ of an inch.

5. Resident care staff are not permitted to have artificial nails or nail extenders of any type.

6. Resident care staff may wear fingernail polish however polish must not be chipped. If a staff member has chipped nail polish, they will be asked to remove their nail polish immediately.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Indwelling Catheter Care

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that the residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice.

**PROCEDURE:**

1. Perform hand hygiene before beginning the procedure and assemble all supplies.
2. Knock before entering room, introduce self and explain procedure to the resident.
3. Place supplies on the bedside stand or over-bed table and arrange supplies so that they can be easily reached. Pull the cubicle curtain around the bed for privacy.
4. Perform hand hygiene and put on gloves.
5. Position resident for comfort.
6. Using disposable wipes cleanse: female labia with single downward, cleansing stroke using a different side of the wipe for each cleansing stroke for each side of the labia and the urethral meatus; male glans with circular strokes from the meatus outward, using a different side of wipe for each cleansing circular stroke as needed. For uncircumcised males, retract the foreskin cleanse the meatus as described and return foreskin to normal position.
7. Secure catheter tubing with non-dominant hand and with a single downward, cleansing stroke cleanse catheter tubing from meatus towards collection bag.
8. Turn resident on side to perform backside cleansing again using single cleansing strokes from front to back and reposition resident for comfort.
9. Discard supplies, remove gloves and wash hands.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Indwelling Urinary Catheter Use

**DATE:**

**INTENT:**

It is the policy of the facility to ensure the appropriate use of indwelling urinary catheters in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Indwelling urinary catheters are to be used when indicated according to national guidelines such as those by the Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines (often referred to as the Centers for Disease Control and Prevention guidelines). Exceptions may be made on a case-by-case basis upon evaluation by infection prevention and control coordinator, director of nursing, and ordering physician.

2. Indications for using indwelling urinary catheters per HICPAC guidelines include:
    a. Resident has acute urinary retention or bladder outlet obstruction;
    b. Need for accurate measurements of urinary output in critically ill residents;
    c. Perioperative use for selected medical procedures;
    d. To assist in healing of open sacral or perineal wounds in incontinent residents;
    e. Resident requires prolonged immobilization; and
    f. To improve comfort for end of life care.

3. Urinary catheters are not to be used to manage incontinence.

4. Urinary catheters are to be discontinued when resident no longer meets indication for use. Resident's indication for use of an indwelling urinary catheter is reviewed regularly by nursing staff.

5. Indwelling urinary catheters and drainage bags should not be changed at routine or fixed intervals. Indwelling urinary catheters and drainage bags are changed when there is indication of infection, obstruction, or as clinically indicated.

6. If an indwelling urinary catheter has been in place for 14 days or more, it should be changed prior to collecting a urine specimen for laboratory testing.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Linen Management

**DATE:**

**INTENT:**

It is the policy of the facility to ensure linens are handling in a way to prevent cross-contamination and the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Clean linens are to be kept covered and protected from dust and other contaminants prior to use.
2. Clean linens are to not to come in contact with staff clothing (i.e. carry linens away from the body).
3. Clean linens should not touch the floor when folded.
4. Laundry equipment should be properly maintained according to manufacturer's instructions.
5. Clean and dirty linen areas should be separate and clearly designated. Only clean linens are transported on clean carts and only dirty linens are transported in containers designated for dirty linens.
6. Dirty linens are contained in a closed container or bag.
7. Dirty linens are not to come in contact with staff clothing (i.e. a gown may be required to prevent contact between staff clothing and soiled linens).
8. Dirty linens are to be handled in a way to prevent aerosolizing infectious agents (i.e. do not shake linens).
9. Dirty linens should be folded inward so that most of the contamination is toward the inside.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Medication Administration

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Hand hygiene is performed prior to handling any medication.
2. Knock before entering room, introduce self and let resident know what medications you will be providing and if any side effects are expected.
3. Verify the resident's identity using two identifiers such as name and date of birth.
4. Verify medication name and label compared to physician order or medication administration record (MAR), verify dosage, and verify route of administration (i.e. orally, intravenous, or subcutaneous).
5. Verify medication is being provided at the right time per physician orders/ medication administration record.
6. Document medication taken, or refused by resident, including time and resident response to medication.
7. Expired medications are to be properly discarded. Medications are labeled and expiration dates are checked regularly.
8. Syringes are unwrapped at time of use.
9. Medications are to be drawn up in a clean area (i.e. away from sinks and not in resident room).
10. If the sterility of a medication is compromised, or suspected of being compromised, the medication is discarded.
11. Refrigerators used to store medications do not include any items other than medications.
12. Temperature is monitored daily and documented.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Point of Care Devices and Injection Safety

**DATE:**

**INTENT:**

It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of infection in accordance with State and Federal Regulations, and national guidelines.

**PROCEDURE:**

1. Shared point of care devices are to be cleaned and disinfected before and after each use with a disinfectant wipe included on Environmental Protection Agency (EPA) List D (https://www.epa.gov/pesticide-registration/list-d-epas-registered-antimicrobial-products-effective-against-human-hiv-1) If device is visibly soiled, it is to be wiped clean prior to using disinfectant wipe.

2. Point of care devices that are not shared are to be stored in plastic bags that are properly labeled with resident's name in order to prevent cross-contamination while device is not in use. Point of care devices are to be wiped clean/disinfected according to manufacturer's instructions.

3. Only a single set of supplies (i.e. test strips, lancets, etc.) may be taken into the resident room. Any additional supplies that are taken into the room that are not used are to be properly discarded in the resident room.

4. Supplies are not to be carried in pockets of clothing.

5. All lancets, finger stick devices, and injection equipment are to be disposed of in an approved sharps container at point of use.

6. Insulin pens are not shared. Insulin pens are assigned to one person.

**Injection Safety**

1. All needles and syringes are used only one time.

2. Only a clean needle and clean syringe may be used to enter a medication vial.

3. Bags or bottles of intravenous solution may only be used for one resident.

**POLICY/PROCEDURE**

**SUBJECT:** Infection Control - Tuberculosis (TB) Screening Program

**DATE:**

**INTENT:**

It is the policy of the facility to ensure the implementation of a Tuberculosis Screening Program in accordance with State and Federal Regulations, and the Centers for Disease Control and Prevention (CDC) guidelines.

**PROCEDURE:**

1. The facility infection control coordinator or designee is responsible for the TB program.
2. The facility will conduct a Tuberculosis (TB) risk assessment annually.
3. The facility staff will be trained on signs, symptoms, and risk factors for TB.
4. The facility will screen all staff upon hire for TB.
    a. Staff who test positive, will require a chest X-ray and follow-up assessment by a health care provider.
5. The facility will screen symptomatic and or high risk residents upon admission.
6. The facility will re-screen staff for TB based on the results of the annual risk assessment and CDC guidelines. If the facility is in the low risk category, as defined by CDC, then staff will not be re-screened.
7. The facility may re-screen staff and residents suspected of being exposed to a person with TB.
8. Residents suspected of having or having active TB will be transferred to a facility with airborne precaution capability as soon as possible.
9. The facility will notify the local health department of suspected or confirmed TB case to conduct an investigation to identify potential health care staff exposures. The facility will follow public health guidance regarding post-exposure screening and prophylaxis protocols.
10. Staff who develop active TB infection will be excluded from work until they are determined to not be infectious by a medical provider. This typically occurs after receipt of adequate therapy (i.e. antibiotics), cough has resolved, and there are three consecutive sputum smears negative for acid-fast bacilli.

11. Residents will be assessed upon admission for signs and symptoms of TB and risk factors for TB exposure. If resident is suspected of having TB will be referred for medical evaluation. Residents who may be at high risk for having had a recent exposure to TB will be screened (i.e. skin test).

PLACE TAB FOR PHYSICAL ENVIRONMENT HERE

**POLICY/PROCEDURE**

**SUBJECT:** Physical Environment

**DATE:**

**INTENT:**

It is the policy of the facility to provide care and services related to Physical Environment in accordance to State and Federal regulation.

**PROCEDURE:**

This policy will include:

1. Emergency Electrical Power System
2. Space and Equipment
3. Essential Equipment, Safe Operating Condition
4. Resident Bed
5. Resident Room
6. Bedroom Number of Residents
7. Bedrooms Measure at Lease 80 Square Ft/Resident
8. Bedrooms Have Direct Access to Exit Corridor
9. Bedrooms Assure Full Visual Privacy
10. Resident Room Window
11. Resident Room Floor Above Grade
12. Resident Room Bed/Furniture/Closet
13. Bedrooms Equipped/Near Lavatory/Toilet
14. Resident Call System
15. Requirements for Dining and Activity Rooms
16. Safe/Functional/Sanitary/Comfortable Environment
17. Procedures to Ensure Water Availability
18. Ventilation
19. Corridors Have Firmly Secured Handrails
20. Maintains Effective Pest Control Program
21. Smoking Policies

**POLICY/PROCEDURE**

**SUBJECT:** Emergency Electrical Power System

**DATE:**

**INTENT:**

It is the policy of the facility to provide Emergency Electrical Power in accordance to State and Federal regulations.

**PROCEDURE:**

**This policy has intentionally been left blank**

**POLICY/PROCEDURE**

**SUBJECT:** Space and Equipment

**DATE:**

**INTENT:**

It is the policy of the facility to provide areas large enough to comfortably accommodate the needs of the residents who usually occupy this space and Equipment maintained in safe and working order, in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's assessment and plan of care.

2. These areas will have space for storing and utilizing mobility devices, assistive technology, physical therapy or adaptive equipment as identified in the resident assessment and plan of care.

3. The facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition.

4. Equipment will be maintained according to manufacturer's recommendations.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Bed

**DATE:**

**INTENT:**

It is the policy of the facility to maintain essential equipment in a safe operating condition, in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment.
2. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible.
3. The facility may refer to “Guide to Bed Safety Rails in Hospitals, Nursing Homes and Home Health Care: The Facts” as to the proper dimensions and distances apart of various parts of the bed such as distance between bed frames and mattresses, bed rails and mattress etc. to prevent entrapment by users of the bed.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Rooms

**DATE:**

**INTENT:**

It is the policy of the facility to provide areas large enough to comfortably accommodate the needs of the residents who usually occupy this space, in accordance to State and Federal regulations.

**PROCEDURE:**

1. Resident rooms will be designed and equipped for adequate nursing care, comfort, and privacy of residents.

2. The facility will ensure bedrooms will:
    a. Accommodate no more than four residents, for facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents;
    b. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;
    c. Have direct access to an exit corridor;
    d. Be designed or equipped to assure full visual privacy for each resident;
    e. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;
    f. Have at least one window to the outside;
    g. Have a floor at or above grade level; and
    h. Each resident room will be equipped with or located near toilet and bathing facilities. For facilities that receive approval of construction from State and local authorities or are newly certified after November 28, 2016, each residential room must have its own bathroom equipped with at least a commode and sink.

3. The facility will provide each resident with:
    a. A separate bed of proper size and height for the safety and convenience of the resident;
    b. A clean, comfortable mattress;
    c. Bedding appropriate to the weather and climate;
    d. Functional furniture appropriate to the resident's needs, and
    e. Individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

**POLICY/PROCEDURE**

**SUBJECT:** Safe Environment

**DATE:**

**INTENT:**

It is the policy of the facility to provide a safe environment in accordance to State and Federal regulations.

**PROCEDURE:**

1. The facility will be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public.
2. The facility will maintain all essential mechanical, electrical and patient care equipment in safe operating condition.
3. The facility will provide one or more rooms designated for resident dining and activities.
4. The facility will ensure that the designated areas are well lighted, well ventilated, adequately furnished and have sufficient space to accommodate all activities.
5. The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
6. The facility will have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.
7. The facility will maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.
8. The facility will provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible.
9. The facility will provide:
    a. housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
    b. clean bed and bath linens that are in good condition;
    c. private closet space for each resident;
    d. furniture, such as a bed-side cabinet, drawer space;
    e. adequate and comfortable lighting levels in all areas;
    f. comfortable and safe temperature levels; and
    g. maintain comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the resident will be tuned to stations of the resident's choice.

10. The facility will equip corridors with firmly secured handrails on each side.
11. The facility will maintain an effective pest control program so that the facility is free of pests and rodents.
12. The facility will maintain adequate lighting levels in all areas suitable to tasks the resident chooses to perform or the facility staff must perform. Comfortable lighting will minimize glare and provide maximum resident control, where feasible, to maintain or enhance independent functioning.
13. The facility will maintain comfortable and safe temperature levels between 71-81 degrees F (Fahrenheit).
14. The facility will maintain comfortable sound levels that do not interfere with resident's hearing and enhance privacy and social interaction as desired.
15. The facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities.
16. The facility will establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
17. The facility will establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

**POLICY/PROCEDURE**

**SUBJECT:** Resident Smoking

**DATE:**

**INTENT:**

This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents in accordance to State and Federal regulations.

**PROCEDURE:**

1. In accordance with the Florida Clean Indoor Air Act and City and County Ordinances, all indoor smoking is prohibited.

2. Effective 3/1/04, Pines of Sarasota SNF was designated as a smoke-free facility. Residents who smoke are not permitted to smoke in any part of the Pines of Sarasota Campus.

3. For residents admitted prior to 3/1/04 who need supervision, staff will accommodate resident's request to smoke on an "as needed" basis.

4. If found violating the facility policy, the individual will be asked to extinguish the lighted tobacco product and may be given a 30 day written notice to leave. Residents who fail to immediately discontinue use of all tobacco products, paraphernalia and or electronic cigarettes, which may be deemed a safety hazard to residents, staff or visitors immediate discharge will be necessary.

5. Employees are permitted to smoke only during their meal or authorized breaks in designated area.

6. Chewing tobacco products are not permitted.

7. Electronic Smoking Devices are not permitted.

8. Safety measures for the designated smoking area will include, but not limited to:
    a. Protection from weather conditions (i.e. covered).
    b. Provision of ashtrays made of noncombustible material and safe design.
    c. Accessible metal containers with self-closing covers into which ashtrays can be emptied.
    d. Accessible fire extinguisher.
    e. Prohibition of oxygen use in the smoking area.
    f. Staff Supervision.

9. No smoking signs will be maintained on the door or gate where oxygen is used or

stored.

10. Residents and family members will be notified of this policy during the admission process, and as needed.

11. All residents will be asked about tobacco use during the admission process, and in conjunction with the RAI Process.

12. Newly admitted residents who smoke will not be permitted to smoke on Campus.

13. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated.

14. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers. Supervision will be provided as indicated on each resident's care plan.

15. If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking, or even discharge.

16. Residents will be allowed to smoke at their discretion332.

17. If you are a smoker and would like Smoking Cessation Education materials please see below:

    Websites
    Visit these websites for self-help support and education material:

    www.quitnet.com
    www.ffsoline.org
    www.quitsmokingsupport.com
    www.gotaquit.com
    www.lungusa.com
    www.americanheart.org
    www.cancer.org
    www.smokefree.gov
    www.cancer.gov

    Phone Support
    1-877-UCANNOW or 877-822-6669 – Florida Quit for life line provides five free counseling sessions
    1-800-4CANCER or 800-422-6237 – National Cancer Institute provides free smoking cessation by phone
    1-866-66-START or 866-667-8278 – Great Start Campaign to reduce smoking during pregnancy

INSERT TAB FOR TRAINING REQUIREMENTS HERE

**POLICY/PROCEDURE**

**SUBJECT:** Training Requirements

**DATE:**

**INTENT:**

It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal regulations.

**PROCEDURE:**

This policy will include:

1. Abuse Neglect and Exploitation Training
2. Required In-Service Training for Nurse Aides
3. Training for Feeding Assistants

**POLICY/PROCEDURE**

**SUBJECT:** Abuse, Neglect and Exploitation Training

**DATE:**

**INTENT:**

It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal regulations.

**PROCEDURE:**

1. The facility will develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles.

2. The facility will determine the amount and types of training necessary based on a facility assessment.

**POLICY/PROCEDURE**

**SUBJECT:** Required In-service Training for Nurse Aides

**DATE:**

**INTENT:**

It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal regulations.

**PROCEDURE:**

1. Training topics will include but are not limited to:
    a. Abuse, neglect, and exploitation training to include in addition to the freedom from abuse, neglect, and exploitation requirements, activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property;
    b. Dementia management & abuse prevention training,
    c. Care of the cognitively impaired; and
    d. Training of feeding assistants.

2. Required in-service training for nurse aides will:
    a. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.
    b. Include dementia management training and resident abuse prevention training.
    c. Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff.
    d. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

3. The facility will not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants.

**POLICY/PROCEDURE**

**SUBJECT:** Staff Education Plan

**DATE:**

**INTENT:**

It is the policy of the facility to provide a Staff Education Plan in accordance with State and Federal regulations.

**PROCEDURE:**

1. The facility will develop, implement, and maintain a written staff education plan, which ensures a coordinated program for staff education for all facility employees.
2. The staff education plan will be reviewed at least annually by the quality assurance committee and revised as needed.
3. The facility will ensure the staff education plan includes both pre-service and annual requirements.
4. The staff education plan shall ensure that education is conducted annually for all facility employees, at a minimum, in the following areas:
   a. Prevention and control of infection;
   b. Fire prevention, emergency procedures-life safety, and disaster preparedness;
   c. Abuse, Neglect, and Exploitation
   d. Accident prevention and safety awareness programs;
   e. Resident's rights to include Advance Directives;
   f. OSHA Training – Biomedical Waste Plan and Bloodborne Pathogens
   g. Federal law Requirements for Long Term Care Facilities, which is incorporated by reference, and state rules and regulations; and
   h. The Florida "Right to Know," Law.
5. The staff education plan will ensure that all non- licensed employees of the nursing home complete an initial educational course on HIV/AIDS. If the employee does not have a certificate of completion at the time they are hired, they must have two hours within six months of employment. All employees shall have a minimum of one hour biennially.
6. The facility will ensure, when employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular in-service education based on the outcome of such reviews.
7. The facility will ensure that the in-service training be sufficient to ensure the continuing competence of nursing assistants and must meet the standards specified in the State Regulations and include, at a minimum:

a. Techniques for assisting with eating and proper feeding;
b. Principles of adequate nutrition and hydration;
c. Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;
d. Techniques for caring for the resident at the end-of-life; and
e. Recognizing changes that place a resident at risk for pressure ulcers and falls; and
f. Include dementia management training and resident abuse prevention training; and
g. Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

8. The facility will ensure that nursing staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

9. The facility will ensure that all employees who are expected to, or whose responsibilities require them to, have direct contact with residents with Alzheimer's disease or a related disorder must, in addition to being provided the information required, also have an initial training of at least 1 hour completed in the first 3 months after beginning employment. This training must include, but is not limited to, an overview of dementias and must provide basic skills in communicating with persons with dementia. An individual who provides direct care will be considered a direct caregiver and must complete the required initial training and an additional 3 hours of training within 9 months after beginning employment. This training will include, but is not limited to, managing problem behaviors, promoting the resident's independence in activities of daily living, and skills in working with families and caregivers.

10. The facility will ensure that Risk Management training be a part of the facilities new hire orientation.

11. The facility will ensure that Risk Management training be a part of the annually required staff education plan.

12. The facility has chosen to use an on-line education system to meet the educational requirements for all staff members.

13. The required education is assigned to an individual staff member based on their position.

14. Each quarter there will be different required education topics that must be completed by staff.

15. Quarterly each employee's education record is printed to evaluate compliance and these reports are forwarded to the appropriate department manager.

16. The Administrator or designee will be responsible for the oversight of the program.

**POLICY/PROCEDURE**

**SUBJECT:** Training for Feeding Assistants

**DATE:**

**INTENT:**

It is the policy of the facility to provide training to feeding assistants in accordance with State and Federal regulations.

**PROCEDURE:**

1. The facility will not use any individual working as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160.