1995

Long Term Care Policy and Procedure Manual

Glynis Warters

LONG TERM CARE POLICY
AND PROCEDURE MANUAL

Glynis Warters, BSN

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Care

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ABSTRACT

This culminating project will focus on the changes that have occurred in themedical world and how those changes have, and will continue to impact the elderly, specifically in the long term care setting.

Over the years the main consideration of health care has changed from direct patient impact to direct dollar impact. With these changes has come the ethical dilemma of providing care for the elderly in a dignified and individualized manner while maintaining a positive cash flow. No longer will society accept mediocre care for the elderly, gone are the days of few and poorly defined regulations that mandate nursing homes.

State and federal regulations mandate how long term care facilities are managed. Indeed, the nursing home industry is one of the most heavily regulated, second only to nuclear waste.

Nursing homes have long been viewed by society as a place elderly patients go to die. A place where there is no dignity, no life, no choices.

The purpose of this manual is to assist a long term care facility in the accurate completion of the admission

process, correct placement of the patient, identification rehabilitative needs and observance of patient rights while adhering to the mandated state and federal regulations in the most cost effective manner.

As with many of the changes emanating from Washington, recently proposed legislation will dramatically change the delivery of health care in the United States. Coupled with the changes already in effect, health care facilities, particularly long term care facilities, are scrambling to stay competitive.

The role of the long term care facility continues to change as hospitals release patients more quickly, and nursing homes see sicker, frailer patients at their door. The nursing home must balance identifying the needs of their patients while adhering to the regulations and observing patients rights, all the while on a very small reimbursement rate.

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TABLE OF CONTENTS

Chapter I

INTRODUCTION

As we contemplate the future, the aging of the baby boomers, the number of Americans over the age 65 is expected to rise from 33 million to 65 to 70 million by 2030 (Turman 47-49).

Carefully pondering its next moves in the midst of intense speculation by providers, industry analysts and academics alike on the future of long term care, all agree on the need for greater diversity and flexibility and an openess to the formation of strategic alliances as payers, including managed care organizations, seek less costly care choices. All envision a spectrum of care that satisfies the customer's and family's desire for the elderly client to live out their life in an affordable and dignified manner.

According to Turman, industry insiders state that medical technology will create increasing opportunities to move patients more quickly from hospitals to less intensive care settings for rehabilitation. Also, managed care organizations will intensify quality monitoring as they hold their networks, including long term care providers, increasingly accountable for cost-effective care that produce positive patient outcomes. Long term care

providers will have their pick of professional nurses as additional nurses graduate with clinical experience in caring for older persons. Even the physical environment in long term care will undergo dramatic innovation in design, becoming more responsive to residents' social and psychological needs. Gone will be a system that limits choices to home or institution. Instead there will be a broad middle range of options that will promote independent living for as long as possible (47-49).

According to Turman, the traditional long term care facility will be reserved for a frailer, sicker and older population. The complete continuum of care will include everything from help with chores and meals to home health services, independent and congregate living, assisted living, skilled nursing and subacute care, as rural areas set up small hospitals within a long term care facility's infrastructure (47-49).

The generation of baby boomers, as predicted, is aging rapidly. Age Wave Health Services Inc. in Emeryville, California cites estimates that by the year 2000 at least 50 percent of all U.S. health care expenditures will cover Americans aged 65 and over, although this age group will comprise only 13 percent of the population (qtd. in Turman 47).

A longer living population is a driving force for many long term care services. Indeed the demand for long term services is growing and will continue to grow.

Donald Steinwachs, Chairman of the Department of Health Policy and Management at the Johns Hopskins University School of Hygiene and Public Health states:

> All of us hope that as we extend our lives we do not extend the period of chronic disease... but there is no evidence that we are reducing chronic disease; its just that we are managing it better. Indeed, Americans must age more healthfully and independently or we will drain our resources (49).

Society does not take aging as seriously as it does youth. However, in all respects the impact of our aging population on health care will be unbelievably dramatic. The whole phenomenon of caregiving is going to hit society like a ton of bricks if we are not prepared for it (Steinwachs 49).

Bruce Clark, Senior Vice President of Age Wave Health Services, Inc., contends that the baby boomers, who are sophisticated consumers and strong advocates for themselves and their elderly parents, will reshape a U.S. health care delivery system. Just as we now focuse on acute care, we pay small heed to its support infrastructure for the elderly

(49-50).

The transformation of the long term care industry is being rapidly propelled by the reality of declining public resources and a commensurate need for more resources from the private sector.

Ongoing attempts to balance the federal budget with proposed cuts in the Medicare and Medicaid programs will compel long term care providers to adopt programs that confront those cuts. In any case, short term or long term, the driving force will be the budget issue and there will be much pain as people try to accommodate this concern. Long term care industry insiders predict dramatic changes in response to this pressure.

According to Dale Buss, creative financing, along with the creative use of home care and day care, is expected to allow elderly Americans, who do not necessarily require institutional care but can no longer care for themselves independently to remain in their own homes longer (10-11).

In order to compete, in the ever changing world of health care, providers are going to have to look outside their walls and provide some of these services. One can envision a community facility with outreach into its community, a geriatric center with respite care, a subacute component, and day care, states Buss (10-11).

Many experts feel the linkage between the managed care

industry and the subacute facility will be what drives health care in the future. Hospitals of the future are being envisioned as sites for emergency departments, operating rooms and intensive care and neonatal intensive care units, with direct physician linkages to subacute facilities for medical and surgical care.

Turman notes that as sicker patients are sent to nursing facilities with subacute care, nurses who once avoided a career in long term care, are now being lured toward this industry. As the boundaries between hospitals and long term care facilities fade, the two are becoming allies to provide a continuum of care (54-57).

In the article by Wagner, we can no longer say a nurse is a nurse is a nurse. We have become very specialized...but we should be more well-rounded (52-53).

Long term care facilities must demonstrate greater opportunities for nurses, and one of the best recruitment techniques is to offer training or retraining for the new environment. In addition, managed care organizations focusing on wellness and health promotion for the elderly will need nurses to implement noninstitutional programs along with the continuum of care.

Throughout the years, the hospital and nursing facility have remained very distinct entities. If managed care can help to improve the connection between hospitals and nursing

facilities, it should not only help the patient but also help caregivers to better help understand the patient.

A complete continuum of care is our ideal future. The continuum will satisfy the customer and the family's desire for the patient to receive quality care, in a dignified manner while emphasizing affordability and independence.

In a effort to meet the growing concerns of families and patients, the physical design of long term care facilities will change in response to forces ranging from residents' needs to marketing needs, technological advances, and treatment philosophies. Instead of the traditional medical model of long corridors with units on both sides, a day room doubling as a dining room and few amenities, facilities will place more emphasis on residential or homelike settings and acknowledge the therapeutic potential of the environment.

There is fairly substantial pressure on facilities to compete, and in order to compete they have to meet public expectations. Consequently, as potential clients and families look for better facilities, there is pressure on long term care facilities to upgrade. By any mark, to take pride and keep up with advances in health care is a good investment, some innovations are not that costly.

Design researchers have realized there is much you can do with the physical environment in order to maintain

the abilities of clients for as long as possible, minimizing some of their symptoms and allowing them to hold onto current abilities as long as possible.

Most design trends for the cognitively impaired are applicable to the general long term care population. Designs include better use of natural light and outdoor parks and gardens; conversion of often understaffed and underutilized rooms, such as beauty salons, into fewer and less specialized activity spaces; smaller numbers of residents on a wing, more personalization of residents, allowing them to bring in furnishings, bedcoverings and other personal items.

Buss, in his work, Newsfronts, states that long term care providers should look at the dynamics of the local marketplace and think about the forces that bring them clients and how these factors will change (10-12).

Instead of relying on cost reports, long term care providers must truly understand their costs in order to compete and negotiate contracts successfully. These types of providers need to work more closely with hospitals and managed care organizations, because they are accepting financial risk for an increasing number of Medicare patients, and seeking more long term care services for aging members.

If Medicare starts bundling payments to hospitals, in effect making hospitals responsible for paying any postacute care fees, then hospitals could begin negotiating

payments with nursing facilities and home health agencies for less costly additional services. This trend could fill a skilled nursing facility's subacute beds, but it could also offer the hospital an advantageous arrangement on services. Long term care providers must offer low costs, provide good care and obtain the information needed to negotiate with managed care providers and hospitals.

While Medicare services have expanded rapidly, they remain only about eight percent of total revenues for skilled nursing facilities, cites Turman. As a result, Medicaid and private pay will continue to be any nursing facility's bread and butter, although the Medicaid side will be increasingly difficult. In addition, in the likely event that payment rates are dramatically cut, then it will be more difficult to maintain quality care and provide more specialized, intensive services (52-54).

At the extremes, it can be seen where the competition will probably be and what needs to be done. At the lower end, nursing facilities must compete with assisted living organizations. At the higher end, nursing facilities must show managed care organizations and hospitals that they can provide cost - effective care.

However, as Turman points out in her book, The Future of Long Term Care, in the broad middle ground areas where nursing facilities are dealing with frail people with a

multitude of activities of daily living problems, Medicaid financing will continue to be an important component (52--54).

In the end, human compassion must take its rightful place at the forefront of long term care. In the coming months good nursing facilities will find ways to liberate employees to spend more quality time with residents. Even as levels of care intensify, providers will create "people oriented," home-like, warm and inviting settings where residents will be able to find a sense of community where their basic spiritual and emotional needs will be met.

Changing the physical environment of the long term care facility will have little effect on the patient if he does not attain and maintain his highest level of functioning. Consequently rehabilitation has become an increasingly important part of nursing home care. Since the enactment of the Medicare Prospective Payment system in 1983, patients have been moved from acute-care hospitals to long-term care facilities much earlier in their convalescence. As a result of this change in managing patients, approximately one-third of admissions to nursing homes are now for convalescence and rehabilitation, Joseph and Wanlass have noted that dramatic increases in institutionalization have been reported that are attributable to shifting elderly patients from hospitals to nursing homes

that lack effective rehabilitative programs (10-13).

In addition the importance of rehabilitation in nursing homes has been further reinforced by the Omnibus Budget Reconciliation Act of 1987, which mandates that there be comprehensive assessment, individual treatment planning, and delivery of services to allow every resident to attain or maintain the highest possible mental and physical functional status.

Literally the word rehabilitation means to make able to live again. This applies not only to physical but also to psychological functioning. Rehabilitation classically seeks to return persons to previous functional levels, social roles, and living situations. However in the nursing home, maintaining current abilities and preventing deterioration is equally important (10-13).

Nursing home rehabilitation falls into two categories: restorative therapy and maintenance therapy. For the one quarter to one-third of individuals admitted to a nursing home who will return to independent or semi-independent living in the community, restorative therapy may be most appropriate. These short-stay residents are often admitted directly from an acute-care hospital for rehabilitation following surgical joint procedures, strokes or amputations. This type of nursing home rehabilitation can proceed at a slower pace and lower intensity, both better suited to

the frail, geriatric patient. However, it serves many nursing home residents who do not return to former levels of independence and who may remain in a long-term care facility for the rest of their lives. For these residents, an individualized treatment program may still improve their activities of daily living, as well as result in enhanced self esteem and independence, in addition to reduced cost to the institution (10-13).

Some nursing home residents may already be functioning at their maximal level. For these individuals, maintenance therapy would be considered appropriate in order to preserve their current functional status, prevent further deterioration, and enhance their psychological well being through the activities involved in the therapy.

It is possible and highly desirable to involve both the resident and his or her family or care givers in the rehabilitation program. Although learning to live with existing disabilities is part of the rehabilitation process, nursing home staff must recognize that depression, apathy, anger or agitation may accompany the failure to achieve a desired goal. As Cornacchione and Slusser note in their article, "Depression in the Long Term Care Facility", it is necessary to strike a balance between encouraging residents to achieve independence and providing the help they need (24).

Chapter 2

LITERATURE REVIEW

Focusing on the fiscal 1996 budget Capital Hill once again Medicare is a prime savings target.

The Medicare situation has been a source of conflict in Washington for well over a year. As lawmakers turn to the program for spending reductions to offset the cost of new programs and to reduce the overall deficit, providers are struggling to shield their Medicare payments from further erosion and senior citizens try to keep their Medicare benefits from shrinking.

With congress offering suggestions that not only include massive savings but also free-market competition, long term care facilities are now in direct competition with hospitals.

The House Budget Committee's proposed Incentive-based Medicare reform includes 35 specific proposals to reform the existing Medicare system to help create more choices and incentives for competition and cost effectiveness. They include the following items:

*Inform beneficiaries of managed care options.

*Establish a preferred provider organization (PPO) option for the entire Medicare program.

*Allow beneficiaries to remain in their employer plans after

retirement, regardless of whether that plan has a contract with Medicare.

*Lift the requirement that health maintenance organizations (HMO) with Medicare contracts draw at least half of their members from commercial plans.

*Allow managed care plans to offer more options, including PPOs, medical savings accounts (MSA) and partial capitation plans.

*Increase incentives for HMOs to participate in Medicare by raising payments by 5 percent a year, with a 1.5 percent hike to plans that now are paid more than 120 percent of the national median.

*Increase premiums by $20 for new Medicare beneficiaries who opt for fee for service, beginning in 1999.

*Raise Medicare deductible to $150 from $100 to more closely reflect private sector plans. Beneficiaries can avoid the deductible by choosing a private plan, such as an HMO, that does not have a deductible.

*Convert Medicare to a program more like the health program for federal employees. Medicare would provide beneficiaries with a capitated voucher in the form of a contribution to the health plan of their choice. Savings accrue after seven years.

*Allow Medicare beneficiaries to share in the savings when Medicare fraud is detected.

*Limit payments to physicians whose costs exceed the national median.

*Bundle postacute care payments with hospital payments.

*Reduce Medicare subsidy to high income beneficiaries.

*The value of the contribution would be determined by setting total Medicare expenditures at an overall growth rate.

*Total Medicare spending would rise from $178.2 billion in 1995 to 258.9 in 2002.

*Medicare growth would be slowed to 5.4 percent annually, mainly through reductions in provider payments.

*Medicare would offer a wider range of private plan options. By the year 2002, 59 percent of enrollees would be in private plans.

The strategy behind this plan is that you get a totally free-market kind of attitude and you find prices change dramatically (O'Conner 1-12).

Paul Willging, Executive Vice President of the American Health Care Association describes the current Medicare reform debate as a sea of change. Congress has traditionally relied on three strategies for lowering Medicare costs: providing lower cost services, reducing the population served, or lowering reimbursement.

Now there is a fourth option, which is the transformation of Medicare "from a defined benefit to a defined contribution program," Willging says. Under this type of system, the federal government would tell senior citizens what it could afford to spend and they in turn would have to "see what kind of deal they could get for that amount."

In Washington, Federal efforts from both the House and Senate are under way to attempt to neatly curtail the federal deficit and finance tax cuts by changing Medicaid into a block grant to each state. At stake are billions of dollars in long-term care reimbursements.

Regarding Medicaid, the Republican leadership has one clear advantage over the opposition-a common goal: trim the growth in federal payments. The leadership initially hoped to cut $100 billion by the year 2000, but eventually settled for reducing the Federal outlays by $80 billion (Stoil 6).

During the fiscal year 1993, according to Stoil in his article, "Nursing Homes, Kick That Block," national Medicaid expenditures totaled $118 billion, with the Federal share accounting for $76.1 billion, or roughly two thirds of the total. In the current fiscal year, Medicaid spending is expected to reach $154 billion and by the year 2000,

in the neighborhood of $254 billion. Without significant change, the Federal share will be $140 billion, while total state contributions will be $114 billion (6).

Simply stated, in the year 2000 the Federal share of Medicaid reimbursement will be more costly than the combined Federal and State contributions to the program today (Stoil 6).

The American Health Care Association, the American Association of Homes for the Aging, The American Public Health Association and a host of other health care related groups have united in opposition to these plans. However, it is apparent that even with rising opposition, health care facilities and particularly long term care facilities, must begin to look at ways of decreasing costs while remaining competitive.

Frost and Sullivan report that National Health Care reform legislation may have failed in 1994, but that has not prevented the U.S. health care industry from cultivating its own reform. Indeed, the health care industry has not only generated significant savings but has succeeded in covering a larger population in the past two years as managed care has become increasingly common. Fear of government imposed cost containment has been one element leading the industry to reform itself, advises Stoil.

Another motivating factor may be the increased mandates the government is considering for long term care facilities (6).

Most experts in the field predict industry evolution, possible public funding changes and additional regulatory oversight are collectively reshaping the way long-term care looks and operates.

John O'Connor reports in his article "Medicaid Reform Debated," that the cost of resident care has been on an incline since 1990. Operating expenses rose from $68.33 per patient day in 1992 to $74.81 per patient day in 1993,- a 9.5 percent increase. Costs were also up for direct care, indirect care, administrative and general expenses and ancillary costs (1-10).

In addition to the increase in cost, long term care facilities will face diversified care-particularly subacute care and increasing patient acuity levels are expected to continue in the coming years. These changes will directly impact the future of long term care facilities (1-10).

However, just as facilities are increasingly shifting from traditional long-term care to a more specialized level of care, diversification into subacute care will also mean greater spending on medical devices. Depending on how the facility plans its future, this could mean thousands of

dollars in revenue or the demise of the facility.

In another facet of health care cost considerations, respiratory therapy supplies are expected to lead the budgetary inflation parade through 1996, increasing four to six percent, while medical-surgical supplies are likely to rise by as much as five percent (O'Conner 1-10).

These dramatic price hikes for raw materials are continuing to fuel cost increases for paper-based products. All types of health care providers, certainly including long term care operators can expect to pay more for disposable products including diapers, packaging and forms, as well as food service items, indicates O'Conner (1-10).

O'Conner continues in his report that rising tangible costs could pale in comparison to the cost of doing business as newly implemented regulations could potentially devastate many bottom lines. For example, new survey, certification and enforcement regulations that took effect in July contain a particularly costly component that allows retroactive fines for non-compliance (1-10).

Consequently this factor, combined with current congressional and administrative budget discussions, could leave nursing facilities with much less in the way of Medicaid and Medicare revenues (11-12).

Just as the previously mentioned factors are negatively affecting health care providers' viability, drastic changes are also appearing to threaten Medicaid's existence. The federal government would give lump sum payments to each state and let it decide how to spend the money. This would end Medicaid as an entitlement program and ultimately place large numbers of older Americans at risk, Squires indicates in her article "Medicaid Makeover" (14).

Pamela Squires reports that Medicaid now pays for the care given to more than half of the country's nursing home patients. However, the severity of the proposed Medicaid cuts would force large numbers of these nursing home residents off the rolls (14).

These cuts would also affect seniors who are currently at, or slightly above the poverty level for whom Medicaid now pays both the Medicaid and Medicare premiums and deductibles (14).

Daniel Perry in the magazine, Secure Retirement expresses his views concerning the fact that Americans are living longer than ever before; certainly that is no longer news. But recent reports do appear to show that disability and chronic disease rates among seniors are going down, even as the elderly population is increasing, that is good news indeed (24).

A series of research reports arising from Duke University continue to challenge the notion that more older people in the U.S. necessarily means more illness and disability.

The latest study published this summer in the Journal of Gerontology shows an overall decline during the 1980's of chronic disease among Americans over the age of 65. Leading the decline were falling incidences of dementia, stroke, arthritis, hardening of the arteries, high blood pressure, circulatory disease and emphysema (24).

The explanations for this surprising and welcome trend include better income and educational status for today's seniors, along with improved nutrition, greater use of joint replacements, improved cataract treatment and public health campaigns against smoking and heart disease (24-25).

If these findings by the Duke Center for Demographic Studies represent the leading edge of a long-running trend, and they need to be bolstered by more research, the impact on Medicare and Medicaid and our strategies to lower health care costs could be profound (24-25).

We have gotten used to equating old age with losses and infirmities. Additionally we are in the habit of spending billions of dollars on nursing home care and other forms of "sick care," instead of preventing and postponing geriatric health problems in the first place (24-25).

But what if we could delay the beginning of chronic health problems of the elderly? If, in effect, we could put aging on hold for just five years, what then?

In fact, this "delay strategy" has captured the imagination of some of the nation's leading medical researchers as the means for accelerating the trend toward a healthier, longer-lived generation of Americans (24-25).

Indeed, dozens of top researchers recently endorsed a report to the White House Conference on Aging saying that federal efforts to implement the delay strategy against diseases of old age would be money well spent (24-25).

This report to the White House Conference on Aging entitled "Putting Aging on Hold," details how we might successfully eliminate half of the costs and the human misery of Alzheimer's disease, hip fractures, stroke and other infirmities of aging by delaying the steeply rising risk factors for these conditions after age 60 by as few as five years (24-25).

This is no longer science fiction, given what we now know about aging and aging-related disease, as the Duke University studies demonstrate. New treatments for old problems, from hormone replacement to new cardiovascular and memory enhancing drugs, genetic research and improved diet and exercise therapies for seniors show the way (24-25).

In one recent report from Duke University the U.S. government estimated that an added investment of one billion dollars over five years would enable American scientists to make the most of the current momentum in aging research. It could be the smartest one billion dollars ever spent by Washington.

The knowledge that would be gained, leading to postponement of common geriatric conditions and disabilities, would be invaluable. It is an investment we can not afford not to make (24-25).

With all of the anticipated changes within the Medicaid and Medicare systems, it is easy to see that long term care facilities have their work cut out for them. In order to stay competitive in an industry where funds are shrinking, patient needs increasing, regulations tightening and penalities stiffening, the nursing facility must be innovative and creative.

The nursing facility not only has a legal, but also a moral obligation to restore a patient to his or her highest level of functioning and whenever possible prevent deterioration. It follows therefore, that rehabilitation is a very important aspect of nursing home care. Rehabilitation is a must if we are to treat the whole person, that is rehabilitate their level of functioning, their social abilities and mental capabilities.

When considering a person's rehabilitation potential, we must also consider where a patient is placed within the nursing facility. This can have a direct impact on his ability to attain and maintain his highest level of functioning. In order to make the best possible placement of the patient, a thorough assessment of his social, psychological, and physical needs must be done upon admission.

To maintain viability, the long term care facility must be committed to providing quality care in an environment that is conducive to enhancing the patient's quality of life and rehabilitating the patient to his highest level of functioning all the while striving to secure an attractive bottom line.

CHAPTER 3

POLICY AND PROCEDURE MANUAL

The facility, according to State and Federal regulations, must make staff and residents aware of residents' rights and ensure those rights are enforced.

RESIDENT RIGHTS

The resident has the right to a dignified existence, self determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

1. 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.
2. The resident has the right to be free of interference, coercion, discrimination and reprisal from the facility in exercising his or her rights.
3. In the case of a resident adjudged incompetent under laws of the State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on behalf of the resident.

NOTICE OF RIGHTS AND SERVICES

1. The facility must inform the resident both orally and 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.

2. The resident or his or her legal representative has the right:
   a. Upon an oral or written request, to access all records pertaining to himself or herself including clinical records within 24 hours;
   b. After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard, photocopies of the records or any portions of them upon request and two working days advance notice to the facility.
3. The resident has 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.
4. The resident has the right to refuse treatment and to refuse to participate in experimental research.
5. The facility must:
   a. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid.
   b. Inform each resident when changes are made to the items and services available.

6. The facility must 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 services, including any charges for services not covered under Medicare or by the facility's per diem rate.
7. The facility must furnish 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 which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.
   c. A posting of names, addresses and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.
   d. A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect and misappropriatiion of

resident property in the facility.

8. The facility must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care.
9. The facility must prominently display in the facility written information and 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.
10. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:
    a. An accident involving the resident which results in injury and has the potential for requiring intervention.
    b. A significant change in the resident's physical, mental or or psychosocial status.
    c. A need to alter treatment significantly.
    d. A decision to transfer or discharge the resident from the facility.
    e. The facility must also promptly notify the resident and if known, the resident's legal representative or interested family member when there is:
        1. A change in room or roommate assignment
        2. A change in resident rights under Federal or State

laws or regulations.

11. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.
12. The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

MANAGEMENT OF PERSONAL FUNDS

1. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility.
2. The facility must deposit any resident's 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 residents' funds to that account:
   a. The facility must maintain a resident's personal funds that do not exceed $50 in a noninterest bearing account, interest bearing account or petty cash fund.
3. The facility must establish and maintain a system that assures 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.
   a. The system must preclude any commingling of resident

funds of any person other than another resident.

b. The individual financial record must be available through quarterly statements on request to the resident or his or her legal representative.

4. The facility must notify each resident that receives Medicaid benefits:

a. When the amount in the resident's account reaches $200 less than the SSI resource limit for one person

b. That, if the amount in the account in addition to the value of the resident's other nonexempt resources, reaches SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

5. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the the resident's estate.

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

7. The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicare or Medicaid.

8. The resident has the right to:

a. Choose a personal attending physician

b. Be fully informed in advance about care and treatment and of any changes in that care and treatment that may affect the resident's well being.

c. Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment

PRIVACY AND CONFIDENTIALITY

1. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
2. Personal privacy includes accomodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups.
3. The resident may approve or refuse the release of personal and clinical records to any individual outside the facility except when the resident is transferred to another health care institution or record release is required by law.
4. The resident has the right to voice grievances without discrimination or reprisal.
5. The resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effort with respect to the facility. The results must be made available for examination by the facility in a place readily accessible to residents.

6. The resident has the right to privacy in written communications including the right to:
   a. Send and promptly receive mail that is unopened.
   b. Have access to stationery, postage and writing implements at the resident's own expense.

ACCESS AND VISITATION RIGHTS

1. The resident has the right and the facility must provide immediate access to any resident by the following:
   a. Any representative of the Secretary
   b. Any representative of the State
   c. The resident's individual physician
   d. The State long term care ombudsman.
   e. The agency responsible for the protection and advocacy system for developmentally disabled individuals
   f. The agency responsible for the protection and advocacy for mentally ill individuals.
   g. Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident.
   h. Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.
2. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

3. The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
4. The resident has 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.
5. The resident has the right to refuse transfer to another room within the facility, if the purpose of the transfer is to relocate:
   a. A resident of a SNF from the distinct part of the facility, that is a SNF to a part of the facility that is not SNF
   b. If a resident of a nursing facility from the distinct part of the facility that is a nursing facility to a distinct part of the facility that is a SNF

TRANSFER AND DISCHARGE

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 and 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

1. The safety of individuals in the facility is endangered
2. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

2. When the facility transfers or discharges a resident, the facility must:

a. Notify the resident and if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

b. Give a 30 day notice, unless it is an emergency situation or:

1. The health of individuals in the facility would be endangered
2. The resident's health improves sufficiently to allow a more immediate transfer or discharge
3. An immediate transfer or discharge is required by the resident's urgent medical needs
4. Before a facility transfers or discharges a resident, the facility must:

a. Notify the resident and if known, a family member or legal representative of the resident of the

transfer or discharge and the reasons for the move in writing and in a language and manner they they understand. The notice must contain:

1. The reason for transfer or discharge
2. The effective date of transfer or discharge
3. The location to which the resident is transferred or discharge
4. A statement that the resident has the right to appeal the action to the State
5. The name, address and telephone number of the State long term care ombudsman
6. Orientation for transfer or discharge. The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

RESIDENT RETURN TO THE FACILITY

The nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed hold period under the State plan, is readmitted to to the facility immediately upon the first availability of a bed.

ADMISSIONS POLICY

1. The facility must:

a. Not require residents or potential residents to waive

their rights to Medicare or Medicaid

b. Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare benefits.

2. The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care, to sign a contract, without incurring personal payment from the resident's income or resources.

3. In the case of a person eligible for Medicaid, a facility must not 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.

4. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request

for and receipt of such additional services

RESIDENT BEHAVIOR AND FACILITY PRACTICES

1. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms.
2. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion.
3. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents, and misappropriation of resident property.
4. The facility must:
   a. Not employ individuals who have been found guilty of abusing, neglecting or mistreating individuals by a court of law
   b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreating individuals or misappropriation of their property
5. The facility must ensure that all alleged violations including mistreatment, neglect or abuse including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials.
6. The facility must have evidence that all alleged violations

are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

7. The results of all investigations must be reported to the administrator or his designated representative and to other officials within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

QUALITY OF LIFE

1. The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life:
   a. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality
   b. The resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care
2. The resident has the right to interact with members of the community both inside and outside the facility
3. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident
4. The resident has the right to organize and participate in resident groups in the facility

5. When a resident or family group exists, the facility must listen to the views and act upon grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

ACTIVITIES

1. The facility must provide for an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident

SOCIAL SERVICES

1. The facility must provide medically related social services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident.
2. The facility with more than 120 beds must employ a qualified social worker.

ENVIRONMENT

1. 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.
2. Housekeeping and maintenance services provided as necessary to maintain a sanitary, orderly and comfortable interior
3. The facility must provide clean bed and bath linens that are in good condition
4. The facility must provide private closet space in resident

room

5. The facility must provide adequate and comfortable lighting levels in all areas.
6. The facility must provide comfortable and safe temperature controls

RESIDENT ASSESSMENT

The facility must conduct initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, according to CSR483.20 of the State and Federal regulations.

1. At the time of admission, the facility must have physician orders for the resident's immediate care .
2. The facility must make a comprehensive assessment of a resident's needs which:
   a. Is based on a uniformed data set specified by the State and approved by the Secretary
   b. Describes the resident's capability to perform daily life functions and significant impairments in functional capacity
3. The comprehensive assessment must include at least the following:
   a. Medically defined conditions and prior medical history
   b. Medical status measurement
   c. Physical and mental functional status
   d. Sensory and physical impairments

e. Nutritional status and requirement

f. Special treatment or procedures

g. Mental and phychosocial status

h. Discharge potential

i. Dental condition

j. Activities potential

k. Rehabilitation potential

l. Cognitive status

4. Assessments must be conducted:

   a. No later than 14 days after admission

   b. Promptly after a significant change in the resident's physical or mental condition

   c. In no instance less often than once every 12 months

5. The nursing facility must examine each resident no less than once every three months, and as appropriate, revise the residents assessment to assure the continued accuracy of the assessment.

6. The results of the assessments are used to develop, review and revise the residents comprehensive plan of care.

7. The facility must coordinate assessments with any State required preadmission screening program.

8. Each assessment must be conducted or coordinated with the appropriate participation of health professionals and signed by a registered nurse who certifies the completion of the assessment.

9. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
10. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet resident's needs.
11. A comprehensive care plan must be:
    a. Developed within seven days after completion of the comprehensive assessment
    b. Prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident and other appropriate staff as determined by the resident's needs.
12. When the facility anticipates discharge, a resident must have a discharge summary that includes:
    a. A recapitulation of the resident's stay
    b. A final summary of the resident's status at the time of discharge
    c. A post-discharge plan of care that is developed with the participation of the resident and/or family, which will assist the resident to adjust to his or her new living environment

ACTIVITIES OF DAILY LIVING

1. Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities

of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:

a. Bathe and dress

b. Transfer and ambulate

c. Toilet

d. Eat

e. Use speech, language or other functional communication systems

2. The resident is given the appropriate treatment and services to maintain or improve his or her abilities.

3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.

a. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities the facility must, if necessary , assist the resident:

1. In making appointments

2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment

4. Based on the comprehensive assessment of a resident, the facility must ensure that:

a. A resident who enters the facility without pressure

sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable

b. A resident having pressure sores receives necessary treatment and services to promote healing, prevention of infection and any new bed sores from developing

5. Based on the resident's comprehensive assessment, the facility must 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 is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible

6. Based on the comprehensive assessment of a resident, the facility must ensure that:

A resident who enters the facility without a 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 was unavoidable

MENTAL AND PSYCHOSOCIAL FUNCTIONING.

1. Based on the comprehensive assessment of a resident, the facility must ensure that:

a. A resident who displays mental or psychosocial adjustment

difficulty, receives appropriate treatment and services to correct the assessed problem.

b. A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

NUTRITION.

1. Based on the comprehensive assessment of a resident the facility must ensure that:

   a. A resident who has been able to eat sufficient food by themselves or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use a naso-gastric tube was unavoidable

   b. A resident who is fed by a naso-gastric or a gastrostomy tube receives the appropriate treatment and services to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

2. Based on a resident's comprehensive assessment, the facility must ensure that a resident:

   a. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is

not possible.

b. Receives a therapeutic diet when there is a nutritional problem.

3. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

DRUGS.

1. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

a. In excessive dose

b. For excessive duration

c. Without adequate monitoring

d. Without adequate indications for its use

e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued

2. Based on a comprehensive assessment of a resident, the facility must ensure that:

a. Resident's who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and:

a. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

NURSING SERVICES.

1. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.
2. The facility must provide services by having 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. Licensed nurse to serve as a charge nurse on each tour of duty.
   b. The facility must designate a registered nurse to serve as the director of nursing on a full time basis.
   c. The director of nursing may serve as a charge nurse only when the facility has a average daily occupancy of 60 or fewer residents.
   d. The facility must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

DIETARY SERVICES.

1. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.
2. The facility must employ a qualified dietitian either full-time, part-time or on a consultant basis.

3. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.
4. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.
5. Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.
6. Menus Must:
   a. Prepared in advance
   b. Followed
7. Each resident receives and the facility provides:

facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

4. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.
5. Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.
6. Menus Must:
   a. Prepared in advance
   b. Followed
7. Each resident receives and the facility provides:
   a. Food prepared by methods that conserve nutritive value, flavor and appearance.
   b. Food that is palatable, attractive and at the proper temperature.
   c. Food prepared in a form designed to meet individual needs.
   d. Substitutes offered of similar nutritive value to residents who refuse food served.
8. Therapeutic diets must be prescribed by the attending physician.
9. Each resident receives and the facility provides at least these three meals daily, at regular times comparable to

normal mealtimes in the community.

10. There must be no more than 14 hours between a substantial evening meal and breakfast the following day.
11. The facility must offer snacks at bedtime daily.
12. The facility must provide special eating equipment and utensils for residents who need them.
13. The facility must:
    a. Procure food from sources approved or considered satisfactory by Federal, State or local authorities.
    b. Store, prepare, distribute and serve food under sanitary conditions.
    c. Dispose of garbage and refuse properly.

PHYSICIAN SERVICES.

1. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.
2. The facility must ensure that:
    a. The medical care of each resident is supervised by a physician.
    b. Another physician supervises the medical care of residents when their attending physician is unavailable.
3. The physician must:
    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.

c. Sign and date all orders.

4. The resident must be seen by the physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.
5. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
6. 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.
7. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.
8. At the option of the State, any required physician task in a nursing facility 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.

SPECIALIZED REHABILITATIVE SERVICES.

1. If specialized rehabilitative services such as but not limited to physical therapy, speech-language, pathology occupational therapy and health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must:

   a. Provide the required services or obtain the required

services from an outside resource from a provider of specialized rehabilitative services.

DENTAL SERVICES.

1. The facility must assist residents in obtaining routine and 24 hour emergency dental care.
2. The facility must provide or obtain from an outside resource, routine, and emergency dental services to meet the needs of each resident.
3. The facility may charge a Medicare resident an additional amount for routine and emergency dental services.
4. The facility must, if necessary, assist the resident:
   a. In making appointments
   b. Arranging for transportation to and from the dentist's office
   c. Promptly refer residents with lost or damaged dentures to a dentist.

PHARMACY SERVICES

1. The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under agreement.
2. The facility must provide pharmaceutical services, including procedures that assure the accurate count, acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of the residents.
   The facility must 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

c. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

4. The drug regimen of each resident must be reviewed by a pharmacist monthly.

5. The pharmacist must report any irregularities to the attending physician and the director of nurses, and these reports must be acted upon.

6. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles

7. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments.

8. The facility must 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.

INFECTION CONTROL

1. The facility must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and

transmission of disease and infection.

2. The facility must establish an infection control program under which it:
   a. Investigates controls and prevents infection in the facility
   b. Describes, what procedures, such as isolation, should be applied to an individual resident
   c. Maintains a record of incidents and corrective actions related to infections
3. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
4. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with the residents or their food.
5. The facility must require staff to wash their hands after each direct resident contact.

PHYSICAL ENVIRONMENT

1. The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.
2. An emergency electrical power system must supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the

event the normal electrical supply is interrupted.

3. The facility must 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
4. The facility shall maintain all essential mechanical, electrical and patient care equipment in safe operating condition.
5. Resident rooms must be designed and equipped for adequate nursing care, comfort and privacy of residents.
6. Bedrooms must:
   a. Accomondate no more than four residents per room
   b. Measure at least 80 square feet in multiple bed rooms per resident
   c. Single bed rooms must measure at least 100 sq. feet
   d. Be designed and equipped to provide privacy for each resident
   e. Have at least one window to the outside
7. The facility must provide each resident with:
   a. A separate bed of proper height and size for 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 individual closet space in the resident's room
   e. Each resident room must be equipped with or located near

a bath and shower room

8. The nurses' station must be equipped to receive resident calls through a communication system from:
   a. Resident rooms
   b. Toilet and bathing facilities
9. The facility must provide one or more rooms desginated for resident dining and activities
0. The facility must provide a safe, functional sanitary and comfortable environment for the residents, staff and public
1. The facility must have adequate ventilation
2. The facility must equip corridors with firmly attached handrails
3. The facility must maintain an effective pest control program

ADMINISTRATION

1. The facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical and mental and psychosocial well being of each resident.
2. The facility must operate and provide services in compliance with all Federal, State and Local laws, regulations and codes and with professional standards and priniciples that are acceptable and apply to professionals providing services in the facility
3. The facility must operate on a nondiscrimnatory basis.
4. The facility must have a governing board that makes operating

policies and hires the administrator

5. The administrator must be licensed by the State
6. The administrator is responsible for the management of the facility

LABORATORY AND RADIOLOGY SERVICES

1. The facility must provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services
2. If the facility does provide these services in the facility, the facility must have an agreement to obtain these services
3. The facility must provide or order these services only with a physician's order.
   a. The facility must notify the physician promptly of the results of the findings
   b. The facility must assist the resident with making transportation arrangements to and from the source of services
   c. The facility must file in the resident's clinical record the signed physician's order and reports of all diagnostic tests

CLINICAL RECORDS

1. The facility must maintain clinical records on each resident that are :
   a. Complete
   b. Accurately documented

c. Readily accessible

d. Systematicaaly arranged

2. Medical records are to be retained for five years after the resident is discharged

3. The facility must safeguard records against loss, destruction or unauthorized use.

4. The facility must keep confidential, all information contained in the resident's record, except when release is required by:

   a. Law

   b. Third party payment contract

   c. The resident

5. The clinical record must contain:

   a. Sufficient information to identify the resident

   b. A record of the resident's assessment

   c. The plan of care and services provided

   d. Progress notes

ADMISSIONS POLICY STATEMENT

THE PROCEDURAL PART OF THIS MANUAL HAS BEEN DERIVED FROM THE STATE AND FEDERAL REGULATIONS THAT MANDATE NURSING FACILITIES. It is the policy of this facility to admit only those whose medical and nursing care can be adequately provided.

PROCEDURE.

1. The following categories of residents will be accepted to the facility, those individuals who are:
   a. Ambulatory;
   b. Bedridden;
   c. Post-operative;
   d. Diabetics;
   e. Diagnosed with cancer;
   f. Incontinent;
   g. Those requiring catheterization;
   h. Those requiring tube feeding;
   i. Diagnosed with neuromusclar disorders;
   j. Demented;
   k. Mentally retarded (mild);
   l. Required I.V. fluids (as permitted by state law); and
   m. Drug/alcohol addiction (mild).
2. Other residents may be admitted if the facility can provide the care prescribed by the resident's admitting or attending physician.
3. The acceptance of residents not listed in these categories

will be achieved only when authorized or approved by the medical director, director of nursing services, and/or the administrator.

POLICY STATEMENT.

It is the policy of this facility to develop and maintain written policies and procedures governing admissions to the facility.

PROCEDURE.

1. The primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility.
2. Our admission policies apply to all residents admitted to the facility without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital, veteran status and/or payment source.
3. The objectives of our admissions policies are to:
   a. Provide uniform guidelines in the admission of residents to the facility;
   b. Admit residents who can be adequately cared for by the facility;
   c. Reduce the fears and anxieties of the resident and family during the admission process;
   d. Review with the resident, and/or his/her representative (sponsor), the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.; and
   e. Assure that appropriate medical and financial records are provided to the facility prior to, or upon the resident's admission.

4. It shall be the responsibility of the administrator, through the admissions department, to assure that the established admission policies, as they may apply, are followed by the facility and resident.
5. The governing board, through the administrator and the Quality Assessment and Assurance Committee, has adopted the policies outlined within this section as those that best reflect the needs and operational requirements in the admission of residents to the facility.
6. Our admission policies and procedures are reviewed for revisions and/or reviews and maintained in the business office.

ADMISSIONS-COMMUNITY POLICY STATEMENT.

It is the policy of this facility to admit residents from the community whose medical and nursing care needs can be adequately met.

PROCEDURE.

1. Residents may be admitted to the facility only upon the written order of the resident's attending physician.
2. Prior to, or at the time of admission, residents admitted from the community must provide the following medical data to the facility to assure that immediate care of the resident is obtained:
   a. Current medical findings;
   b. Admitting diagnosis and prognosis;
   c. Physician's orders for immediate care;
   d. The admitting physician's certification that the resident is free from communicable, infections, or contagious diseases; and
   e. Others as necessary or appropriate.
3. A physical examination must be completed within forty-eight (48) hours of the resident's admission unless such examination was completed not more than five (5) days prior to the resident's admission.
4. A copy of the physical examination must be provided to the facility and filed in the resident's admission record.
5. A summary of the resident's previous treatment and

rehabilitative potential (long-term and short-term) must be provided to the facility within forty-eight (48) hours of the resident's admission.

ADMISSIONS - HEALTH CARE FACILITIES POLICY STATEMENT.

It is the policy of this facility to admit residents from other facilities.

1. Residents may be admitted to the facility only upon the written order of the resident's attending physician.
2. Residents admitted from a hospital or other healthcare facility must furnish the following data to the facility prior to or upon the resident's admission.
   a. Physical examination (current within five (5) days);
   b. Admitting diagnosis and prognosis;
   c. Chest x-ray or skin test;
   d. Physician's order for immediate care and treatment;
   e. Rehabilitation potential (long/short-term);
   f. Current medical findings;
   g. Transfer form (from transferring facility);
   h. The admitting physician's certification that the resident is free from communicable, infections, or contagious diseases;
   i. Resident assessment (MDS);
   j. Developmentally disabled/mentally retarded prescreening documentation; and
   k. Others as necessary or appropriate.
3. Should the transferring facility fail to provide the necessary medical data upon admission, the director of nursing services, or his/her designee, shall contact the

facility and request that such data be made available so that nursing care can be implemented.

4. Should the transferring facility refuse to provide such data, our emergency admission procedures shall be implemented.
5. The medical director and administrator must be promptly notified of such circumstances.
6. Documentation of the incident must be recorded in the resident's admission notes.

ADMISSION AGREEMENT POLICY STATEMENT.

It is the policy of this facility that all residents have on file a signed and dated admission agreement.

PROCEDURE.

1. At the time of admission, the resident (or his/her representative) must sign an Admission Agreement (contract) that outlines the services covered by the basic per diem rate, as well as any additional services by the resident that are not covered by the basic per diem rate.
2. The Admission Agreement (contract) will reflect all charges for covered and non-covered items, as well as identify the parties that are responsible for the payment of such services.
3. With respect to our admission agreement, our facility:
   a. Shall not require individuals applying to reside (or residing) in our facility to waive their rights to benefits under Medicare/Medicaid
   b. Shall not require oral or written assurances that such residents or applicants are not entitled or eligible for such benefits
   c. Shall not require oral or written assurances that such residents or applicants will not apply for such benefits
   d. Shall not require that the sponsor or legal guardian guarantee payment as a condition of admission, or to expedite the admission

e. In the case of a resident or applicant who is entitled to Medicare/Medicaid benefits for nursing care, charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under Medicare/Medicaid programs, any gift, money, donations or other consideration as a precondition of admitting the applicant to the facility.

4. Bona-fide contributions may be accepted and solicited by the facility from a charitable, religious or philanthropic organization or from a person not related to the facility, but only to the extent that such a contribution is not a condition of admission or continued stay in the facility
5. A copy of the admission agreement will be provided to the resident or his/her representative.
6. Residents will be informed of any change in the cost or availability of services at least 15 days prior to such changes.

ADMISSIONS-EMERGENCY

POLICY STATEMENT

It is the policy of this facility to permit emergency admissions should such measures be necessary to meet the immediate medical and nursing needs of the resident.

PROCEDURE

1. The medical director may permit emergency admissions if and when he/she deems it necessary for the well-being of the resident.
2. Residents who are admitted under emergency conditions must provide the facility with physician's orders for his/her immediate care and treatment.
3. Should medical orders be unobtainable on admission, the medical director or emergency care physician may issue temporary orders until the resident's attending physician can be reached.
4. All required medical data must be furnished to the facility within 48 hours of the resident's admission.
5. Failure of a resident or his/her representative to provide required medical data may be grounds for immediate discharge.

ADMISSION NOTES

POLICY STATEMENT

It is the policy of this facility to record certain data upon a resident's admission to the facility.

PROCEDURE

1. When a resident is admitted to the nursing unit, the charge nurse must record the following data in the nurses' notes:
   a. The date and time of the resident's admission
   b. The resident's age, sex, race and marital status
   c. The name of the person accompanying the resident and his/her relationship to the resident
   d. From where the resident was admitted
   e. Reason for the admission
   f. Current vital signs and the condition of the resident upon admission
   g. The time the attending physician was notified of the admission
   h. The time the physician orders were received and verified
   i. Description of any lab work completed
   j. Acute conditions
   k. The presence of a catheter or dressings,etc.
   l. The time the dietary department was notified of the diet order

m. The time medications were ordered from the pharmacy

n. Body audit:birth marks ostomy site, site and size of scars, rashes, bruises, pressure sores, lesions, general cleanliness of overall body, hair, nails, etc.

o. A brief description of any disability

p. Any known allergies

q. The weight and height

2. The nurses's original admission note must remain in the chart

ADMISSION, TRANSFER, AND DISCHARGE REGISTER

POLICY STATEMENT

It is the policy of this facility to maintain an Admission, Transfer and Discharge register

PROCEDURE

1. Our facility maintains an Admission, Transfer and Discharge Register so that an accurate record of admissions, transfers and discharges can be maintained.
2. Our admission, Transfer and Discharge Record contains the following data:
   a. The resident's medical record identification number
   b. The date of admission and room assignment
   c. The resident's full name
   d. The age and sex of the resident
   e. The resident's classification
   f. The resident's diagnosis
   g. The name of the resident's attending physician
   h. From where the resident was admitted
   i. The date the resident was discharged or transferred
   j. The reason for the discharge or transfer
   k. To where the resident was discharged, transferred
   l. The length of the resident's stay

ADVANCE DIRECTIVES

POLICY STATEMENT

It is the policy of this facility to ensure that a resident's choice about advance directives be respected.

PROCEDURE

1. Prior to, or upon admission, the care plan team will ask residents and/or their family members, about the existence of any advance directive.
2. Should the resident indicate that he or she has issued advance directives about his or her care and treatment, the facility will require that copies of such directives be included in the medical record.
3. The facility has defined advance directives as preferences regarding treatment options and include, but are not limited to:
   a. Living Will-a document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis
   b. Do Not Resuscitate-Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy have directed that no cardiopulmonary resuscitation or other life-saving methods are to be used

c. Do Not Hospitalize-Indicates that the resident is not to be hospitalized, even if he she has a medical condition that would usually require hospitalization

d. Organ Donation-Indicates that the resident wishes his or her organs to be available for transplantation upon his or her death

e. Autopsy Request-Indicates that the resident, legal guardian, healthcare proxy or representative requested that an autopsy be performed upon the death of the resident

f. Feeding Restriction-Indicates that the resident, legal representative or healthcare proxy does not wish the resident to be fed by artificial means if he or she is unable to eat by oral means

g. Medication Restrictions-Indicates that the resident, legal guardian, healthcare proxy or legal representative does not not wish the resident to receive life-sustaining drugs

h. Other Treatment Restrictions-Indicates that the resident, legal guardian or healthcare proxy does not wish for the resident to receive certain medical treatments

4. If the healthcare directive was developed in another state, the resident must have such documents reviewed and revised by legal counsel in this state before the facility may accept such directives.

5. The nurse responsible for the care plan will review the directive with the resident, responsible family member

or healthcare proxy annually.

6. Changes or revocations must be submitted to the facility in writing.

RELEASE OF INFORMATION

POLICY STATEMENT

It is the policy of this facility to maintain the confidentiality of the resident's personal and clinical records.

PROCEDURE

1. Release of resident's information will be governed by the principle that the facility's first concern is for the protection of the rights of the resident.
2. Each resident is assured confidential treatment of his or her personal medical records and may approve or refuse their release to any individual outside the facility, except in case of transfer to another healthcare facility, or as required by law.
3. Access to the resident's medical records is limited to the staff and the consultants providing service to the resident.
4. Residents' records, whether medical, financial or social in nature, are safeguarded to protect the confidentiality of the resident.
5. Residents may initiate a request to release such information to anyone they wish. Such requests will be honored only upon the receipt of a written, signed and dated request.
6. At least 24 hours advance notice must be given to the facility when photocopies of the resident's records or a visual

review of the records are requested.

RESIDENT ORIENTATION

Policy Statement

It is the policy of this facility to orient residents, and/or their representatives to the operational structure of our facility.

PROCEDURE

1. Prior to, or upon admission, the resident, or his or her representative will be provided with an orientation of our facility and its policies. Such orientation includes:
   a. The resident's rights and trust fund
   b. The resident's assessment and care plan
   c. The resident's responsibilities to the facility
   d. The financial agreement
   e. Facility smoking regulation
   f. Resident care policies
   g. Physician services
   h. Activity and social services programs
   i. Tour of the facility
   j. others as necessary or appropriate
2. Written records of such orientation are maintained and a copy is filed in the resident's medical record.
3. Should the resident be medically incapable of understanding his/or her rights, the resident's sponsor will be required to signed the orientation process.

4. Inquiries concerning the resident's orientation program should be referred to the director of nursing.

RESIDENT RIGHTS

POLICY STATEMENT

It is the policy of this facility to promote and protect the rights of residents residing in our facility.

PROCEDURE

1. Residents are entitled to exercise their personal and legal rights and privileges to the fullest extent possible.
2. Our facility will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, dignity and kindness.
3. Copies of our facility's residents' rights are posted on the bulletin and a copy is provided to the resident and/or his or her representative.
4. An oral review of such rights is provided to assist the resident and his/her representative to understand our established rights and governing regulations.

QUALITY ASSURANCE AND ASSESSMENT PLAN

POLICY STATEMENT

It is the policy of this facility to develop, implement and maintain an ongoing program designed to monitor and evaluate the quality of resident, pursue methods to improve quality care, and to resolve identified problems.

PURPOSE

1. To provide a means whereby negative outcomes relative to resident care and safety can be identified and resolved through an interdisciplinary approach and an effective system of services and positive care measures rendered can be reinforced and expanded to improve care.
2. To establish and provide a system whereby a specific process, and the documentation relative to it, is maintained to support evidence of an ongoing Quality Assessment and Assurance Plan, encompassing all aspects of resident care including safety, infection and quality control and quality of life.
3. To develop monitoring tools that provide an effective mechanism to assure that each resident receives the necessary care and services to attain or maintain his or her highest level of functioning and mental and physical well-being.
4. To assist departments, and ancillary services that provide direct or indirect care to residents to delineate lines of

authority, responsibility and accountability so that open lines of communication and negative outcome resolutions may be achieved for optimum resident care on a continuous basis.

5. To develop plans of correction and evaluate corrective actions taken to obtain the desired results.
6. To provide a centralized, coordinated approach to quality assessment and assurance activities so as to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility.

DIRECTOR OF NURSING RESPONSIBILITIES FOR QUALITY ASSURANCE AND ASSESSMENT

1. Developing maintaining and periodically updating written policies and procedures that govern the day-to-day functions of the nursing department.
2. Developing, maintaining and periodically updating the nursing services with other resident services to ensure the continuity of the residents' care.
3. Developing and maintaining the nursing procedure and policy manual.
4. Developing job descriptions for each level of nursing personnel.
5. Developing, maintaining and implementing an ongoing Quality Assessment and Assurance Program for the nursing department.

6. Developing and implementing an active and on-going in-service program for the nursing department.

DIETARY SERVICES DUTIES AND RESPONSIBILITIES FOR QUALITY ASSURANCE AND ASSESSMENT

1. Developing and maintaining written dietary policies and procedures.
2. Developing and maintaining written job descriptions and performance evaluations for each level of dietary personnel.
3. Performing administrative duties such as completing necessary forms, reports, evaluations, etc. to assure control of equipment and controls.
4. Inspecting food storage rooms, utility closets, etc. for upkeep and supply control.
5. Assisting the infection control coordinator in identifying evaluating, and classifying routine and job related dietary functions to ensure that Universal Precautions tasks are correctly identified.
6. Assisting the Quality Assessment and Assurance Committee in developing and implementing appropriate plans of action to deficiencies as identified.
7. Visiting residents periodically to determine likes and dislikes of food.
8. Reviewing therapeutic and regular diet plans and menus to ensure that they are in compliance with the physician's order.

SOCIAL SERVICES DUTIES AND RESPONSIBILITIES FOR QUALITY ASSURANCE AND ASSESSMENT

1. Developing and implementing policies and procedures for the identification of medically related social and emotional needs of the resident.
2. Interviewing residents and family members in a private setting.
3. Referring resident/family members to appropriate social services agencies when the facility does not provide the services or needs of the resident.
4. Providing consultation to members of our staff, community agencies, etc. in efforts to solve the needs and problems of the resident through the development of social services programs.
5. Assisting the Quality Assessment and Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies.

ACTIVITY SERVICES DUTIES AND RESPONSIBILITIES FOR QUALITY ASSURANCE AND ASSESSMENT

1. Providing an on-going program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental and physocial well-being of each resident.
2. Making available empowerment activities that promote increased

self-respect by providing opportunities for self-expression, personal responsibility and choice.

3. Making available maintenance activities that provide a schedule of events that promote physical, cognitive, social and emotional health.
4. Making available supportive activities that provide solace or stimulation to residents who cannot generally benefit from either maintenance or empowerment activities.
5. Maintaining an activities program that reflects those activities desired by the resident.
6. Participating in community planning related to the interests of the facility and the services and needs of the resident and family.
7. Performing administrative requirements , such as completing necessary forms, reports, etc. and submitting as required.
8. Assisting the Quality Assessment and Assurance Program in developing and implementing appropriate plans of action to correct identified deficiencies.
9. Developing and implementing an on-going orientation program.

SAFETY RESPONSIBILITIES OF THE QUALITY ASSESSMENT AND ASSURANCE PROGRAM

1. Reviewing employee accident and incident reports to identify health and safety hazards.

2. Reviewing resident accident and incident reports to identify health and safety hazards.
3. Promoting a safe and sanitary environment.
4. Reviewing handicap accessibility.
5. Summarizing the monthly accident and incident reports.
6. Demonstrating knowledge of trends, problems and recommended solutions to minimize accidents and safety hazards in the environment.
7. The medical director reviewing, dating and signing incident reports and making recommendations as needed.
8. Assuring that fire drills are conducted and properly documented in accordance with current regulations.
9. Assuring that the water temperatures are checked and adjusted as necessary for resident comfort and safety.
10. Assuring that a preventative maintenance schedule is maintained to keep the facility operating in an optimal manner.
11. Reviewing facility practices to ensure that acceptable standards of practice are maintained.

ENVIRONMENTAL SERVICES DUTIES AND RESPONSIBILITIES FOR QUARTERLY ASSURANCE AND ASSESSMENT

1. Assisting the environmental services staff in the development and use of departmental policies, procedure, equipment, supplies, etc.

2. Performing administrative duties such as completing forms, reports, evaluations, studies etc. to assure control of equipment and supplies.
3. Reviewing the department's policies, procedure manuals, job descriptions, etc. at least annually for revisions and recommendations.
4. Inspecting storage rooms, work areas, utility closets, etc. for upkeep and supply control.
5. Establishing a preventative maintenance program.

STAFF DEVELOPMENT JOB DUTIES AND RESPONSIBILITIES FOR QUARTERLY ASSURANCE AND ASSESSMENT

1. Developing, evaluating and controlling the quality of in-service educational programs in accordance with established policies and procedures.
2. Making written and oral reports to the Q.A.A. program.
3. Assisting with standardizing the methods in which will be accomplished.
4. Assisting the Q.A.A. coordinator in developing and implementing a Quality Assurance and Assessment Program for inservice training.
5. Developing, directing and scheduling refresher training, as necessary, for assigned staff and professional personnel.
6. Developing and maintaining an orientation for new employees.
7. Implementing recommendations from the Quality Assessment

and Assurance Committee as they relate to the educational needs of the facility.

8. Assuring that annual in-service training programs are conducted for:
   a. Prevention and control of infection
   b. Fire safety
   c. Confidentiality of resident information
   d. Preservation of dignity, including resident privacy
   e. Personal and property rights
   f. Disaster preparedness
   g. Universal Precautions to include CDC OSHA Guidelines
   h. OSHA guidelines for chemical use, including MSDS

INFECTION CONTROL FOR QUARTERLY ASSURANCE AND ASSESSMENT

1. Developing written policies and procedures for the prevention and control of infectious or communicable diseases within the facility.
2. Assisting in the development of the content and scope of the employee health program and disseminating current information on health practices to all employees.
3. Developing written policies and procedures for techniques and systems for identifying infections within the facility.
4. Notifying appropriate government agencies of contagious or infectious diseases.
5. Reviewing food handling procedures, laundry practices, waste

disposal, pest control, traffic control, visiting rules for high risk areas and sources of air-borne infections.

6. Evaluating each task performed within the facility to determine its risk exposure potential to blood and/or body fluids.
7. Developing written policies and procedures for the care of residents who have contagious, infectious or communicable diseases.
8. Monitoring the health status of all employees, ensuring that all personnel has appropriate skin tests, chest x-rays, physicals, etc. prior and during employment.
9. Ensuring that employees with contagious diseases are not assigned resident care services.
10. Ensuring that the facility is maintained in a sanitary manner.
11. Ensuring that infection control orientation and in-service training programs are provided to employees on a timely basis.
12. Making changes in isolation techniques as needed.
13. Reviewing all written policies and procedures for infection control at least annually for necessary changes.
14. Monitoring all findings from any resident care quality assessment activities that relate to infection control.
15. Evaluating the disposal systems for all liquid and solid waste.

RESTRAINTS

POLICY STATEMENT

It is the policy of this facility to provide the least restrictive environment possible. Restraints are used only as a last resort and only upon the consent of the resident and a written order from the physician. Under no circumstances will convenience of staff be an acceptable basis for use of restraints.

PROCEDURE

1. Drugs such as tranquilizers will not be used to limit or control resident behavior for the convenience of the staff.
2. Physical restraints such as belts, wrist or ankle cuffs and geri chairs will be used only upon the authorization of a physician. Physical restraints will not be used for the convenience of staff.
3. Our written policies and procedures governing the use of restraints specify which staff member may authorize the use of restraints and clearly delineate the following:
   a. Orders indicate the specific reason, type and period of time for the use of the restraints
   b. Their use is temporary and the resident will not be restrained for an indefinite amount of time
   c. Orders for restraints will not be enforced for longer

than twelve hours, unless the resident's condition requires continued treatment

d. A resident placed in a restraint will be checked at least every 30 minutes and released from the restraint every two hours for exercise and and repositioning

e. Their use is not employed as a form of punishment

4. There shall be no prn orders for restraints.

5. Physical restraints shall be applied in such a manner that they can be easily removed in the case of a fire or other emergency.

6. The resident's care plan shall indicate the type, and reason for the restraint.

PHYSICAL RESTRAINTS

POLICY STATEMENT

It is the policy of this facility that restraints be use only for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. In all instances their use is temporary only.

PROCEDURE

1. Restraints shall be used only with a physician's order.
2. Restraints shall be only of the soft type, with absolutely no locking restraints.
3. Restraint orders shall include:
   a. The specific type
   b. Reason for the restraint
   c. Length of time the restraint is to be used
4. Residents who are restrained shall be monitored every 30 minutes and released for exercise and repositioning every two hours.
5. The need for restraints shall be re-evaluated at least quarterly to determine their continued need.

CHEMICAL RESTRAINTS

POLICY STATEMENT

It is the policy of this facility that chemical restraints be used only after alternative methods have been unsuccessfully tried and only after informed consent has been obtained from the resident's representative and attending physician.

PROCEDURE

1. A chemical restraint is defined as a psychotropic or behavior modifying drug used to prevent a resident from exhibiting an identifiable maladaptative behavior.
2. Chemical restraints will not be used to limit or control resident behavior for the convenience of the staff.
3. In the case of evacuation, residents under the influence of chemical restraints will be placed in first priority of evacuation.
4. Antipsychotic drug therapy will be used only to treat a specific condition which includes:
   a. Schizophrenia
   b. Schizo-affective disorder
   c. Delusional disorder
   d. Psychotic mood disorders
   e. Acute psychotic disorders
   f. Brief reactive psychosis

g. Atypical psychosis

h. Tourette's disorder

i. Huntington's disease

j. Organic mental syndromes, including dementia, with associated psychotic and /or agitated features as defined by:

1. Specific behaviors, such as biting, kicking and scratching which are documented by the facility and cause the resident to:

a. Present a danger to themselves

b. Present a danger to others

c. Actually interfere with the ability to provide care

2. Continuous crying out, yelling or pacing, if these behaviors cause an impairment in functional capacity, and if they are documented by the facility

3. Antipsychotic drugs should not be used if one or more of the following is/are the only indication:

a. Wandering

b. Poor self care

c. Restlessness

d. Impaired memory

e. Anxiety

f. Depression

g. Insomnia

h. Unsociability

i. Indifference to surroundings

j. Fidgeting

k. Nervousness

l. Uncooperativeness

RESIDENT ASSESSMENTS

POLICY STATEMENT

It is the policy of this facility to develop and maintain an accurate, comprehensive assessment of the resident's needs which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

PROCEDURE

1. Preliminary Assessments
   a. Within 48 hours of the resident's admission, a preliminary assessment will be made so that the facility will know what care and services are necessary to meet the immediate needs of the resident.
   b. The preliminary assessment of the resident will be based on a medical evaluation completed at the time of admission and includes:
      1. Current medical finding
      2. Diagnosis
      3. Rehabilitation potential
      4. Summary of prior treatment
      5. Orders of immediate care of the resident
   c. The preliminary assessment is used to develop a care plan to assure that the immediate needs of the resident are met.

2. Comprehensive Assessments

a. Within 14 days of the resident's admission to the facility, a comprehensive assessment of the resident's needs will be made. This assessment includes:

1. Medically defined condition and prior medical history
2. Medical status measurement, including functional and mental capabilities
3. Sensory and physical impairments
4. Nutritional status and requirements
5. Special treatment or procedures
6. Phychosocial status
7. Discharge potential
8. Dental condition
9. Activity potential and interests
10. Rehabilitation potential
11. Cognitive status
12. Drug therapy

b. Short-term and long term goals and timetables to meet the needs of the resident are established from the comprehensive assessment.

c. Comprehensive assessments are reevaluated, and if necessary, updated every three months after the first comprehensive assessment.

d. The resident and his or her family will be an integral part of the comprehensive assessment.

RESTORATIVE SERVICES

POLICY STATEMENT

It is the policy of this facility that rehabilitative nursing care be provided for each resident admitted.

PROCEDURE

1. General rehabilitative nursing care is that which does not require the use of a qualified professional therapist to render such care.
2. Nursing personnel of the facility are trained in rehabilitative nursing care, and our facility has an active program of rehabilitative nursing care which is developed and coordinated through the resident's plan of care.
3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self care and independence.
4. Rehabilitative nursing care is performed daily for those residents who require such service. Such a program includes:
   a. Maintaining good body alignment and proper positioning
   b. Encouraging and assisting bed residents to change positions at least every two hours to stimulate circulation and prevent decubitus ulcers, contractures and deformities.
   c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contrary

indicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care and ambulation activities

d. Assisting residents to carry out prescribed therapy exercises between visits of the therapist
e. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests, if necessary
f. Assisting residents with routine range of motion exercises
g. Bowel and bladder training

REQUEST FOR THERAPY SERVICES

POLICY STATEMENT

It is the policy of this facility that therapy services be ordered by the resident's attending physician.

PROCEDURE

1. A physician's order must be obtained prior to requesting therapy services.
2. Once an order is obtained, the director of nursing services shall forward a request to the therapist.
3. Requests for therapy services must include at least:
   a. The resident's name and room number
   b. Age and sex of the resident
   c. Type of therapy ordered
   d. Diagnosis or complaint
   e. Objectives of the treatment
   f. Physician's recommendation

SCHEDULING THERAPY SERVICES

POLICY STATEMENT

It is the policy of this facility that therapy services be scheduled in accordance with the resident's treatment plan.

PROCEDURE

1. The therapist shall interview the resident and consult with the attending physician as to type of treatment to be administered.
2. Therapy is scheduled in coordination with nursing services and is to be documented in the resident's medical records.
3. A listing of residents receiving therapy is posted at each nurses' station. The listing contains:
   a. The name of the resident
   b. The room number of the resident
   c. The type of therapy ordered
   d. The time therapy is scheduled
   e. Where therapy is scheduled
   f. The name of the attending physician

SPECIALIZED REHABILITATIVE SERVICES

POLICY STATEMENT

It is the policy of this facility to provide or obtain rehabilitative services for every resident in this facility.

PROCEDURE

1. In addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel.
2. Specialized rehabilitative services include the following:
   a. Physical therapy
   b. Speech pathology/audiology
   c. Occupational/activity therapy
   d. Activity therapy
3. Rehabilitative services are provided only with physician authorization

CHAPTER 4

RESULTS

In the author's view, the overall feedback which was received on the culminating project, Policy and Procedure Manual for Long Term Care Facilities was definitely positive

After reading the manual, the majority of those interviewed, like many of us the long term care industry, indicated they are confused and uneasy about where the many changes facing the health care industry will lead us.

Most of these individuals wonder if the impact on nursing facilities would be so severe that long term care facilities would eventually be a thing of the past.

On the brighter side, all were in agreement that the new regulations governing long term care facilities would be an incentive for nursing facilities to operate in a manner that enhances the patient's quality of life.

The resident's rights should help to reinforce to perspective patients that maintenance of individual dignity and warmth and a homelike environment that is as warm and homelike as can be.

Six individuals, health care providers in the long term care field were interviewed. Their comments are as follows:

K.S. has been an administrator for the last five years in a 220 bed skilled facility commented.

During the last five years Medicare has undergone many changes. Each time the government begins to look at the budget, speculation runs wild. Owners and operators of the nursing facilities panic in the beginning only to see that, in the end, that while some changes did take place, they did not have as dramatic an impact as first thought. I am taking a wait and see attitude while putting some precautionary measures in place.

Looking at the new regulations going into effect, my facility should have little concern. We try to run our facility according to the needs of our residents as they would like to be treated. If they would not like it, chances are the patients will not like it either. It works for us.

E.R. has been the director of nursing in a 268 bed facility for the last three years. Prior to that she worked as a charge nurse in a 400+ bed facility for twelve years. She gave two different viewpoints, one as a member of the administrative team and the other as a member of the direct care staff.

Prior to becoming a director of nursing I had little concern for the bottom line. As a staff member my only concern was that administration must give me what I need to do my job with no thought of cost. Now, being in administrations, I have begun to understand the importance of balancing quality patient care with being cost effective.

With the changes that may take place in the foreseeable future, I often wonder if my facility will be able to maintain that competitive edge. With 99 percent of the patients in this facility being Medicaid, I am already comparison shopping, using more than one vendor and tightening the availability of overtime all the while maintaining quality care to the residents, It certainly has not been easy and the battle is not over yet.

A.D. has been a licensed nursing home administrator and one of the owners of four nursing facilities, two in South St. Louis and two in West County. She offered these comments.

When my husband and I first got into this business, it was relatively easy to make money on the Medicare patients. But each year we have seen changes in Medicare. Covered and number of Medicare days have decreased while the paper work required for reimbursement has increased.

I do feel that many of the changes that directly affect the patients are good, but there are some that are counter-productive and actually decrease the amount of time the professional staff provides care to the patient but increases the amount of paperwork, some of which is redundant. If a patient is clean, well cared for, happy, and active in his surroundings surely we must be doing something right.

With three out of four homes being predominately Medicaid, we are concerned with what impact the changes will have. So far we have survived the changes in the past, hopefully we will weather this new storm that is brewing.

R.P. and D.P. are the owners and operators of a 168 bed skilled facility that also has 13 residential care beds. They have operated the facility for 21 years and now include their two children as part of the administrative staff. These are their comments:

The changes that are inevitable to long term care facilities are so frightening that retirement is looking more and more appealing. If this facility does not pull through these changes, our lives and the lives of our children will be devastated.

We are all for quality care and treating the residents in a dignified manner. But now it appears there is a likelihood the same hospitals that turned their backs on the Medicaid patient in the past are now taking a second look and saying we can make money off of these patients; they are not returning these patients but are putting them in their own long term care facility. It is quite sad that the government appears to be sanctioning this and even appears to be pushing the non-hospital affiliated long term care facility out the back door by giving us such low reimbursement rates making it impossible for us to compete with the hospitals.

All we can do is cross our fingers and wait and see what happens. In the meantime, we will began to prepare for the upcoming inspections. We are definitely looking at the residents' rights issues that are being focused on. We will begin by educating our staff on the rights of the residents

but we will go further and have several of our more alert patients talk to staff to give their input on what it is like to live in this facility. They will tell us what they like and what they would like to change. In essence we will encourage our resident council group to be more active and verbal about their concerns. If we keep our residents happy, we will most likely keep our survey team happy and stay in compliance with the state and federal regulations.

A.B. is the medical director of three long term care facilities. Dr. B. has been involved in nursing facilities for eight years and offers the following comments:

I have spoken with the operators of the three facilities in which I am involved. All three speak of the uncertainty of the health care field, especially for long term care facilities.

From my perspective I see the regulations intensifying while the reimbursement rate is being seen in the traditional long term care setting. I must be very careful and very creative when billing Medicare and Medicaid. A claim can be denied easily if not billed under the correct code; these seem to change every two years or so.

I feel that some facilities try harder than others to provide their patients with quality care. There are those owners and operators who are only interested in the profits to be made, these are the facilities that will not do well in the survey process under the new regulations.

Those facilities willing to work very hard to find the most competitive vendors and who watch their pennies will probably survive the "new era of the health care system."

Physicians are becoming more aware of the needs of long term care facilities and are not as reluctant to get involved as they have been in the past. With the elderly population living longer, physicians now realize the importance of timely

and accurate diagnosis with appropriate treatment. No longer do we just assume because the patient is elderly that he had little or no rehabilitation potential.

The new regulations that mandate long term care facilities will also have a significant impact on the physician. We are being held accountable for the overall care of the patient but are not necessarily allowed to practice medicine in complete autonomy. Gone is the misnomer that the physician is all knowing. Today's long term care physician obtains information and input from the facility staff, family members and whenever possible, the patient, before prescribing a treatment plan.

Certainly some physicians are having difficulty releasing some of their power and autonomy, but if they are to remain in the long term care industry they will realize that it is in the best interest of the patient.

CHAPTER 5

SUMMARY

If any industry needed a global perspective, it is today's nursing home industry. Pushed away by various influences from its traditional chronic role and toward creating and competing with new levels of care, the industry seems to be scrambling in several different directions at once. "Go with the flow" may be the order of the day, but determining which flow to choose and exactly what "going with it" means is the problem.

The nursing home industry is becoming the most heavily regulated industry in the United States. Until this July 1, HCFA (Health Care Financing Administration) required correction of only major deficiencies by nursing facilities. If these were not corrected, homes could lose their certification. However before this year fewer than one percent each year did lose certification. Those days are over; HCFA is determined that all OBRA (Omnibus Reconciliation Act) mandates will be met. All deficiencies must be corrected, and if this is not done to surveyors' satisfaction, a variety of penalties can be imposed, including monetary fines and a change of management.

The author feels that long term care facilities must start today in preparing for the nest survey by addressing one Standard of Care at a time. As the facility looks at each Standard of

Care separately and identifies areas that need work, the leaders need to pull the team together to solve these problems; make the entire facility a part of the problem solving team. Failure to prepare now will only result in incurring huge fines, possible loss of some positions, and possibly some embarrassing local and national news. Worse yet, the facility would have neglected the welfare of human beings who have been entrusted to the facility's care.

The rights of residents have been a main focus during the last decade. One right in particular has been highly emphasized, and that is the right to be free of chemical or physical restraints. Using restraints on the elderly population became a focal point after several alarming incidents occurred: first, several long term care facilities across the country reported instances of elderly residents becoming becoming entangled in their vest restraints, strangling and dying; secondly, numerous complaints were received from family members that their loved ones who were once lively, involved people now sat for hours in wheelchairs staring listlessly about in a more or less constant stupor.

These incidents motivated HCFA to demand that long term care facilities find another way to protect elderly patients from self harm.

The author feels that facilities will be more successful if they employ a team approach, with input from occupational

therapy, physical therapy, nursing, social services and administration.

Education remains as one of most effective ways to reduce misuse. Educate them regarding the myths of restraint use, the side effects of use and the need for alternatives. The next step; is to assess why the restraint was considered to begin with. Many times the reasons are based simply on the patient's age or it is used for convenience for the staff. Third, as the patient becomes involved in activities, restraint use becomes less and less necessary.

Over time it has become quite apparent that finding the right alternative, the right activity, ant the right restorative program is essential for each and every resident, if we are to seriously reduce and eliminate restraint usage. The most important aspect of restraint reduction is establishing a facility philosophy and then educating all the staff accordingly. Ultimately you must believe that the use of restraints is not the solution, it is the problem. That is essential toward setting a new standard of care and enhancing the patient's quality of life.

Quality of life! Quality of care! What about the quality of staff. Why do some of our most important jobs get rewarded with such low status and pay?

While professional baseball players squabble over who gets

how many hundreds of thousands of dollars a year for batting a ball around, the nursing assistants who provide the bulk of the day-to-day care for our frail elderly usually earn not much more than minimum wage, and often get few or no benefits.

This is work that you would think we would value highly. After all, it could be our parents, or grandparents they are caring for, and one of these days, it may be us.

But that is not the message the government sends when it sets Medicaid rates too low to allow nursing assistants to earn more than minimum wage, no matter how much experience they have or how good they are at their job.

That is not the message we send as taxpayers, when we allow our money to be meted out that way.

That is not the message sent by many long term care administrators, who are too busy to learn their nursing assistants names, let alone to thank them for a job well done.

And finally that is not the message the media sends when they air or publish so few stories about good nursing assistants and so many about bad ones. That is not to say that a story like January's harrowing 20/20 report on patient abuse and theft by nursing assistants in long term care facilities is not valid, or that it does not need to be told. But many nursing assistants saw the story as part of the media's relentless focus on the negative in their profession. This one-sided view demoralizes the nursing assistants who care about what they do.

Those who care know their work is important. They hear it from their residents, and they feel it in their hearts. But that is not always enough to make up for low pay and a general lack of respect for their work. Over time, such things can erode lofty ideals about patient care, forcing even the most dedicated nursing assistants from the profession.

That is where long term care administrators can help, providing positive feedback to counteract the negative messages undermining their nursing assistant's morale. Even at facilities that cannot provide pay raises or opportunities for advancement, managers can still do a great deal. There is one simple principle: let your nursing assistants know that you value them and their work.

The author feels that the final insult, or assault compounding the long term care industry's already overwhelming concerns is the cut in financing that the government is proposing. The Federal government is about to "dump" the nation's elderly on the doorsteps of long term care facilities. A joint House-Senate budget agreement designed to balance the federal ledger contains provisions to dramatically cut program funding.

Specifically, lawmakers plan to parcel out Medicaid funds to states in the form of block grants in an effort to reduce Medicaid growth by $180 billion during the next seven years. Under a block grant program, states will essentially obtain

the authority to allocate Medicaid funds the way they see fit.

However, block grants are a budget policy, not a health policy. As such, they ignore the real problems associated with Medicaid: finding sufficient funding to meet demand without destroying the deficit. By failing to address the root causes of the problems associated with Medicaid spending, these problems will continue to plague both policy and beneficiaries. Block grants will result in states underfunding Medicaid, leaving nursing home residents and facility operators vulnerable to a huge financial liability.

The author feels strongly that there should be some reform for Medicaid and Medicare. However, it appears that the government once again is targeting one of the most vulnerable groups of people, the elderly. How sad that the government is sending this message to its elderly population: You are no longer of use, let's put you out to pasture now that our time of usefulness is over.

There is not a lot of hoopla surrounding the space project and little is being said about cutting this program. In addition maybe the government should consider spending fewer of our tax dollars to foreign countries and care for its population that has funded the federal government over the years.

With large numbers of people trying to contemplate the future of long term care, eventually a solution will be found. It would appear to the author that one viable consideration

might be to look at the ways other cultures provide for their elderly. Surely other countries have searched for and found more workable solutions.

Long term care operators will face two separate but interdependent dynamic forces this year: changes in the environment where they practice and changes in the practice itself.

In the business world there is a saying, "if you conduct business today the way you did yesterday, you will not be in business tomorrow."

Change in the long term care environment will be marked by continued evolution and adaptation as the industry adjusts to meet a changing marketplace.

Market forces will continue to fuel long term care's expansion toward a more complete continuum ranging from retirement housing to subacute care and specialty programs. Ultimately, as managed care continues to grow, the providers will see more contractual relationships.

Strategic planning and positioning will be the buzz words for 1996. Providers will work with their boards and communities to find new and better ways to provide long term care services. Provider organizations will be obsessed with positioning themselves to achieve maximum market penetration and service opportunities.

Health care reform has been driven not only by Washington

but also in response to changing market conditions that have been driving the environment for years and will continue to do so in 1996.

Ongoing regulatory mandates will do little to relieve anxiety among providers. But at the same time, facilities will be testing new concepts and venturing into new areas. They will do this in an attempt to meet the needs of an over-expanding long term care population.

Quality care is an issue that will continue to dominate the health care landscape as administrators grapple with how best to balance financing, quality of life and quality of care.

Increased consumer options and financing alternatives will further fragment the market. One result of these changes will be a compelling organizational mandate for administrators will face increased pressure to strategically localize their thinking and respond to local market needs.

Faced with market changes, administrators will be forced to seek stability to adapt so they can position themselves in a comfort zone of transition.

There is speculation that the United States could follow in the footsteps of Europe. In 1987, Denmark enacted legislation to place a moratorium on the construction of nursing homes and made group housing, what we call assisted living, the preferred type of long term care.

The moratorium served two purposes. In a country noted

for its social welfare programs and its recent crisis in funding these programs, it allowed the government to curtail spending on care for the elderly. A rapid rise in the number of elderly people being placed in nursing homes, which are funded by local municipalities, had resulted in a considerable increase in spending. Since the switch to group housing, these municipalities are spending much less.

Secondly, the moratorium was a response to an intensive review as to the purpose of the nursing home. So the focus in planning long term care was shifted from high cost, high tech skilled nursing care to low cost, residential group housing.

The remaining nursing homes now provide day care, subacute care, rehabilitation, and other outcome-oriented recuperative services. Danish and other Western European nursing homes are still well ahead of its American counterparts in both service programs and design. Most facilities are comprised completely of single private rooms, and the patients and family members play an active role in their operating, setting on various committees, including those that hire and fire employees.

Each staff member works exclusively with eight to twelve residents in a cluster or neighborhood and is considered part of the family group. Within these family groups, discussions are held to determine if the residents' needs are being met. Residents' biological families are also incorporated into the daily lives of the homes.

Up to now, the United States has been five to ten years behind Europe in its efforts to accommodate an increasing number of older, frailer people while containing costs. If that trend continues, Americans will soon see the waning of the nursing home. While some facilities will continue to provide long term medical care, most will house subacute and rehab programs. Most elderly people do not need the expensive 24 hour medical supervision of the skilled nursing environment. And it is difficult to imagine that, given a choice, people would opt to spend their last years in a medical institution rather than a residential home setting.

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